PEDIGREE OVENS INC.

EMPLOYEE HEALTH PLAN

PLAN DOCUMENT

TABLE OF CONTENTS

PEDIGREE OVENS INC.

PLAN DOCUMENT

ARTICLE I
DEFINITIONS

This Article defines the terms used in this Plan. The inclusion of a term in Article XVI does not imply that a service is a Covered Service under this Plan.

"**Allowable Amount**" Maximum amount on which payment is based for Covered Services.

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

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

"**Appeal**" It is a review of an adverse benefit determination by the Third-Party Administrator, as required under this Plan's claims and internal Appeals procedures.

"**Authorized Representative**" A person designated by the Claimant or this Plan to act on behalf of the Claimant.

"**CHIP/CHIPRA**" The Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to as such act, provision or section may be amended from time to time, including the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

"**Claim**" It is a submission to the Plan for payment made under the Plan in accordance with the Plan requirements.

"**Claimant**" Is a Covered Individual (or the Authorized Representative of the Covered Individual) who is entitled to and makes a Claim for benefits under the Plan.

"**Claims Administrator**" The term "Claims Administrator" means a person or persons, or entity or entities, appointed by the Plan Administrator to serve as the Claims Administrator for the Plan. The Claims Administrator's responsibilities include making the initial determination of the validity of the Claims and administering benefit payments under this Plan. The actual responsibilities of the Claims Administrator are described in the agreement between the Plan Administrator and the Claims Administrator. The Claims Administrator is the TPA.

"Clean Claim" It is a properly completed paper or electronic billing instrument submitted by Provider to Third-Party Administrator for payment of Covered Services which contains all of the UB-92 or HCFA 1500 (or successor standard) data elements, and is submitted within the timeframes set forth in Section XIII containing all reasonable necessary information that does not involve coordination of benefits for third-party liability, pre-existing condition investigations or subrogation, and that does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.

"**COBRA**" The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Code**" The Internal Revenue Code of 1986, as amended.

"**Co-insurance**" It is a Covered Individual's share of Covered Services and supplies, not counting the deductible (if applicable), copays or access fees. It is usually a percentage of the allowable amount.

"**Concurrent Claim**" A claim that requires Pre-Authorization under this Plan that is reconsidered after a course of treatment has been initially approved. There are two types of Concurrent Care Claims: 1) where reconsideration by this Plan results in a reduction or termination of coverage for a previously approved benefit, and 2) where an extension is requested by the Claimant for coverage beyond the initially approved benefit.

"**Co-Payment**" The amount a Covered Individual must pay for certain Covered Services. Covered Services subject to a Co-Payment and the amounts are listed in the Medical Benefits Schedule or Pharmacy Benefits Schedule, as applicable. A Co-Payment is a flat dollar amount. In some instances, the Covered Individual will be responsible at the time and place of service to pay any Co-Payment directly to the Health Care Provider. In other instances, the Covered Individual will be billed by the Health Care Provider.

"**Cost-Sharing Amounts**" The dollar amount a Covered Individual is responsible for paying when Covered Services are received from a Health Care Provider. Cost-Sharing Amounts include Cost-Sharing Percentages, Co-Pts, and Deductibles where applicable. Cost-Sharing Amounts are identified in the applicable Medical Benefits Schedule or Pharmacy Benefits Schedule. Health Care Providers may bill a Covered Individual directly or request payment of Cost-Sharing Amounts at the time Covered Services are provided. Cost-Sharing Amounts for Covered Services provided by In-

Network Health Care Providers count toward the Out-of-Pocket Maximum. Cost-Sharing Amounts for Covered Services provided by Out-of-Network Health Care Providers do not count toward the Out-of-Pocket Maximum, and they continue after the Out-of-Pocket Maximum has been met.

"**Cost-Sharing Percentage**" The charge a Covered Individual must pay for certain Covered Services after any applicable Deductibles and Co-Payments have been paid. The Cost-Sharing Percentage is a percentage of the Covered Charge, not the actual billed charge. In some instances, the Covered Individual will be responsible at the time and place of service to pay any Cost-Sharing Percentage directly to the Health Care Provider. In other instances, the Covered Individual will be billed by the Health Care Provider. These arrangements are between the Covered Individual and the Health Care Provider.

"**Coverage Year**" It is the time period, not to exceed twelve (12) months, from the effective date of this Plan to the anniversary date. All subsequent Coverage Years shall begin on the anniversary date and consist of a period of not more than twelve (12) months. This Plan's Coverage Year is the 1st day of August to the 31st day of July.

"**Covered Charge**" It is the Reasonable and Maximum Allowable Charge, or portion of the charge, by Health Care Providers for Covered Services eligible for payment under this Plan. It is the established negotiated rate for In-Network charges, and it is the Plan's Maximum Allowable Charge for approved Out of Network services.

"**Covered Dependent**" It is a Dependent who is participating under this Plan in accordance with the Eligibility Article and whose coverage has not terminated.

"**Covered Employee**" It is an employee who is participating under this Plan in accordance with the Eligibility Article and whose coverage has not terminated.

"**Covered Individual**" It is a Covered Employee or Covered Dependent who is participating under this Plan in accordance with the Eligibility Article and whose coverage has not terminated. Covered Individual also includes former Covered Employees and former Covered Dependents who are otherwise entitled to coverage and properly enrolled under this Plan.

"**Covered Services**" Are those Medically Necessary, Reasonable services, drugs, supplies and equipment identified as Covered Charges in the Benefit Schedule subject to the Plan's Maximum Allowable Charge. In determining whether an expense is a Covered Service all Plan definitions, provisions, limitations and exclusions will be considered for which coverage benefits are available under the Plan per the Benefit Schedule.

"**Creditable Coverage**" Coverage required by law to be counted for purposes of offsetting a preexisting condition period, and includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO Covered Individual, an individual health insurance policy, Medicaid, Medicare, or public plans. Creditable Coverage does not include coverage consisting solely of dental or

vision benefits. Creditable Coverage does not include coverage that was in place before a significant break of coverage of sixty-three (63) days or more.

"**Deductible**" The aggregate amount for certain Covered Services that is a Covered Individual's responsibility each Calendar Year before this Plan will begin to pay for most Covered Services under the terms of the Plan. Co-Payments do not count toward the Deductible.

