Best American Hospitality Corporation

Minimum Essential Coverage Plan

Plan Document
&
Summary Plan Description

Plan Administered By:

Preferred
BENEFIT ADMINISTRATORS
INCORPORATED

<u>This MEC Plan is NOT a comprehensive major medical plan</u>; covered services are limited to the Preventive Care benefits listed in the Schedule of Benefits.

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR
BEST AMERICAN HOSPITALITY CORPORATION MINIMUM ESSENTIAL COVERAGE PLAN
Effective January 1, 2016

INTRODUCTION

This document is a description of Best American Hospitality Corporation Minimum Essential Coverage Plan (the Plan). The Plan described is designed to provide Plan Participants with wellness/preventive care Benefits. This Plan is NOT a comprehensive major medical plan.

Changes in the Plan may occur in any or all parts of the Plan including Benefit Coverage, deductibles, maximums, exclusions, limitations, definitions and eligibility.

The purpose of the Plan is to pay covered preventive care medical expenses that are reasonable in amount. Charges in excess of reasonable fees will not be paid by the Plan.

The Plan will pay benefits only for expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage is terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

Best American Hospitality Corporation may amend or terminate the Plan at any time and will provide notice to all Participants.

If the Plan is terminated, the rights of covered Participants shall be limited to covered charges incurred before the date of termination.

Keep this document in a safe place for future use and reference. The Plan contains provisions, limitations and exclusions that could result in disqualifications, ineligibility, denial or loss of Benefits.

Any questions about Coverage should be directed to:

Preferred Benefit Administrators, Inc.
PO Box 916188
Longwood, FL 32791-6188

(407) 786-2777 or (888) 524-2777

The preventive care benefits described herein are provided through a Plan established and funded by your Employer.

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I. PLAN NAME

The name of the Plan is the Best American Hospitality Corporation Minimum Essential Coverage Plan. In this Plan Document and Summary Plan Description it will be referred to as the "Plan".

II. PLAN IDENTIFICATION NUMBER

The Employer identification number (EIN) assigned by the Internal Revenue Service is 06-1803115 and the Plan number is 501. The Group number assigned by the Claims Administrator is 427.

III. PLAN ADMINISTRATOR AND HEADQUARTERS

Best American Hospitality Corporation
1717 Elm Hill Pike, Suite B1
Nashville, TN 537210
Telephone Number: (615) 231-2333

IV. PLAN YEAR

The Plan year is from January 1st of each Calendar Year through December 31st of the same Calendar Year.

V. PLAN SPONSOR

Best American Hospitality Corporation established and sponsors the Plan.

VI. LEGAL PROCESS

Legal process may be served on Best American Hospitality Corporation, Plan Administrator, at the address shown above.

VII. PLAN CONTRIBUTIONS

Plan contributions are made jointly by Best American Hospitality Corporation and its covered Employees. COBRA Participants are responsible for the full cost of Coverage and are subject to the premium payment requirements outlined in this document.

VIII. PLAN TYPE AND ADMINISTRATION

Routine / Preventive Care Benefits are self-funded by the Plan. The self-funded Benefits are summarized in this document.

IX. CLAIMS ADMINISTRATOR

Preferred Benefit Administrators, Inc.
PO Box 916188
Longwood, FL 32791-6188
(407) 786-2777 or (888) 524-2777

X. DEFINITIONS

The following definitions have distinctive meanings and when used in this Plan will be capitalized.

A. "**Accident**" means an unforeseeable, unintentional and unplanned event resulting in a traumatic injury to a Participant occurring while this Plan is in force and resulting directly and independently of all other causes of loss covered by this Plan.

B. "**Actively at Work**" means the expenditure of time and energy by an Employee in the service of the Employer except that an Employee shall be deemed Actively at Work on each day of regular paid vacation or on a regular non-working day, on which he/she is not disabled provided he/she was Actively at Work on the last preceding regular working day. The Employer is responsible for providing documentation of active service if requested by the Claims Administrator.

C. "**Benefits**" or "**Coverage**" means Hospital, medical, surgical and authorized related expenses as hereinafter provided for which payment shall be made to or on behalf of a Participant.

D. "**Calendar Year**" means the period of twelve (12) consecutive months commencing at 12:00 a.m. on January 1 and ending at 12:00 midnight on December 31 of a given year. For Participants enrolling

during a Calendar Year, the “Calendar Year” begins on the effective date of their Coverage and ends on December 31 of that same year.

E. “**Claims Administrator**” means Preferred Benefit Administrators, Inc. or any Successor Corporation or entity.

F. "**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985 (H.R. 3128) signed into law on April 7, 1986 as Public Law number 99-272 and as amended.

G. "**Continuation Coverage**" means Coverage under the Plan that, at the time it is being provided, is the same as Coverage under the Plan being provided to similarly situated Employees and Dependents for whom a Qualifying Event has not occurred.

H. “**Co-pay/Co-payment**” means the portion of a Covered Expense that is paid by the Participant as specified in the Schedule of Benefits.

I. "**Covered Expenses**" means expenses up to a reasonable fee, for the services outlined in this Plan. The amount of a Covered Expense paid by the Plan may be subject to limitations as further set forth in this Plan or in the Schedule of Benefits.

J. “**Dependent**” means the Participant’s legal spouse who is a resident of the same country in which the Participant resides. The spouse must have met all of the requirements of a valid marriage contract in the state of marriage of the parties.

The Plan also recognizes a Domestic Partner as a Dependent and defines a Domestic Partnership as the personal relationship between individuals who are living together and sharing a common domestic life together but are not joined by any type of legal partnership, marriage or civil union.

The Definition of Dependent also includes any children from birth through the end of the Calendar month following the child’s 26th birthday.

The term “children” shall include:

1. Any natural or legally adopted children of the Employee or children placed in the covered Employee’s home in anticipation of adoption.

2. Any stepchildren of the Employee or the Employee’s legal spouse.

3. Any other children for whom the Employee has been appointed by a court as a legal guardian or legal custodian.

A Totally Disabled child that has reached the maximum age for a Dependent under the Plan shall continue to be considered an eligible Dependent provided:

1. the child is incapable of self-sustaining employment by reason of mental or physical handicap;
2. the child is unmarried; and,
3. the child is dependent upon the Employee for support.