"**Dependent**" A dependent of the Covered Employee who may qualify for coverage under this Plan in accordance with the following requirements: a spouse, a Covered Employee's child who is a resident of the United States and is either less than twenty-six (26) years of age as of the close of the tax year, or regardless of age, is incapable of self-sustaining employment due to a severe physical or mental condition that is expected to last indefinitely and who is dependent on a Covered Employee for support and maintenance. The child must have been covered under this Plan immediately prior to reaching the age limitation. For the child to be a Dependent, the Plan Administrator must be notified within thirty (30) days after the date coverage under this Plan would normally end. Proof of incapacity may be requested from time to time. Moreover, the child must be the Employee's natural child, the Employee's stepchild, the Employee's legally adopted child, a child placed in the Covered Employee's physical custody whom the Covered Employee intends to adopt, the Employee's foster child, a child for whom the Covered Employee and/or the Spouse has been named Legal Guardian, or the Covered Employee's child or children for whom the Covered Employee has a QMCSO. Individuals specifically excluded from the Plan's definition of a Dependent are any person on active military duty, any person covered under this Plan as a Covered Employee, and any person covered as a Dependent by another Covered Employee.

"**Effective Date**" The date the Covered Individual's coverage begins.

"**Eligible Employee**" An Employee or former Employee who meets the eligibility criteria for this Plan as described in the Eligibility Article and who has not ceased to meet the eligibility criteria.

"**Employee**" A common-law employee of the Employer, as determined solely from the employment records of the Employer. If an individual who provides or provided services to the Employer is classified by the Employer as an independent contractor, such individual shall not be treated as an Employee for purposes of this Plan.

"**Employer**" Pedigree Ovens Inc. or affiliated entity that has been recognized by Pedigree Ovens Inc. as eligible to participate and has agreed to participate in this Plan.

"**ERISA"** The Employee Retirement Income Security Act of 1974 as amended.

"**Family Out-of-Pocket Maximum**" The Out-of-Pocket Maximum amount that if satisfied by the Family Covered Individuals, in aggregate, in a Coverage Year will cause each Family Covered Individual to be treated as having met the Out-of-Pocket for the remainder of that Coverage Year.

"**FMLA**" The Family and Medical Leave Act of 1993, as amended.

"**Genetic Information**" This is the Information about the genetic tests of an individual or his family of Covered Individuals, and information about the manifestations of disease or disorder in family Covered Individuals of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, which detects genotypes, mutations, or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

"**GINA**" The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233).

"**Health Care Provider**" These are the Institutional Health Care Providers or professional Health Care Providers providing Covered Services to Covered Individuals. Each Health Care Provider must be licensed, registered, or certified by the appropriate state agency where the Covered Services are performed. Where there is no appropriate state agency, the Health Care Provider must be registered or certified by the appropriate professional body. Health Care Providers include Advanced Practice Registered Nurses (including a Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, and Nurse Practitioner, Ambulatory Surgical Facility (a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis, provides treatment by or under the direct supervision of a Physician or other Health Care Provider, does not provide inpatient accommodations, and is not a facility used as an office or clinic for the private practice of a Physician or Dentist), Audiologist, Chiropractor, Dentist including D.D.S., Oral Pathologist, Oral Surgeon or Doctor of Dental Medicine, Durable Medical Equipment Health Care Provider, Home Health Agency, Hospice, Hospital, Licensed Practical Nurse (L.P.N.), Licensed Registered Dietician, Occupational Therapist, Optometrist—a Doctor of Optometry (D.O.), Physical Therapist, Physician—(M.D. or D.O.), Physician Assistant-an individual licensed by the medical examining board to provide medical care with Physician supervision and direction, Podiatrists, Psychiatrist, Psychologist, Radiation Therapist, Registered Nurse (R.N.), Respiratory Therapist, Skilled Nursing Facility, Social Worker, Speech Therapist, Speech Pathologist, Urgent Care Facility.

"**Health Care Reform**" The provisions of the Patient Protection and Affordable Health Care Act ("PPACA", as amended by the Health Care and Education Reconciliation Act ("Reconciliation Act") and related administrative guidance issued pursuant thereto.

"**HIPAA**" The Health Insurance Portability and Accountability Act of 1996, as amended.

"**Hospital**" A short-term acute care facility which:

- Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Health Care Organizations or is certified as a hospital provider under Medicare;

- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians for compensation from its patients;

- Has organized departments of medicine and major surgery and maintains clinical records on all patients;

- Provides 24-hour nursing services by or under the supervision of a registered nurse;

- Has a hospital utilization review plan; and

- Is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, sanitarium, place for rest, place for the aged, place for the treatment of chemical dependency, hospice, or place for the provision of rehabilitative care.

"**Illegal Acts**" Illegal Act shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

"**Illness**" Is a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

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

"**Injury**" It is an accidental physical injury to the body caused by unexpected external means.

"**In-Network**" The Actin Care Groups network of Health Care Providers as indicated on the Covered Individual's Covered Individual Card.

"**Late Enrollee**" A Covered Individual who enrolls under the Plan other than during the first thirty (30) day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

"**Legal Guardian**" A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

"**Maximum Amount and/or Maximum Allowable Charge**" The benefit payable for a specific Covered Service or benefit under the Plan subject to Network Adequacy. Maximum Allowable Charge(s) will be the least of: 1) the Usual and Customary Rate amount; 2) the allowable charge specified under the terms of the Plan; 3) the negotiated rate established in a contractual arrangement with a Health Care Provider; or 4) the actual billed charges for the Covered Services. The Plan will reimburse the actual charge billed if it is less than the Usual and Customary Rate amount. The Plan has the discretionary authority to decide if a charge is a Usual and Customary Rate and for a Medically Necessary and Reasonable service.

"**Medical Benefits**" Benefits available under this Plan.

"Medical Benefits Schedule" The schedule of Covered Charges for Covered Individuals under this Plan.

"**Medical Care Facility**" This is a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

"**Medical Necessity**" It is a treatment that is or will be provided for the diagnosis, evaluation, and treatment of an illness or injury and that is:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the patient's illness or injury.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting, or level of service that can safely be provided to the patient, and which cannot be omitted consistent with recognized professional standards of care; for a hospitalization, it means that safe and adequate care could not be obtained in a less comprehensive setting or level of care.
- Cost-effective compared to alternative interventions, including no intervention.

- Not experimental/investigational: The fact that a service is the only available treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to the definition in this Plan.

- Not primarily for the convenience of the patient, the patient's family, or the provider.

- Be reasonably expected to improve the individual's condition and prevent further relapse or regression. Treatment that does not meet this standard is not Medically Necessary and is not a Covered Service

The fact that a provider may prescribe, order, recommend, or approve any care or treatment does not, of itself, make any care or treatment Medically Necessary or a covered expense and does not guarantee payment.