It shall be the responsibility of the Employee to furnish acceptable proof documenting any such incapacity or dependency to the Claims Administrator.

No person may be covered as an Employee and Dependent under this Plan and no person may be covered as a Dependent of more than one Employee under this Plan.

The Claims Administrator may request documentation substantiating all Dependent relationships to the Employee at the time of enrollment or at any other time while the Dependent is covered under this Plan.

Children under age 18 who are in the “pre-adoption period” are eligible Dependents under the Plan and are not subject to any waiting periods or pre-existing limitations of the Plan. Such children are considered eligible Dependents under the Plan even though the adoption proceeding may not be final.

This Plan also recognizes Qualified Medical Child Support Orders (QMCSOs) by providing Benefits for Participants’ children without regard to Plan limitations requiring that Participants have custody or that they are able to claim the Dependent for tax purposes. A child who is the subject of a QMCSO is considered to be an “alternate recipient” under the benefit Plan and shall be treated as a Participant under the Plan. Children subject to QMCSOs shall not be excluded from waiting periods.

K. “**Employee**” means a person who is an active Employee of the Employer who meets one of the following eligibility requirements and holds a valid social security number:

1. Full-time or Part-time Salaried Manager or All Other Team Members.
2. Full-time Variable Hour Manager working at least 30 hours per week or All Other Team Members.

3. Part-time Variable Hour Managers working at least 30 hours per week or All Other Team Members.
4. Part-Time ACA Hourly / Non-Exempt Associate who works an average of at least 30 hours per week during the measurement period. You will be notified by the Employer if you meet the eligibility requirements during the measurement period. You will be eligible for Coverage through the Plan for a minimum of 12 months from the beginning of your stability period, unless termination of employment with the Employer occurs or you experience a qualified family status change.

L. "**Employer**" means Best American Hospitality Corporation and any subsidiaries, as defined in the Claims Administration Contract creating the Minimum Essential Coverage Plan.

M. "**Employment Waiting Period**" means the continuous period of time after full time employment begins before an Employee is first eligible to enroll. The Employment Waiting Period is 60 days with Coverage becoming effective on the day of the month following completion of the Employment Waiting Period.

N. "**ERISA**" is the Employee Retirement Income Security Act of 1974, as amended.

O. "**Experimental and/or Investigational**" means services, supplies, care 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 Administrator shall obtain an independent evaluation of the Experimental/non-Experimental standings of specific technologies.

The Experimental and/or Investigational procedure is any medical or surgical procedure, treatment, course of treatment, equipment, drug or medicine:

1. that is under investigation or is limited to research;

2. that is restricted to use in disciplined clinical efforts and scientific studies;

3. which is not proven in an objective way to have therapeutic value or benefit;

4. whose effectiveness is medically questionable;

5. which is not generally accepted by the medical community; or

6. which is a drug or device that has not received a required approval of the U.S. Food and Drug Administration.

This does not include any drug, or the Medically Necessary services associated with the administration of that drug, prescribed for the treatment of cancer that is not approved by the U.S. Food and Drug Administration for a particular indication, if that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature.

If a technology does not meet the above criteria, in whole or in significant part, it will be deemed Experimental and/or Investigational. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decisions of the Plan Administrator will be final and binding on the Plan.

P. "**Generic Drug**" means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Q. "**HIPAA**" means Health Insurance Portability & Accountability Act of 1996.

R. "**Illness**" means bodily disorder, Sickness, disease or infirmity of a Participant that has been or is diagnosed by a Physician.

S. "**Immediate Family**" means a covered Employee's mother, father, sister, brother, spouse or child(ren).

T. "**Late Entrant**" means an individual who enrolls for Coverage during an Open Enrollment Period after waiving initial eligibility to the Plan. Note, however, a Special Enrollee shall not be considered a Late Entrant.

U. "**Legal Separation**" means a marital and residential separation of a husband and wife whose respective rights and responsibilities to each other have been reduced to a legally binding agreement.

V. "**Medicare**" is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

W. "**Non-Participating Provider**" means a Provider who has not entered into an agreement with the Preferred Provider Organization (PPO).

X. "**Open Enrollment Period**" means the one-month period prior to the beginning of each Plan year in which a Late Entrant may access the Plan upon completion of an enrollment application.

Y. "**Outpatient**" means a patient who has not been admitted to a Hospital as an Inpatient.

Z. "**Participant**" means and includes the Employee and any of his or her legal Dependents covered under this Plan. Participant also means a Late Entrant and Special Enrollee and includes those Employees and their Dependents who qualify for Continuation Coverage under COBRA. Any Employee retiring shall not be eligible to participate in the Plan and shall not be a Participant.

Participant also means and includes those Employees who qualify for and take leave under the Family Medical Leave Act of 1993.

AA. "**Participating Provider**" means a Provider who has entered into an agreement with the Preferred Provider Organization (PPO).

BB. "**Pharmacy**" means a licensed establishment where Prescription drugs are dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices and acting within the scope of his/her license.

CC. "**Physician**" means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor or Chiropractic (D.C.), Psychologist (Ph.D.), Licensed Professional Physical Therapist, Physio-therapist, Licensed Professional Counselor, Psychiatrist, Audiologist, Speech Language Pathologist, Midwife, Licensed Social Worker, Licensed Mental Health Professional and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

DD. "**Plan**" means this Plan Document and Summary Plan Description including any Schedule of Benefits and Amendments attached hereto.

EE. "**Plan Administrator**" means Best American Hospitality Corporation, unless a person or committee of persons is designated by the Employer to administer the Plan on behalf of the Employer.

FF. "**Prescription**" means a request for medication or supplies by a Physician and/or pharmacist acting within the scope of their license.

GG. "**Provider**" means a person or organization providing services deemed to be Covered Expenses.

HH. "**Qualifying Event**" means the occurrence of an event as defined by COBRA and as specified in the Plan Document.

II. "**Reasonable and Customary**" is a charge that does not exceed the usual charge made by most Providers of like service in the same area. It will also consider the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience. All Benefits are computed on the basis of Reasonable and Customary fees as approved by the Plan Administrator. However, the PPO allowance will become Reasonable & Customary for services rendered by a PPO Provider when the contracted rates exceed the Reasonable & Customary charge.