MCM determines Medical Necessity by Interqual criteria and physician review. Retrospective review of the Medical Necessity of services is determined by physician

"**Medicare**" It is the Health Insurance for Teen Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

"**Membership Identification Card**" An identification card issued in the Covered Employee's name identifying the Covered Individual number of the Covered Employee.

"**Michelle's Law**" Pub. L. No. 110-381 (2008).

"**Named Fiduciary**" is the Employer.

"**NMHPA**" The Newborns' and Mothers" Health Protection Act.

"**Other Plan**" Shall include, but is not limited to any primary payer besides the Plan, any other group health plan, any other coverage or policy covering the Covered Individual, any first-party insurance through medical payment coverage, personal injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist coverage, any policy of insurance from any insurance company or guarantor of a responsible party, any policy of insurance from any insurance company or guarantor of a Third-Party, workers' compensation or other liability insurance company, or any other source including crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

"**Out-of-Network**" Health Care Providers that are not in-Network. When Covered Individuals seek Covered Services from Out-of-Network Health Care Providers, they will generally receive a lower level of benefit payment. In addition to Cost-Sharing Amounts, the Covered Individual will be responsible for any charges above the Maximum Allowable Charge when receiving Covered Services from Out-of-Network Health Care Providers. This Plan is under no obligation to pay for Covered Services provided by an unapproved Out of Network Provider except in an emergency. Emergency services provided by any health care provider are Covered Services.

"**Out-of-Pocket Maximum**" The total Cost-Sharing Amounts for Covered Services provided by In-Network Health Care Providers that are a Covered Individual's responsibility during a Calendar Year. The Out-of-Pocket Maximums are stated in Article II, 2.10, page 31. When the Out-of-Pocket Maximum is met, this Plan will pay one hundred (100%) percent of the Covered Charges for most Covered Services provided by In-Network Health Care Providers Incurred during the remainder of the Calendar Year. The Out-of-Pocket Maximum renews each January 1st. Cost-Sharing Amounts for Covered Services provided by Out-of-Network Health Care Providers, charges that are not Covered Services under this Plan (including, but not limited to, charges that exceed Usual and Customary Rates and costs paid by the Covered Individual as a result of the Covered Individual's failure to comply with Pre-Authorization requirements), and charges in excess of applicable Plan maximums are not considered with respect to the Out-of-Pocket Maximum. (There is no Rollover from prior year).

"**Outpatient Care and/or Services**" The treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient, or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

"**Physician**" A Doctor of Medicine (M.D.), Doctor of Osteopathy, Doctor of Podiatry, Doctor of Chiropractic, Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work, Midwife, Occupational Therapist, Doctor of Dental Surgery, Physiotherapist, Psychiatrist, Psychologist, Speech Language Pathologist, 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.

"**Plan**" This Pedigree Ovens Inc. Employee Health Plan, as amended from time to time.

"**Plan Administrator**" The term "Plan Administrator" means the Employer or its designated representative(s). The Plan Administrator retains ultimate authority for this Plan including final Appeals determinations. The Plan Administrator is also the Named Fiduciary for purposes of ERISA.

"**Plan Sponsor**" Pedigree Ovens Inc.

"**Plan Year**" It is the twelve-(12) month period beginning on August 1 of each year.

"**Pre-Authorization**" It is the approval by the Plan for coverage of specific services, supplies, Durable Medical Equipment or drugs before they are provided to the member. Pre-Authorization includes verification of eligibility, at the time of Pre-Authorization (member must continue to be eligible on the date service is incurred for Pre-Authorization to remain valid), verification that the service is a Covered Service and is within Plan limits, and verification that the service is Medically Necessary. In the context of this Plan all inpatient services, certain outpatient services, specialist visits and Durable Medical Equipment and supplies require Pre-Authorization.

"**Prescription Drug**" A Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend:" Caution: federal law prohibits dispensing without prescription", insulin for purposes of injection, hypodermic needles or syringes, buts only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an illness or injury. Prescription Drugs include Brand Name Drugs (patent protected Prescription Drugs), Generic Drugs (a Prescription Drug whose patent has expired and is manufactured by several pharmaceutical companies. FDA A-rated Generic Drugs contain the same active ingredient as the Brand Name Drug, are manufactured under the same FDA standards, and are considered equivalent in all respects to the Brand Name Drug. The Formulary is a list of Prescription Drugs approved by this Plan for use by Covered Individuals, as amended from time to time.

"**Pre-Service Claim**" Any Claim for a benefit under this Plan where receipt of the benefit is specifically conditioned on receiving approval in advance of obtaining the medical care. Benefits under this Plan that are Pre-Service Claims are described in the Utilization Management Programs Article of this Plan document.

"**Preventive Care**" Covered Services rendered primarily for the purpose of health maintenance and not for the treatment of an illness or injury. Preventive Care includes 1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, 2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, and 4) with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. For example, Well-Adult Preventive Care includes (at ages, times, or risk status designated in federal requirements) abdominal aortic aneurysm one-time screening, alcohol–abuse screening and counseling, aspirin use (to prevent cardiovascular disease), blood pressure screening, cholesterol screening, colorectal cancer screening, depression screening, diabetes screening, diet counseling, HIV screening, immunizations, obesity screening and counseling, sexually transmitted infection prevention counseling, syphilis screening, and tobacco used screening. Well-Woman Preventive Care generally includes (at ages, times, or risk status designated in federal requirements), anemia screening, breast cancer genetic test counseling, breast cancer mammography screening, breastfeeding comprehensive support and counseling, cervical cancer screening, chlamydia infection screening, contraception, domestic and interpersonal violence screening and counseling, folic acid supplements, gestational diabetes screening, gonorrhea screening, hepatitis B screening, HIV screening and counseling, human papillomavirus DNA test, osteoporosis screening, Rh incompatibility screening, sexually transmitted infections counseling, syphilis screening, tobacco use screening and interventions, urinary tract or other infection screening, and well-woman visits. Well-Child Preventive Care generally includes (at ages, times, or risk status designated in federal requirements) autism screening, behavioral assessments, blood pressure screening,

cervical dysplasia screening, depression screening, developmental screening, dyslipidemia screening, fluoride chemoprevention supplements, gonorrhea preventive medication, hearing screening, height, weight, and body mass index measurements, hemoglobin or sickle cell screening, HIV screening, hypothyroidism screening, immunizations, iron supplements, lead screening, medical history, obesity screening and counseling, oral health risk assessment, phenylketonuria (PKU) screening, sexually transmitted infection prevention counseling and screening, tuberculin testing and vision screening. Specific details on what services are covered as Preventive Care are provided in detailed schedules available from the Claims Administrator.