JJ. "**Registered Graduate Nurse**" or "**Licensed Practical Nurse**" means a person duly licensed as such by the state in which such person is engaged in the practice of nursing.

KK. "**Sickness**" means a bodily disorder, Illness, or infirmity that has been or is diagnosed by a Physician.

LL. "**Special Enrollee**" means an eligible Employee or Dependent who is entitled to and requests enrollment in the Plan in accordance with a Special Enrollment Period.

MM. "**Special Enrollment Period**" means the thirty (30) day period following an individual's loss of other health coverage due to ineligibility, exhaustion of COBRA coverage, termination of employment, reduction in work hours or termination of employer contributions. Voluntary termination of coverage does not constitute a loss of eligibility.

An individual's loss of other health coverage may not be the result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim).

It shall also mean the thirty (30) day period following marriage of the Employee or the birth, adoption or placement for adoption of a dependent child.

An individual has sixty (60) days from the termination date of Medicaid or CHIP coverage to enroll for coverage under the Special Enrollment provisions of this Plan.

NN. "**Totally Disabled / Total Disability**" means a medically determinable physical or mental impairment which renders a Participant so incapacitated as to be unable to engage in most of the normal activities of a person of like age and sex in good health.

XI. ELIGIBILITY OF EMPLOYEES AND DEPENDENTS

A. A full-time Employee, as defined in Section X., Item K of this document, is eligible to participate in this Plan upon completion of the Employment Waiting Period.

B. Dependents eligible to participate are outlined in Section X., Item J. of this document. Benefits may be continued for a Dependent child who is physically or mentally handicapped.

C. If an Employee is eligible for Benefits, he/she is not eligible as a Dependent, except when both the Employee and the Employee's spouse are eligible Employees and he/she desires Dependent child(ren) Coverage. In this case the Employee may cover his/her spouse and children as Dependents for routine / preventive care benefits.

XII. ENROLLMENT AND COVERAGE EFFECTIVE DATE

A. To be covered under this Plan, an Employee must enroll for the routine / preventive care Benefits offered by the Employer.

B. To be assured Coverage, the Employee must complete an enrollment application before the end of the Employment Waiting Period. The Employee's Dependents should be enrolled at the same time, if they are eligible. The enrollment application must be completed in its entirety and must include social security numbers for all members enrolling in the Plan, as required by CMS-Medicare Secondary Payer Mandatory Reporting provisions (MMSEA Section 111). Once an Employee enrolls for Dependent Coverage, all newborn eligible Dependents are automatically covered.

C. If an Employee enrolls during the Employment Waiting Period and the enrollment application is received by the Claims Administrator no later than thirty (30) days following the eligibility date, Coverage will begin on the day following completion of the Employment Waiting Period.

D. Those eligible Employees who refuse Coverage under this Plan or fail to apply for Coverage within thirty (30) days following their eligibility date, may apply for Coverage during the next scheduled Open Enrollment Period or Special Enrollment Period, if applicable.

E. Coverage for a person who becomes an eligible Dependent of an Employee due to marriage shall become effective provided the Employee files an application within thirty (30) days of marriage and the Employee is duly enrolled. The effective date of such Coverage shall be the first day of the month following receipt by the Claims Administrator of notification. If the Employee fails to apply within the thirty (30) day period Coverage may not be requested until the next Open Enrollment Period or during a Special Enrollment Period, if applicable.

F. When changing from single to family Coverage due to the birth of a baby, a change application must be completed within thirty (30) days of the baby's birth for Coverage to be effective at the time of birth. If Coverage is not changed to family Coverage within this thirty (30) day period, Coverage may not be requested until the next Open Enrollment Period or Special Enrollment Period, if applicable. Once an Employee enrolls for family Coverage all newborn eligible Dependents will be automatically covered from the date of birth.

G. In the event an actively working Employee or spouse of an actively working Employee reaches age 65 or above, the Employee and/or spouse may elect to continue to be covered for the same Benefits available to Employees and spouses under age 65. If the Employers Health Plan is elected as the primary payor of claims, this Plan will pay all eligible expenses first and Medicare will process any remaining Medicare eligible expenses. If Medicare is elected as the primary Coverage, the Participant will not be eligible for Benefits under this Plan.

H. A covered Employee may remain eligible for a limited time if active, full-time work ceases due to disability. This continuance, for disability leave only, will end on the last day of the month following the three (3) calendar month period that the person last worked as an active Employee.

While continued, Coverage will be that which was in force on the last day worked as an active Employee. However, if Benefits reduce for other covered Employees, they will also reduce for the continued person.

I. Regardless of the established leave policies mentioned above and herein, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family Medical Leave Act, the Employer will maintain Coverage under this Plan on the same conditions as Coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

XIII. TERMINATION OF COVERAGE

Important Notice: If an Employee or any covered Dependent no longer meets the eligibility requirements of the Plan, the Employee and/or covered Dependents are responsible for notifying the Employer or Claims Administrator of the change in status. Coverage will not continue beyond the last date of eligibility even if notice has not been given to the Employer or Claims Administrator. Lack of timely notice could void COBRA eligibility.

Unless a Participant or his/her Dependents elect to continue Coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985:

A. Coverage will terminate on the last day of the month following termination of active full-time employment.

B. Coverage will terminate if the covered Employee fails to remit required contributions for Coverage when due.

C. Coverage will terminate on the day a covered Participant enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any Calendar Year. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

D. Coverage will terminate when a covered Participant ceases to maintain full-time residency in the United States of America or Canada.

E. Coverage for an Employee shall automatically cease at the end of the month such Employee no longer meets the definition of an Employee in this Plan.

F. Coverage for the spouse of an Employee shall automatically cease at the end of the month upon a divorce or Legal Separation of the spouse and Employee.

G. Coverage for the spouse and Dependents of an Employee shall automatically cease at the end of the month upon the death of the Employee.

H. Coverage for a Dependent child of an Employee shall automatically cease at the end of the month when the child no longer meets the definition of a Dependent.

I. Coverage for a spouse and Dependents will automatically cease when the Employee becomes entitled to and elects to receive primary Benefits provided under Title XVIII of the Social Security Act (Medicare).

J. Coverage for all Participants shall cease upon termination of this Plan.

XIV. CONTINUATION COVERAGE FOR COBRA PARTICIPANTS

As required by COBRA, each qualified beneficiary who will lose Coverage under the Plan as a result of a Qualifying Event shall be entitled to elect, within the election period, Continuation Coverage under the Plan.

A. "Qualifying Events" are:

1. The death of a covered Employee.

2. The termination of a covered Employee's employment, or the reduction in hours of a covered Employee's employment, except by reason of gross misconduct, ("termination/reduction").

3. The divorce or Legal Separation of the covered Employee.

4. A Dependent child ceasing to be eligible for Coverage as a Dependent child under the Plan.

5. The covered Employee becoming entitled to Medicare Benefits.

B. Qualified beneficiaries are specified individuals who will lose Coverage under the Plan as a result of a Qualifying Event. In general, an individual is deemed to "lose Coverage" under the Plan if Coverage under the Plan will no longer be available to him/her under the same terms and conditions as in effect

prior to the Qualifying Event. For all Qualifying Events, "qualified beneficiaries" are the spouse and Dependent children of a covered Employee who are Participants on the day before a Qualifying Event. In the case of a Qualifying Event that is a termination/reduction, the covered Employee is also a qualified beneficiary.

C. Subject to this Section, Continuation Coverage for COBRA Participants and paragraph E of this Section, the maximum required period of Continuation Coverage shall be determined as follows:

1. For a termination/reduction, the period of Continuation Coverage begins on the date of the termination/ reduction and ends eighteen (18) months later. If a qualified beneficiary is Totally Disabled at the time of or within sixty (60) days following the Qualifying Event as determined under Title II or XVI of the Social Security Act, Continuation Coverage may extend to a maximum of twenty-nine (29) months, provided the qualified beneficiary has given notice of Total Disability to the Plan Administrator before the end of the eighteen (18) months.

2. For any other Qualifying Event, the period of Continuation Coverage begins on the date of the Qualifying Event and ends thirty-six (36) months later. **EXCEPTION**: If a Qualifying Event other than a termination/reduction occurs within the eighteen (18) months following a termination/reduction, then the thirty-six (36) month period of Continuation Coverage begins on the date of the termination/reduction. (Also see paragraph **G.2.** of this Section.)

D. Continuation Coverage for all qualified beneficiaries shall end on the date the Employer ceases to provide any group health plan to any Employee or on the date the maximum Continuation Coverage period expires for a Qualifying Event. Furthermore, Continuation Coverage for a qualified beneficiary shall not be provided on or after the date the first of the following occurs:

1. Payment of a contribution for the qualified beneficiary's Continuation Coverage is not made within thirty (30) days of the date it is due.

2. The qualified beneficiary is covered under another group health plan, unless the other group health plan excludes or limits Pre-Existing Conditions, and the qualified beneficiary has a Pre-Existing Condition.

Note: Qualified beneficiaries who are covered under another group health plan on the date of election may elect Continuation Coverage, however, this Plan shall be considered the secondary payor for all claims incurred.

3. The qualified beneficiary is entitled to Medicare Benefits.

E. Qualified beneficiaries shall make contributions for Continuation Coverage which shall not exceed 102% of the reasonable estimate of the cost of providing Coverage for similarly situated Employees and Dependents for whom a Qualifying Event has not occurred, as determined on an actuarial basis in accordance with any regulations under COBRA. Employers may charge 150% of the reasonable estimate of the cost for disabled qualified beneficiaries beginning in month nineteen (19) to month twenty-nine (29). Contributions for Continuation Coverage shall be made in monthly installments. If an election is made after the Qualifying Event, a qualified beneficiary shall have forty-five (45) days from the date of election to pay the applicable contribution for Coverage that was in effect prior to the date of election.

F. The "election period" begins no later than the date Coverage under the Plan would otherwise terminate and ends sixty (60) days following the later of the date notice is sent to qualified beneficiaries or the date Coverage under the Plan would otherwise terminate. Continuation Coverage shall not be provided to any qualified beneficiary for whom an election is not made during the election period.

G. The following notice requirements apply:

1. In the event of a covered Employee's death or termination/reduction, the Employer shall within thirty (30) days notify the Plan Administrator. The Plan Administrator shall then, within fourteen (14) days, notify qualified beneficiaries of their right to elect Continuation Coverage.

2. In the event of a covered Employee's divorce or Legal Separation or a Dependent child ceasing to be eligible for Coverage as a Dependent under the Plan, the Employee or the qualified beneficiary is required to notify the Plan Administrator within sixty (60) days of the Qualifying Event. Upon receipt of notice, the Plan Administrator shall, within fourteen (14) days, notify qualified beneficiaries of their right to elect Continuation Coverage. Continuation Coverage shall not be provided to any qualified beneficiary on whose behalf notification of divorce, Legal Separation or a Dependent child ceasing to be eligible for Coverage as a Dependent under the Plan is not made to the Plan Administrator within sixty (60) days.

3. Qualified beneficiaries must notify the Plan Administrator within sixty (60) days after it has been determined that they were disabled at the time of or within sixty (60) days following the Qualifying Event, as determined under Title II or XVI of the Social Security Act, and within thirty (30) days after a determination has been made that the qualified beneficiary is no longer disabled. The Participant must submit their letter from the Social Security Administration confirming the disability status.

4. Notice to qualified beneficiaries shall be by first class mail to their last known address. The Employer shall notify the Claims Administrator as soon as possible of an election of Continuation Coverage.

H. If a qualified beneficiary's Continuation Coverage lasts the maximum required period, the qualified beneficiary may apply for any conversion Plan otherwise generally available during the last one hundred and eighty (180) days of his/her Continuation Coverage.

XV. DEDUCTIBLE & CO-PAYMENTS

This Minimum Essential Coverage Plan does not contain any Deductibles or member Co-payments. All routine / preventive care services are outlined in the Schedule of Benefits.

XVI. MAXIMUM EXPENSE TO PARTICIPANTS

This Minimum Essential Coverage Plan does not require any member cost sharing. All routine / preventive care services outlined in the Schedule of Benefits are payable at 100% by the Plan.

XVII. PREFERRED PROVIDERS & NON-PREFERRED PROVIDERS

A. Expenses incurred by Non-Participating Provider's are not eligible for reimbursement by the Plan.

B. The Claims Administrator and/or Plan Administrator reserve the right to obtain direct provider discounts and/or contracts that result in Plan savings. Payment to the providers of service shall be at the PPO Provider level if a comparable PPO discount is obtained.