"**Primary Care Provider**" A Primary Care Provider can be a Doctor, a Nurse Practitioner or a Physician's Assistant that a person sees for preventive care, for treatment of acute illnesses and for management of common chronic conditions. A Primary Care Practitioner establishes an individual care plan and coordinates care among specialists and other providers.

"**QMCSO**" Qualified Medical Child Support Order as determined by the Plan Administrator under procedures established by the Plan Administrator.

"**Rescind or Rescission**" The process to retroactively terminate coverage under the Plan.

"**Special Enrollee**" A Covered Individual who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan and during a Special Enrollment Period. A Late Enrollee is not a Special Enrollee.

"**Special Enrollment Period**" Is the period of time during which a person may become a Covered Individual if they do not enroll within 30 days of eligibility.

"**Spouse**" An individual who is treated as the Covered Employee's spouse for federal tax purposes. A common-law spouse shall be eligible for coverage under this Plan if the foregoing requirement is met and the Covered Employee submits a written notarized statement affirming the person as his or her spouse and naming the state of marriage. An individual who is legally separated or divorced from the Covered Employee is specifically excluded from the definition of Spouse. The Plan Administrator may require documentation of an individual's status as a Spouse.

"**Urgent Care**" Urgent Medical Condition means a medical or behavioral condition other than an emergency condition, manifesting itself by acute symptoms of sufficient severity that, in the assessment of a 'prudent layperson', possessing an average knowledge of medicine and health, could reasonably be expected to result in serious impairment of bodily functions, serious dysfunction of a bodily organ, body part, or mental ability, or any other condition that would place the health or safety of the Enrollee or another individual in serious jeopardy in the absence of medical or behavioral treatment within twenty-four (24) hours.

"**USERRA**" The Uniformed Services Employment and Reemployment Rights Act of 1994.

"**Usual and Customary Rate**" The median of ACTIN's rates with its contracted providers using the same method of payment, specifically Medicare's method of inpatient and outpatient facility payments and payments for professional services.

"**Utilization Review**" The process in which the utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment, or will determine if the services meet the definition of Medically Necessary as defined by the Plan. The Utilization Review Administrator may be made available through the Claims Administrator or a separate entity with a direct contractual relationship with the Plan.

"**WHCRA**" The Women's Health and Cancer Rights Act of 1998.

ARTICLE II
INTRODUCTION

Pedigree Ovens Inc. (the "Plan Sponsor") has established this Pedigree Ovens Inc Employee Health Plan to provide health care coverage for Covered Employees and their Covered Dependents. This Plan is established effective August 1, 2018.

2.1 Nature of the Plan. This Plan is an employee welfare benefit plan within the meaning of section 3(1) of ERISA. This Plan is a self-insured medical plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Code so that the portion of the cost of coverage paid by the Employer, and any benefits received by a Covered Individual through this Plan, are not included in the taxable income of such covered Individual. The Plan is self-insured and any amounts paid for Claims approved under the Plan will be paid from the Employer's general assets. Approved Claims are not paid by an insurance company.

2.2 Plan Administration. The Plan Administrator has contracted with ACTIN Care Groups ("ACTIN"), an Illinois licensed Preferred Provider Program Administrator, to provide access to its network of providers, to coordinate and manage care and to arrange for provision of primary care services to Covered Individuals of Plans that contract with ACTIN.

The Plan Administrator and any representative designated by it in writing shall have the discretionary authority to administer the Plan as specified herein, and in accordance with Article XI of the Plan.

2.3 Medical Benefits Schedule. The schedule of benefits payable for Covered Individuals under this Plan is attached to this Plan document and incorporated by reference.

2.4 Non-Grandfathered Status under Health Care Reform. This Plan is not a "grandfathered health plan" under Health Care Reform. Questions regarding the Plan's status can be directed to the Plan Administrator. You may also contact the Employee

Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform.

2.5 Questions. The Claims Administrator's customer service representatives are available to answer questions regarding the Plan. Hours of service are 8 a.m. to 4 p.m. Monday through Friday excluding holidays. For enrollment or eligibility questions, please contact Pedigree Ovens Inc. or ACTIN Care Groups representatives who are available to answer questions regarding the Plan from 8 a. m to 4 p. m. Monday through Friday excluding holidays.

ARTICLE III
ELIGIBILITY

3.1 Employee Eligibility. An Employee becomes an Eligible Employee on the first day of the first month after 60 consecutive days as a full-time Employee. For purposes of eligibility, a full-time Employee is regularly scheduled to work 30 or more hours per week or who works 30 or more hours per week, or 130 or more hours per month, over the measurement period selected by the Employer in accordance with Health Care Reform.

3.2 Dependent Eligibility. An Eligible Dependent is any one of the following persons (see Definitions, page 4):

- A Covered Employee's Spouse.
- A Covered Employee's child who is less than twenty-six (26) years of age.
- Any child of a Covered Employee who is an alternate recipient under a qualified medical child support order (QMCSO) as defined in Section 609(a)(2)(A) of ERISA and that otherwise meets the applicable age requirements to qualify as a Dependent under the Plan.
- A Covered Employee's child, regardless of age, who is incapable of self-sustaining employment due to a severe physical or mental condition that is expected to last indefinitely and who is dependent on a Covered Employee for support.
  - Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within thirty (30) days after the date the child attains twenty-six (26) years of age. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan.
- If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during, and after the change in status, credit will be given for all Cost-Sharing amounts.

- If both mother and father are Covered Employees, any children will be covered as Dependents of the mother or father, but not of both.

NOTE: The Plan does not cover, as a Dependent, any person who is enrolled as an Eligible Employee.

3.3 Eligibility Requirements for Dependent Coverage. A Dependent becomes eligible for Dependent coverage on the first day that the Covered Employee is eligible for Employee coverage and the Dependent satisfies the requirements for Dependent coverage.

ARTICLE IV
ENROLLMENT AND WHEN COVERAGE BEGINS

4.1 Enrollment. An Eligible Employee must enroll for coverage by completing an enrollment application. If the Employee intends to cover Dependents, those Dependents must also be enrolled on the enrollment application. Charges for the delivery of a newborn child will be attributed to his or her parent who is a Covered Individual with respect to this Plan. A newborn child who qualifies as a Dependent must be enrolled within thirty (30) days of birth. If not enrolled during that special enrollment period, he or she will not be covered under the Plan until the next available Open Enrollment Period. Enrollment is effective the first day of the first month following 60 consecutive days of employment as a full-time employee.

4.2 Enrollment Periods. An enrollment is late if it is not made within thirty (30) days of eligibility. Late enrollees and their Dependents may join only during an Open Enrollment Period from July 5, 2018 to July 19, 2018 unless a Special Enrollment Period applies. An Eligible Employee or Dependent who was covered under another plan who loses that coverage may enroll during the Special Enrollment Period.

A Spouse may be enrolled as a Covered Individual within thirty (30) days of marriage to a Covered Employee.

A child of a Covered Employee may be added as a Dependent within thirty (30) days of birth or adoption, or becoming a stepchild of a Covered Employee.

If an Eligible Employee or Dependent is covered under a Medicaid plan or a State Child Health Insurance Program (CHIP) and coverage of the Employee or Dependent terminates due to loss of eligibility for such coverage, the Eligible Employee or Dependent is eligible for a Special Enrollment Period and may enroll within sixty (60) days of termination.

An Eligible Employee or Dependent will be covered on the first day of the calendar month immediately following the date that eligibility and enrollment requirements are satisfied.

4.3 USERRA Reinstatement. Special rules apply to those Eligible Covered Employees whose coverage is reinstated following a leave of absence governed by the

Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA). Under USERRA, a Covered Individual entitled to have coverage reinstated upon returning to work following a military leave of absence shall be treated as if no break in coverage occurred during the leave.

4.4 Covered Individual ID Card. The Covered Individual ID Card issued by ACTIN is for identification purposes only and is to be presented to the Health Care Provider before services are delivered. To be eligible for services or benefits under this Plan, the holder of the Covered Individual ID Card must be a Covered Individual. Any person receiving services or benefits which he/she is not entitled to receive pursuant to the provisions of this Plan will be charged for such services or benefits at prevailing rates.

ARTICLE V
WHEN COVERAGE ENDS

5.1 Employee Termination of Coverage. Covered Employee coverage will terminate upon the earliest to occur of the following events:

- The Plan is terminated.
- The last day of the calendar month that the Covered Employee requests coverage be terminated, as long as the request is made on or before the date such termination of coverage is to take effect.
- The last day of the period for which the Employee has made a contribution, if he/she fails to make a required contribution for coverage when it is due.
- The last day the Covered Employee ceases to be an Eligible Employee. This includes death or termination of employment of the Covered Employee.
- If a Covered Employee commits fraud or makes material misrepresentation in applying for or obtaining benefits under the Plan, then the Plan may terminate coverage as of a date to be determined at the Plan Administrator's discretion, consistent with applicable law including rules regarding rescission.

5.2 Dependent Termination of Coverage. A Dependent's coverage will terminate upon the earliest to occur of the following events:

- The Plan is terminated.
- The last day of the period for which the Employee has made a contribution for a Dependent, if he/she fails to make a required contribution for coverage when it is due.
- The date that the Covered Employee's coverage under the Plan terminates.

- The day that a Dependent child ceases to meet the requirements for Dependent status under the Plan.
- If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan may terminate coverage as of a date to be determined at the Plan's discretion, consistent with applicable law including rules regarding rescission.
- For a Dependent child whose coverage is required pursuant to a QMCSO, the last day of the month as of which coverage is no longer required under the terms of the order.
- In the case of a child age twenty-six (26) or older for whom coverage is being continued due to mental or physical disability, the earliest to occur of:
  - Cessation of such disability.
  - Failure to furnish any required proof of disability or to submit to any required examination.
  - Upon the child's no longer being dependent upon the Covered Employee for support.

5.3 Rehiring a Terminated Employee. A terminated employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, including any applicable waiting period, unless his or her break in service is less than one hundred eighty (180) days. Under these circumstances, he or she does not have to satisfy the eligibility waiting period.

5.4 Rescission of Coverage for Fraud or Intentional Misrepresentation of a Material Fact. Under this Plan, coverage may be canceled or terminated (rescinded) if a Covered Individual acts fraudulently or intentionally makes material misrepresentations of fact. It is the Covered Individual's responsibility to provide accurate information and to make accurate and truthful statements.

ARTICLE VI
COBRA AND OTHER CONTINUATION COVERAGE

6.1 COBRA Continuation Coverage. A Covered Individual whose coverage is ending may be able to elect to continue the coverage under COBRA. Continuation Coverage is available when a "Qualifying Event" occurs. Upon the occurrence of a Qualifying Event an individual who loses coverage under the Plan has rights as a "qualified beneficiary".

A qualified beneficiary is an individual who, on the day before the Qualifying Event, was covered under the Plan. A child who is born to or placed for adoption with a covered beneficiary during a period of COBRA continuation coverage is a qualified beneficiary. In

addition, an individual for whom the covered beneficiary must provide coverage under this Plan pursuant to a QMCSO is a qualified beneficiary.

A Covered Employee who becomes a qualified beneficiary may elect continuation coverage if he or she loses coverage under the Plan due to any of the following Qualifying Events: termination of employment (other than for gross misconduct), or a reduction in hours.

A Covered Individual who is the Spouse of a Covered Employee may elect continuation coverage if he or she loses coverage under the Plan because of any of the following Qualifying Events: 1) the Covered Employee is terminated (other than for gross misconduct) or hours of work are reduced, 2) the Covered Employee's death, 3) the Covered Employee's entitlement to (actual coverage under) Medicare, or 4) divorce or legal separation of the Covered Employee.

A Covered Individual who is the Dependent child of a Covered Employee may elect continuation coverage if he or she loses coverage due to any of the reasons in the preceding paragraph or, if the Dependent no longer qualifies as a "Dependent" under the terms of the Plan.

A qualified beneficiary or his or her legal representative has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing Dependent status under the Plan within sixty (60) days of the latest of the date of the Qualifying Event, the date coverage would be lost because of the Qualifying Event, or the date on which the qualified beneficiary was informed of the responsibility to provide notice and the procedures for doing so. The notice must be provided in writing and be mailed to the Plan Administrator. All notices electing continuation coverage must contain the following information: 1) the name of the Plan; 2) the name and address of all qualifying beneficiaries; 3) a detailed description of the Qualifying Event including its effective date; and 4) any documentation providing proof of the Qualifying Event. If the required notification is not received within the required time period, no continuation coverage will be provided.