C. PPO Provider charges are not subject to the Reasonable & Customary provisions of the Plan.

D. Participants are responsible for verifying that a provider is considered a PPO Provider prior to or at the time services are rendered.

XVIII. CONDITIONS FOR RENDERING SERVICE

A. The Participant should present the identification card issued by the Claims Administrator when applying for Physician services.

B. The Participant is at liberty to select his or her Physician. Nothing contained herein shall interfere with the ordinary relationship between the Participant and the Physician selected by the Participant.

C. The Plan does not undertake to furnish any services but merely to pay Physicians for services to the Participant to the extent herein specified. The Plan shall not, in any event, be liable for any negligence, misfeasance, nonfeasance, malfeasance, malpractice or any act of commission or omission on the part of any Physician, Hospital, or other health care Provider, or the agent or employee of any Physician, Hospital, or other health care Provider.

XIX. COVERED EXPENSES

Each Participant is entitled to the services listed below when incurred while the Plan is in force and when necessary and consistent with the Preventive Care services for which the Participant is being treated.

A. Preventive Care / Wellness Services

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 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 as specified in the Schedule of Benefits.
12. Obesity screening and counseling for all 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.

B. Preventive Care 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 1 to 2 years for women over 40.
5. Breast Cancer Chemoprevention counseling for women at higher risk.
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
7. Cervical Cancer screening 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 and 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 24 to 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 years for women with normal cytology results who are 30 or older.
17. Osteoporosis screening for women over age 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.

C. Preventive Care Services for Children

1. Alcohol and drug use assessments for adolescents.
2. Autism screening for Children at 18 and 24 months.
3. Behavioral assessments for Children of all ages (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years).
4. Blood Pressure screening for Children (ages: 0 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 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.

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 18 as specified in the Schedule of Benefits.

18. Iron supplements for Children ages 6 to 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 and screening for adolescents at higher 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.

XX. EXCLUSIONS AND LIMITATIONS

Coverage under this Plan is subject to the following exclusions and limitations for which no Benefits shall be paid:

A. Fees in excess of any maximums specified in the Schedule of Benefits or fees in excess of reasonable fees.

B. Any Benefit or service provided after Coverage has been terminated for the group or for the Participant.

C. Treatment, care, services or supplies that are obtained without cost to the Participant.

D. Treatment, care, services or supplies for which the Participant would have no obligation for payment if such Participant were not eligible under this Plan.

E. Professional medical or surgical services rendered by an individual who is related to the Participant by blood or marriage.

F. Benefits payable under this Plan will be limited to services provided and expenses incurred within the United States.

G. Alcohol and substance abuse treatment.

H. Treatment of mental and nervous conditions.

I. Ambulance and medical transportation services.

J. Emergency Room services.

K. All services and treatment related to an inpatient hospital confinement.

L. Home Health Care services.

M. Hospice Care services.

N. Prosthetic appliances.

O. Durable Medical Equipment.

P. Crutches, braces, standard model wheelchair or other mechanical appliances.

Q. Cardiac Pacemakers.

R. Services of a cardiac rehabilitation facility for cardiac rehabilitation.

S. Services rendered by any Physician employed by, or rendered in, any Veterans Hospital or other Hospital or health facility operated by the United States Government or any agency thereof, or operated by any other government, for service connected or related conditions.

T. Services for injuries sustained or Sickness contracted while in any military force of any country while such country is engaged in war (whether or not declared) or hostilities of any kind, or while performing police duty as a member of any military organization.

U. Services or supplies for injury or Sickness resulting from suicide or attempted suicide, self-inflicted injury or self-induced Sickness.

V. Services, supplies and any and all expenses resulting from substance abuse, alcohol abuse, intoxication, consumption, and/or injuries resulting from such.

W. Charges in connection with an illness or injury of the Participant resulting from or occurring during the commission or attempted commission of a criminal battery or felony by the Participant or if the Participant is engaged in an illegal occupation.

X. Fees for physical examination or periodic checkups, except as otherwise specifically stated.

Y. Mastectomy services.

Z. Occupational therapy, Physical therapy and /or Speech therapy.

AA. Chiropractic care and all services related to the adjustment of the spine.

BB. Dental care and treatment rendered by a Physician or dentist.

CC. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

DD. Excision of benign bony growths of the jaw and hard palate.

EE. External incision and drainage of cellulitis.

FF. Incision of sensory sinuses, salivary glands or ducts.

GG. Removal of Impacted Teeth.

HH. Eye examinations, refractions, keratotomy, eyeglasses, hearing aids and examinations or the Prescription or fitting thereof.

II. Services or supplies for beautifying or cosmetic purposes or for complications of such surgery.

JJ. All services, supplies and surgical procedures for the treatment of weight control and morbid obesity including, but not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict the ability to assimilate food.

KK. Services or supplies for surgery for sexual reassignment or reconstruction, reverse sterilization or for complications of all such surgery. This exclusion includes medications, implants, hormone therapy, surgery and medical or psychiatric treatment.

LL. Services for any occupational condition, Sickness or injury arising out of or in the course of employment for wage or profit or any other endeavor for potential profit or gain including self-employment. The Participant shall have no right under this Plan to receive Benefits for services for any occupational condition, Sickness or injury described in this paragraph even though he elects to waive his rights under the laws of the United States or any state or political subdivision to such Benefits or services.

MM. Services and supplies provided by any custodial institution, rest home, nursing home, sanitarium, health spa, health resort; or place for rest, the aged, drug addicts, alcoholics or for the treatment of pulmonary tuberculosis or mental or nervous disorders.

NN. Any service to a Participant hospitalized primarily for rest, rest/cure, or primarily for observation.

OO. Rehabilitative services, such as recreational therapy, or any similar services by whatever name.

PP. Diagnosis, care and treatment of developmental delays and learning disabilities.

QQ. Biofeedback.

RR. Personal comfort or convenience items, services or supplies not directly related to the Participant's care, including, but not limited to: admission kit, guest meals, accommodations, telephone charges, communications, travel or travel time even if prescribed by a Physician.

SS. Air conditioners, dehumidifiers, air purifiers, home exercise or rehabilitative equipment, or any non-Durable Medical Equipment.

TT. Treatment, care, services or supplies for maintenance care.

UU. Transplants of any type.

VV. Charges for maternity expenses.

WW. All Maternity and pregnancy related charges, including any complications of such pregnancy, incurred by a covered Participant serving as a surrogate mother shall not be considered an eligible Plan expense. For the purpose of this plan, the child of a surrogate mother will not be considered a Dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth.

XX. Artificial insemination, in-vitro fertilization or any other form of artificial impregnation, and any treatment, testing, care, services, supplies or complications related to the artificial impregnation.

YY. Infertility.

ZZ. Elective abortions.

AAA. Over-the-counter medications including vitamins.

BBB. Prescriptions medications, unless otherwise specifically stated.

CCC. Routine foot care, including the paring and removing of corns and calluses or trimming of nails.

DDD. Treatment of flat feet or subluxation of the foot including but not limited to shoes, shoe orthotics, shoe inserts and arch supports.

EEE. All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

FFF. Services for procedures, appliances or restorations necessary to increase vertical dimension in the oral cavity, to restore occlusion or for purposes of splinting to include craniomandibular orthopedic repositioning, orthotics, or interdental wiring.

GGG. Acupuncture or acupressure treatment.

HHH. Massage Therapy.

III. Treatment of sleep apnea, including sleep studies.

JJJ. Travel or accommodations, whether or not recommended by a Physician.

KKK. Hypnosis.

LLL. Charges for nicotine addiction, diet control and/or diet supplements.

XXI. COORDINATION OF BENEFITS

Some persons have medical Coverage in addition to Coverage under this Plan. When this is the case the Benefits from "other plans" will be taken into account. This may mean a reduction in Benefits under this Plan.

A. All routine / preventive care Benefits provided under this Plan are subject to Coordination of Benefits. When a Participant is covered by an "other plan", the order of Benefit determination in Paragraph B of this Section outlines which plan is primary and which plan is secondary. The primary plan pays Benefits first without any consideration of the "other plan". The secondary plan then pays the difference between all allowable expense and the Benefits paid by the primary plan, not to exceed the Benefits available under this Plan. At no time should the total Benefits paid exceed 100% of all allowable expenses.

B. The following determines which plan is primary when the claim is for the Employee or for a covered spouse:

1. The group plan that has no coordination of Benefits.

2. The group plan that covers the Participant as an Employee.

3. When (1) or (2) of this paragraph do not establish which group plan is primary, the Benefits of the group plan which has covered the Participant for the longer period of time shall be determined before the Benefits of a group plan which has covered the Participant the shorter

period of time, provided the Benefits of the group plan covering the Participant as a non-active Employee shall be determined after the Benefits of any other group plan covering the Participant as an active Employee.

4. The group plan that covers the individual as an Employee (or as that person's Dependent) when that individual has elected to continue Coverage with COBRA on another group plan.

C. The following determines which group plan is primary when the claim is for a covered Dependent child:

1. The group plan that has no coordination of Benefits.

2. When the parents are legally married, the group plan covering the parent whose birthday falls earlier in the year.

3. When the parents are divorced, and a court of law has decreed financial responsibility for health care costs, the group plan of that parent is primary.

4. When the parents are divorced, and the parent with custody has not remarried, that parent's group plan is primary. If the parents are subject to joint custody and neither is designated in the divorce decree as being specifically responsible for health care costs, the parent whose birthday falls earlier in the year is primary.

5. When the parents are divorced, and the parent with custody has remarried, the following order will apply:

   a. The group plan of the parent who has custody.

   b. The group plan of the step-parent.

   c. The group plan of the parent who does not have custody.

   d. If the parents are subject to joint custody and neither is designated in the divorce decree as being specifically responsible for health care costs, the parent whose birthday falls earlier in the year is primary.

6. The group plan that covers the individual as an Employee (or as that person's Dependent) when that individual has elected to continue Coverage with COBRA on another group plan.

7. If the primary group plan cannot be determined by items 1 through 6, the plan which has continuously covered the child longer will be primary.

D. "**Other plan**" means the following plans or insurance Coverage:

1. Any group plan, program or insurance policy providing Benefits for Hospital, medical and/or other health care expenses under a group master policy including, but not limited to, policies issued to any health maintenance organization or any entity to which such policies may legally be issued for the purpose of insuring a group of individuals.

2. Any plan, program or insurance policy and/or medical payment automobile insurance or Personal Injury Protection (PIP) Coverage as required and defined by statute where the Participant legally resides, which provides Benefits or make payments to or on behalf of a Participant for Hospital, medical and/or other health care expenses.

3. Any group contract issued to this Plan.

4. Any Coverage under a group plan or law of any federal, state or local government or any political subdivision thereof, including but not limited to, Coverage under Medicare and/or other federal, state or local government sponsored program or programs, unless otherwise provided by law. Medicare will be primary or secondary to the extent stated in Federal Law.

E. A Participant shall have no right to Benefits under this Plan if the Participant elects to waive any entitlement to Benefits provided under any plan described in paragraph D. The Participant shall provide any information, execute and deliver any legal instruments or papers, and do whatever else is necessary to secure the Plan's rights under this Section.

XXII. HOW TO SUBMIT A CLAIM

In most circumstances, the medical provider of service will file claims on a Participants behalf with the Claims Administrator. However, in the event a Participant pays the medical provider at the time of service, the Participant may file a claim directly with the Claims Administrator for reimbursement. In order to avoid a delay in processing, the Participant should follow the steps outlined below:

A. Review the medical claim to be sure the Employee name, patient name, member ID number and group number appear on the bill.

B. Verify that the medical provider name, address and Tax ID number appear on the bill.

C. Verify that the bill you are submitting is an actual claim with dates of service, procedure codes and corresponding charges on it. Balance due bills from providers usually do not contain this pertinent information on them.

D. Keep a copy for your own records and mail all claims to:

Preferred Benefit Administrators, Inc.
PO Box 916188
Longwood, FL 32791-6188

XXIII. WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the services were incurred. Claims filed later than that date may be declined or reduced **unless**:

A. it is not reasonably possible to submit the claim in that time; and

B. the claim is submitted within one year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

Note: The Employer has no responsibility to fund claims that are submitted after the above filing deadline.