In addition, the covered qualified beneficiary or his or her legal representative must notify the Plan of the death of the Employee, divorce or separation from the Employee, or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan, if that event occurs within the eighteen (18) month continuation period (or extension of that period for disability or for pre-termination Medicare entitlement. The notification must be provided in writing and be mailed to the Plan. It must include the 4 elements of information described in the preceding paragraph. If the required notification is not received within the required time period, no continuation coverage will be provided.

The Covered Individual, or his or her legal representative must notify the Plan Administrator when a qualified beneficiary has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of the date of the disability determination, the date of the Qualifying Event, the date coverage would be lost because of the Qualifying Event, or the date on which the qualified beneficiary was informed of the

responsibility to provide the notice and the procedures for doing so. The notice must be provided in writing and mailed to the Plan Administrator. The notice must contain the following information: the name of the plan; the names and addresses of all qualified beneficiaries who lost coverage due to the initial Qualifying Event and who are receiving COBRA coverage at the time of the notice; the nature and date of the initial Qualifying Event that entitled the qualified beneficiaries to coverage; the name of the disabled qualified beneficiary; the date upon which the disabled qualified beneficiary became disabled; the date upon which the Social Security Administration made its determination of disability; and include a copy of the determination of the Social Security Administration. If the required notification is not received within the required time period, no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the Plan Administrator of that determination within thirty (30) days of the later of a) the date of such determination, or b) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be in writing and mailed to the Plan Administrator. Regardless of when the notification is provided, continuation coverage will be terminated retroactively on the first day of the month that begins thirty (30) days after the date of the determination, or the end of the initial coverage period, if later. If you do not provide the notification within the required time, the Plan reserves the right to seek reimbursement of any benefits provided by the Plan between the date coverage terminates and the date the notification is provided.

When a Qualifying Event occurs, or when the Plan Administrator is notified that a Qualifying Event has occurred in the case of those events in which the Employee has an obligation to provide notice, the Plan Administrator must notify the qualified beneficiaries of the right to elect continuation coverage. Qualified beneficiaries have sixty (60) days to elect continuation coverage measured from the later of a) the date coverage would be lost because of a qualified event, or b) the date a notice of election rights is provided. An election is considered “made” on the date sent. If continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If continuation coverage is not elected within this period, coverage ends.

Qualified beneficiaries are allowed to maintain continuation coverage as follows: Eighteen (18) months. If the Qualifying Event is the Employee’s termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is eighteen (18) months measured from the date coverage would otherwise be lost because of the Qualifying Event.

For qualified beneficiaries receiving continuation coverage because of the Employee’s termination or reduction in hours, the continuation period may be extended an additional eleven (11) months, for a total of twenty-nine (29) months where a qualified beneficiary receives a determination under the Social Security Act that at the time of the Employee’s termination of employment or reduction of hours, or within sixty (60) days of the start of the eighteen (18) month continuation period, the qualified beneficiary was disabled. The extension is available to all qualified beneficiaries in the family group.

The eighteen (18) month continuation period may be extended if the Employee became entitled to (actually covered under) Medicare prior to the Employee's termination of employment (other than for gross misconduct) or a reduction in hours. Qualified beneficiaries other than the Employee are entitled to the greater of a) eighteen (18) months measured from the Qualifying Event, or b) thirty-six (36) months measured from the date of the Employee's Medicare entitlement.

For Qualifying Events other than termination of employment (other than for gross misconduct) or a reduction of hours, the continuation period is thirty-six (36) months measured from the date coverage would otherwise be lost because of the Qualifying Event. If during the initial eighteen (18) month continuation period (or during an extension of that period for disability or for pre-termination Medicare entitlement) a second Qualifying Event occurs (e.g. divorce, death of Employee, loss of Dependent status) that would have caused the qualified beneficiary to lose coverage under the Plan had the first Qualifying Event not occurred, the continuation period for the particular qualified beneficiaries affected by the second Qualifying Event may be extended to thirty six (36) months.

Initially, the coverage will be the same coverage as immediately preceding the Qualifying Event. Thereafter, coverage must be identical to the coverage provided to similarly situated Covered Employees and Dependents that have not experienced a Qualifying Event. Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active Covered Employees to change their coverage options or to add or eliminate coverage for Dependents at open enrollment. In addition, Special Enrollment Rights under HIPAA will apply to those who have elected COBRA.

Under the law, a person electing continuation coverage may be required to pay all or part of the cost of continuation coverage. You will receive additional information regarding the cost requirements following the occurrence of a Qualifying Event. The amount charged cannot exceed 102% of the cost to the Plan of providing the coverage. The amount charged may be increased to 150% for the months after the eighteenth (18th) month of continuation coverage when the additional months are due to a disability under the Social Security Act.

Continuation coverage shall automatically end before the end of the Maximum Continuation Period for any of the following reasons: the Employer no longer provides group health coverage to any of its Employees; the premium for continuation coverage is not paid on time; after electing COBRA, the qualified beneficiary becomes covered under another group plan; after electing COBRA coverage, the qualified beneficiary becomes entitled to (actually covered under) Medicare; with respect to disability extension coverage, a final determination that the qualified beneficiary is no longer disabled; or termination for cause under the generally applicable terms of this Plan. A qualified beneficiary does not have to demonstrate insurability to elect continuation coverage.

6.2 Continuation Rights under USERRA. In addition to COBRA rights, a Covered Individual may be entitled to continue coverage under the Uniformed Services

Employment and Reemployment Rights Act of 1994 ("USERRA"). USERRA requires your Employer to offer Covered Employees and their families the opportunity to pay for a temporary extension of health coverage at group rates where health coverage under Employer sponsored group health plans would otherwise end because of the Employee's service in the uniformed services. This Section is intended to inform Covered Individuals, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe your USERRA continuation coverage rights. For additional information about your rights and obligations you should contact the Plan Administrator.

The Employee has the right to elect USERRA continuation coverage for himself, his Spouse, and his Dependents if they lose coverage under this Plan due to an absence from employment for service in the uniformed services (a service leave). The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

You have sixty (60) days to elect USERRA continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. An election is considered "made" on the postmark date. If USERRA continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If USERRA continuation coverage is not elected within this period, coverage under the Plan ends. However, if no election is made in a situation in which you are not required to provide advance notice of your service, your coverage will be reinstated on a retroactive basis upon your election to continue coverage and payment of all unpaid amounts due. The law requires that you generally be allowed to maintain USERRA continuation coverage for a twenty-four (24) month period beginning on the date of your absence from employment for the purpose of performing service begins.