XXIV. CLAIM DETERMINATION

A. Urgent Care Claims:

Determination for any pre-service Urgent Care Claims (whether adverse or not) must take place as soon as possible but no longer than seventy-two (72) hours, unless the Participant fails to provide sufficient information to determine whether, or to what extent, Benefits are covered or payable under this Plan. In the case of such failure, the Claims Administrator shall notify the Participant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Participant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Claims Administrator shall notify the Participant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded by the Participant to provide the additional information.

Urgent Care Claims must be decided within seventy-two (72) hours. There is no extension of time allowed for claims involving urgent care.

B. Pre-Service Claims:

Pre-Service Claims must be decided within a maximum of fifteen (15) days at the initial level and up to thirty (30) days following and Adverse Benefit Determination. In the case of a failure by a Participant or and Authorized Representative of a Participant to follow the Plan's procedures for filing a Pre-Service Claim, the Participant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for Benefits. This notification shall be provided to the Participant or Authorized Representative, as appropriate, as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Participant or Authorized Representative.

C. Post-Service Claims:

Post-Service Claims must be decided within thirty (30) days for the initial decision and a maximum of sixty (60) days on review.

D. Filing Extensions:

The Plan may extend determination on both Pre-Service and Post-Service claims for one additional period of fifteen (15) days after expiration of the relevant initial period, if the Claims Administrator determines that such an extension is necessary for reasons beyond the control of the Plan. Delays caused by cyclical or seasonal fluctuations in claims volume are not considered to be matters beyond the control of the Plan that would justify an extension.

If the reason for taking the extension is the failure of the Participant to provide necessary information, the time period for making the determination is tolled from the date on which notice of the necessary information is sent to the Participant until the date on which the Participant responds to the notice. The time periods for making a decision are considered to commence to run when a claim is filed in accordance with the reasonable filing procedures of the Plan, without regard to whether all the information necessary to decide the claim accompanies the filing.

E. Concurrent Care Decisions:

If a plan has approved an ongoing course of treatment to be provided over a period of time, or a number of treatments, any reduction or termination by the Plan (other than by plan amendments or termination) before the end of such period of time or number of treatments shall be considered an Adverse Benefit Determination. The Claims Administrator shall notify the Participant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving urgent care, shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator shall notify the Participant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

F. Adverse Benefit Determination:

The notice of an Adverse Benefit Determination will either include the protocol in which it was based upon or a statement that a protocol was relied upon and that a copy is available free of charge upon receipt by the Participant.

Notification of an Adverse Benefit Determination (at both the initial level and on review) based on medical necessity, experimental treatment, or other similar exclusion or limit will be explained as to the scientific or clinical judgment of the Plan to the Participant's medical circumstances, or an explanation will be provided free of charge to the Participant upon request.

Where the Plan utilizes a special internal rule or protocol, it must furnish the protocol to the Participant or their Authorized Representative upon request.

G. The Plan will recognize an Authorized Representative, including a health care provider, acting on behalf of a Participant. The Plan will recognize a Health Care Professional with knowledge of a Participant's medical condition as the Claimant's representative in connection with an Urgent Care Claim. Procedures will be established by the Plan for verifying that an individual has been authorized to act on behalf of a Participant.

XXV. RIGHT OF REVIEW AND APPEAL

A Participant has up to one hundred eighty (180) days to file an appeal of an Adverse Benefit Determination. As part of the appeal process, a Participant has the right to (a) review this Plan and other relevant documents, (b) argue against the denial in writing, and (c) have a representative act on behalf of the Participant in the appeal. All relevant documents will be provided free of charge, upon request by the Participant, after receiving an Adverse Benefit Determination. A document, record or other information is considered relevant if it was relied upon in making the benefit determination, if it demonstrates compliance with the administrative processes, or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Participant's diagnosis, without regard to whether such advice or statement was relied upon in making the determination.

If the Participant or Authorized Representative appeals an Adverse Benefit Determination, the Claims Administrator will respond to the appeal within seventy-two (72) hours for an Urgent Care Claim, thirty (30) days for a Pre-Service Claim, and sixty (60) days for a Post-Service Claim. The notice will specify the reason for the denial or describe the additional information required to process the claim. Written denial will include the specific reasons for the denial with reference to this Plan Document, a description and need for any other material pertinent to the claim and an explanation of this Plan's review procedures with the names of any medical professionals consulted as part of the claims process.

A full and fair review of an Adverse Benefit Determination will be performed by an appropriate named fiduciary, which is neither the party who made the initial adverse determination, nor the subordinate of such person. The review will not defer to the initial Adverse Benefit Determination. The review will take into account all comments, documents, records and other information submitted by the Participant, without regard to whether such information was previously submitted or considered in the initial determination.

If the review results in another Adverse Benefit Determination, it shall include specific reasons for denial, written in a manner understandable to the Participant, and will contain specific reference to the pertinent Plan provisions upon which the decision was based.

A Participant must follow the Right of Review and Appeal procedures listed above before initiating any legal actions. These are the Participant's administrative remedies, which must be exhausted before legal action may be pursued.

If the Plan fails to provide procedures in compliance with the regulation, or the required procedures, the Participant is deemed to have exhausted the administrative remedies and is free to pursue legal action as provided in ERISA on the basis that the Plan has failed to provide a reasonable claim procedure that would yield a decision on the merits of the claim.

XXVI. PAYMENT OF BENEFITS, ASSIGNMENT

Benefits provided under this Plan may be paid to the Participant or to the institution or person who has provided or paid for such services or supplies for which such Benefits are payable. Such Benefits may be assigned by the Participant to such institution or persons and will be paid according to the Participant's designation on the claim form, but only to the extent such institution or person's interest shall appear; otherwise this Plan and such Benefits are non-assignable. If Benefits are paid prior to the receipt and acceptance by the Claims Administrator of any assignment of such Benefits, the assignment shall be null and void and unenforceable against the Plan.

In the event an Employee or Dependent dies, or is physically, mentally or otherwise incapable of making payments due to a Provider, Plan Benefits may be paid directly to the Provider or to any person or institution appearing to assume responsibility for the expense. This payment shall discharge the Plan's obligation for such expense.

XXVII. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a Participant in Best American Hospitality Corporation Minimum Essential Coverage Plan you are 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:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. 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.

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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) Benefit or exercising your rights under ERISA.

If your claim for a (pension, welfare) Benefit is denied in whole or in part you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of a reason beyond the control of the administrator.

If you have a claim for Benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA and the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you should contact either the nearest Area Office of the U.S. Pension and

Welfare Benefits Administration, Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

XXVIII. USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Plan will use Protected Health Information (PHI) to the extent and 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.

A. Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibilities for coverage and provision of plan benefits that relate to an individual whom health care is provided. These activities include but are not limited to the following:

1. Determination of eligibility;
2. Coverage and cost sharing amounts (for example, cost of a Benefit, plan maximums and Co-payments as determined for a Participant's claim;
3. Coordination of Benefits;
4. Adjudication of routine / preventive benefit claims (including appeals and other payment disputes);
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 health care 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. Utilization review, including pre-authorization, concurrent review and retrospective review;
12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name, address, date of birth, social security number, payment history, account number and name and address of the provider and/or health plan); and
13. Reimbursement to the Plan.

B. Health care operations include, but are not limited to the following activities:

1. Quality assessment;
2. Population-based activities relating 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 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 ceding, 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 analysis 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 Participants, Plan Sponsors or other customers.
8. Resolution of internal grievances; and
9. Due diligence in connection with the sale or transfer of assets to a potential successor or in interest, if the potential successor in interest is a covered entity under HIPAA or, following completion of the sale or transfer, will become a covered entity.

C. The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or beneficiary. With an authorization, the Plan will disclose PHI to the benefit plan of the Employer.

D. The Plan may disclose PHI to the Plan Administrator and the Plan Administrator agrees:

1. Not to use or further disclose PHI other than as permitted or required by the plan document or as required by law;

2. To ensure that any agents, including a subcontractor and the Claims Administrator, 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 to use or disclose PHI for employment related actions and decisions unless authorized by the Employee;

4. Not to use or disclose PHI in connection with any other benefit or Employee benefit plan of the Plan Administrator unless authorized by the Employee;

5. To report to the Plan any PHI use or disclosure that is inconsistent with the uses and disclosures provided for of which it becomes aware;

6. To make PHI available to an individual in accordance with HIPAA's access requirements.

7. To make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. To make available the information required to provide an account of disclosures;

9. To make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

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).

E. Adequate separation between the Plan and the Plan Administrator must be maintained. In accordance with HIPAA, only the following Employees or classes of Employees may be given access to PHI:

1. The Benefits Manager or other authorized representative of the Plan; and/or

2. Staff designated by the Benefits Manager or other authorized representative of the Plan.

F. The persons described in this section may only have access to and use and disclose PHI for Plan administration functions that the Plan Administrator performs for the Plan.

G. If the persons described in this section do not comply with this Plan document, the Plan Administrator shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

XXIX. GENERAL PROVISIONS

A. The Claims Administrator will issue to the Employer for delivery to each Participating Employee covered hereunder a Plan Document and Summary Plan Description and an identification card, which the Employee or his eligible covered Dependents can present to a Hospital and/or Physician in claiming Benefits due under this Plan.

It shall be the Employer's responsibility to disseminate to the Employees the Plan Document and Summary Plan Description and the Employee identification card. The Employee's Benefits are non-assignable prior to a claim. If any amendment to this Plan shall materially affect any Benefits, Summary Plan Descriptions, or Schedules of Benefits as required by law shall be delivered to the participating Employer to be distributed to Employees. The Plan shall provide Benefits that are designed to meet the needs of the Participants and that are based on actuarial soundness. The Plan may be modified or discontinued by the Plan Administrator at any time. Notices of modification or discontinuance must be given to the Participants and all parties of interest as required by law.

B. All statements made by the Employer or the Employees of such Employer shall be deemed representations and not warranties, and no such statement made for the purpose of effecting Coverage shall void such Coverage or reduce Benefits unless contained in a written instrument signed by the Employer or Employee of such Employer and a copy furnished to such Employer or Employee as the case may be.

Any material misrepresentations or omissions on any written instrument to obtain insurance Coverage within three (3) years from the date Coverage continuously began shall be reason for the Plan to void any such Coverage or to deny a claim for loss.

C. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate Coverage otherwise validly in force or continue Coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future Benefits payable.

D. No reduction in Benefits shall be made by reason of change in the occupation of any Employee while in the employ of the Employer or by reason of the Employee's doing any act or thing pertaining to any other occupations.

E. No representative has authority to change this Plan or waive any of its provisions. No change in this Plan shall be valid unless approved by the Plan Administrator.

F. Benefits provided in this Plan will be payable to the Hospital or Physician rendering service under this Plan or to the Participant upon receipt, by the Claims Administrator, of paid Hospital or Physician bills in acceptable form.

G. No action at law or in equity shall be brought to recover under this Plan prior to the expiration of sixty (60) days written notice to the Plan. No such action shall be brought after the expiration of the specified statute of limitations on such action.

H. Except as otherwise provided herein, the Plan waives a physical examination of the Participant as a condition of participation in the Plan and, in consideration of such waiver, the Participant and/or each Dependent of the Participant agrees that any Physician or Hospital that has made or may hereafter make a diagnosis, render service, attendance or treatment of or to a Participant may furnish and is authorized to furnish to the Claims Administrator at any time upon its request a report containing all information and records or copies of records pertaining to diagnosis, attendance, service or treatment. The Participant and/or each Dependent of the Participant agrees to execute a medical authorization as may be required by the Claims Administrator.

I. The Claims Administrator shall not be responsible for the payment of any charge for services not covered by this Plan or any amounts in excess of the maximum Benefits allowed by this Plan.

J. Eligible new Participants may be added to the Plan in accordance with the terms and conditions of this Plan Document and Summary Plan Description.

K. No Employee shall be refused Coverage or be charged an unfairly discriminatory rate for participation solely because such Employee is mentally or physically handicapped; provided, however, this Section shall not be construed as requiring the Plan to provide Coverage against a handicap which the applicant or policyholder has already sustained.

L. Benefit Payments are paid directly from the funds of the Employer. The Claims Administrator does not contribute funds to pay benefits, nor does the Claims Administrator have any liability to do so. Benefit payment checks issued to providers or Participants are paid out of the Employer funds. The Claims Administrator's name may appear on the check, however, in no way should this be construed as any financial obligation on the part of the Claims Administrator.

M. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the law.