Initially, the coverage will be the same as coverage immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated Covered Employees or Dependents that are not on service leave.

A person electing USERRA continuation coverage may be required to pay all or part of the cost of such coverage. If you perform service in the uniformed services for fewer than thirty-one (31) days, you will pay the same amount for the coverage that you normally pay. If your service exceeds thirty (30) days, the amount charged cannot exceed 102% of the cost to the Plan of providing the coverage. Payment is considered made on the date sent.

USERRA continuation coverage may be terminated before the end of the Maximum Continuation Period for any of the following reasons: the Employer no longer provides group health coverage to any of its Employees; the premium for USERRA

continuation coverage is not paid on time; your failure to return from service or apply for a position of employment as required under USERRA; or termination for cause under the generally applicable terms of this Plan.

6.3 Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff. An Employee may remain eligible for a limited time after he would no longer be an Eligible Employee due to reduction in hours due to disability, leave of absence, or layoff. This continuation of coverage will end as follows: for disability leave only: the end of the three-calendar-month period that next follows the month in which the person last worked as an Eligible Employee, provided the Employee pays the applicable contribution.

For leave of absence or layoff only: the end of the three-calendar-month period that next follows the month in which the person last worked as an Eligible Employee, provided the employee pays the applicable premium.

For worker's compensation only: the end of the three-calendar-month period that next follows the month in which the person last worked as an Eligible Employee provided the employee pays the applicable premium.

While continued, coverage will be the same coverage that was in force on the last day worked as an Eligible Employee. However, if coverage changes for other Employees, the same changes will be made to the continued coverage. Coverage continued during this period will count against the maximum continuation period under COBRA.

6.4 Coverage during a Family and Medical Leave Act (FMLA) Leave. Coverage during an FMLA leave of absence will be administered in accordance with the policies established by the Employer and applicable law including the following: a) during an FMLA leave, coverage under this Plan shall be maintained on the same terms and conditions as the coverage that would have been provided had the Covered Employee not taken the FMLA leave; and b) if Plan coverage lapses during the FMLA leave, it will be reinstated upon the employee's return to work at the conclusion of the FMLA leave but only for the person who had coverage under the Plan when the leave began. It is the intention of the Employer to provide FMLA benefits only to the extent required by applicable law and not to confer greater rights than those required by law on any Covered Individual.

ARTICLE VII
UTILIZATION MANAGEMENT

7.1 Introduction. This Article describes the utilization management programs available under this Plan and Covered Individuals' responsibilities under these programs. Utilization management programs assist Covered Individuals to obtain coverage information under this Plan while receiving appropriate care in a cost-effective manner. Utilization management programs assist the patient in evaluating alternative care opportunities, coordinating care needs, identifying applicable benefit limits and exclusions, and establishing expectations about the outcome or efficacy of treatment.

7.2 Utilization Review and Pre-Authorization. Utilization review is one type of utilization management program designed to help Covered Individuals receive necessary and appropriate care while avoiding unnecessary expenses. The program consists of Pre-Authorization to determine whether Non-Emergency services to be delivered in a Medical Care Facility are appropriate and Medically Necessary.

7.3 How to Pre-Authorize. The Health Care Provider, Covered Individual, or someone on the Covered Individual's behalf must call MCM, Plan's case management nurse or Actin to preauthorize procedures that are enumerated in the Plan Document and Benefit Schedule as requiring Pre-Authorization. The following information is needed: The name of the Covered Individual and the relationship to the Covered Employee; the name, employee identification number, and address of the Covered Employee; the name of the Employer; the name and telephone number of the treating Physician; the name of the Medical Care Facility, proposed date of Admission, and the proposed length of stay; and the proposed medical services.

7.4 Penalty for Not Obtaining Pre-Authorization for Inpatient, Specified Outpatient Services and Certain Durable Medical Equipment, that Require Pre-Authorization. Failure to obtain Pre-Authorization for services that require Pre-Authorization under this Plan will result in the Covered Individual being responsible for a $75 Penalty to the provider in addition to any co-insurance if Pre-Authorized according to the amounts listed in the Medical Benefits Schedule or Pharmacy Benefits Schedule as applicable. The $75 Penalty does not apply to the out of pocket maximum.

7.5 Penalty for Not Obtaining Pre-Authorization from ACTIN for Specialist visits. ***All*** visits to specialists except during the global period after surgery and visits to Obstetricians for well-woman or maternity care require Pre-Authorization by ACTIN's Care Coordinating Center. Failure to obtain Pre-Authorization will result in the Covered Individual being responsible for a $75 Penalty to the provider that does not apply to the out of pocket maximum.

7.6 Penalty for Employees and Spouses Obtaining professional services at an in-network Primary Care Provider who is not the Member's elected Primary Care Provider Clinic. Each Employee and Spouse must elect an in-network Primary Care Provider or an approved out-of-network Primary Care Provider. Any in-network Primary Care Provider practicing in the same clinic location under the same Tax ID number may act as the Member's Primary Care Provider. Members may change Primary Care Provider once during the Plan Year. If a Member obtains professional services at an in-network Primary Care Provider who is not either that Member's Primary Care Provider or an in-network Primary Care Provider practicing in the same clinic location under the same Tax ID number, the Covered Individual is responsible for a $75 Penalty to the provider in addition to any co-insurance. The $75 Penalty does not apply to the out of pocket maximum**.**

7.7 Penalty for Emergency Department Services that Are Not Medically Necessary. Emergency services provided at a hospital Emergency Department that are reviewed after provision of service and found not to be Medically Necessary under the Plan's definition of an Emergency, are not covered services. If a licensed physician, Physician's Assistant, or Nurse Practitioner refers the patient to the Emergency Department, the service is Medically Necessary and not subject to review for Medical Necessity.

7.8 Concurrent Review and Discharge Planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are types of utilization management programs. If the treating Physician recommends that a Covered Individual (a) receive additional services, or (b) stay in the Medical Care Facility for a greater length of time than has been per-certified, the treating Physician must request additional Pre-Authorization (described above) of the additional services or days. Failure to do so will trigger the Penalty for failing to obtain required Pre-Authorization for the additional services or days. The Utilization Review Administrator will monitor the Covered Individual's Medical Care Facility stay or use of other medical services and coordinate either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

7.9 Additional Opinion Program. To reduce the harm from Overuse of medical services, or confirm the propriety of an initial recommendation, the additional opinion program fulfills the dual purpose of protecting the health of the Covered Individuals and fulfilling a fiduciary obligation to the risk pool. Benefits will be provided for a second or third opinion consultation to determine the Medical Necessity of a health service.

7.10 Pre-Admission Testing Services. A medical facility confinement typically requires certain testing be completed prior to Admission. These services will be considered for diagnostic lab tests and imaging exams payable as described in the Medical Benefits Schedule in the Summary of Benefits Section of this document when: (a) performed on an outpatient basis within seven days before a hospital confinement; (b) related to the condition which causes the confinement; and (c) performed in place of tests while hospital confined.

ARTICLE VIII
COORDINATION OF BENEFITS

8.1 When Coordination of Benefits Applies. Coordination of benefits sets out rules for the order of payment of Covered Charges when the Covered Individual is covered by two or more plans, including Medicare. When a Covered Individual is covered by this Plan and one or more other plans, the plans will coordinate benefits when a Claim is received. The plan that pays first according to the coordination of benefits rules of the plans will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to one hundred (100%) of the total allowable charge.

8.2 Excess Insurance. If at the time of injury, illness, disease, or disability there is available, or potentially available any coverage (including coverage resulting from

a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits will be excess to, whenever possible: (a) any primary payer besides the Plan; (b) any first party insurance through medical payment coverage, personal injury protection, No-fault auto insurance coverage, uninsured or underinsured motorist coverage; (c) any policy of insurance from any insurance company or guarantor of a Third-Party; (d) workers' compensation or other liability insurance company; (e) any other source, including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

8.3 Allowable Charge. For a charge to be "allowable" it must not exceed 150% of the amount that Medicare would pay and the service must be a Covered Service under the Plan.

8.4 Automobile Limitations. When medical payments are available under any vehicle insurance (including no-fault automobile insurance, uninsured motorist coverage, or underinsured motorist coverage), the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policy deductibles. This applies to all forms of medical payments vehicle plans and/or policies regardless of its name, title, or classification.

8.5 Benefit Plan Payment Order. When two or more benefit plans provide benefits for the same Allowable Charge, the benefit payment will follow these rules:

- Plans with a coordination provision will pay their benefits up to the Allowable Charge.
- The benefits of the plan which covers the person directly (that is, as an employee) are determined before those of the plan which covers the person as a dependent.
- The benefits of a benefit plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee.
- The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid-off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid-off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- The benefits of a benefit plan which covers a person as a non-COBRA beneficiary are determined before those of a plan which covers the person as a COBRA beneficiary.
- When a child is covered as a Dependent and the parents are not separated or divorced, these rules apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year. If both parents have the same birthday the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

- When a child's parents are divorced or legally separated these rules will apply:
  - This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
  - This rule applies when the parent with custody of the child has remarried. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last. Notwithstanding the foregoing two sentences, a court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

- For parents who were never married to each other, the rules apply as set out above so long as paternity has been established. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Amount when paying secondary.

- Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid be Medicare under Parts A and B regardless of whether the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS.

- If a Covered Individual is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- The Plan will pay primary to TRICARE and a State child health plan to the extent required by federal law.

8.6 Claims determination period. Benefits will be coordinated on a Coverage Year basis. This is called the Claims determination period.

8.7 Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. Each and every Covered Individual hereby authorizes the Plan to give or obtain any medical or other personal information reasonably necessary to apply the provisions of this Article. A Covered Individual will give this Plan the information it asks for about other plans and their payment of Allowable Amount.

8.8 Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

8.9 Right of Recovery. Whenever payments have been made by this Plan with respect to Allowable Amount in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organization which the Plan determines are responsible for payment of such Allowable Amount, and any future benefits payable to the Covered Individual.

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

8.11 Worker's Compensation. Coverage under this Plan is not in lieu of worker's compensation.

ARTICLE IX
THIRD-PARTY RECOVERY, SUBROGATION, & ERRONEOUS PAYMENT

9.1 Subrogation and Refund. A Covered Individual may incur medical expenses due to illness or injury that may be caused by the act or omission of a Third-Party. Also, a Third-Party may be responsible for payment on account of the actions of

another person or entity. In such circumstances, the Covered Individual may have a claim against the Third-Party for payment of medical expenses. Accepting benefits under this plan for those medical expenses automatically assigns to the Plan any rights the Covered Individual may have to recoveries from any Third-Party up to the full amount of such benefits. This subrogation right allows the Plan to pursue any claim that the Covered Individual has against any Third-Party. The Plan may make a claim directly against the Third-Party, but in any event the Plan has an equitable lien on any amount of the recovery of the Covered Individual whether or not designated as payment for medical expenses. In addition, each Covered Individual agrees to hold recoveries in a constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid in full.

In the event that the Covered Individual dies as a result of his or her injuries and a wrongful death claim is asserted against a Third-Party, the Plan's subrogation and refund rights still apply. The Covered Individual automatically assigns to the Plan his or her rights against any Third-Party when this provision applies and, must repay to the Plan the benefits paid on his or her behalf. Each Covered Individual as obligated to comply with the provisions of this section.

When a Covered Individual receives or claims Plan benefits for an illness or injury caused by another, the Covered Individual agrees to immediately reimburse the Plan from any recovery for benefits paid out by the Plan. This Plan repudiates the make whole doctrine, which if applicable, would prevent the Plan from receiving a Recovery unless a Covered Individual has been "made whole" with regard to illness or injury that is the responsibility of a Third-Party. This Plan also expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the Plan to pay a portion of the attorney fees and costs expended in obtaining a recovery. These doctrines have no application to this Plan, since the Plan's refund rights apply to the first dollar payable by a Third-Party.

All Covered Individuals are required to cooperate with the Plan Administrator to effectuate the terms of this section. If a Covered Individual fails to do so the Plan shall have no obligation whatsoever to pay medical benefits to a Covered Individual. Failure by a Covered Individual to comply with any of the requirements described in this Article may, at the Plan's discretion result in a forfeiture of payment by the Plan of future medical benefits, and any funds or benefits otherwise payable under this Plan to or on behalf of the Covered Individual may be withheld until the Covered Individual satisfies his or her obligation.

9.2 Erroneous Payments. To the extent payments made by this Plan with respect to a Covered Individual are in excess of the maximum amount of payment necessary under the terms of the Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following sources, as Plan shall determine any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are either responsible for payment or received payment in error, and any future benefits payable to the Covered Individual.

9.3 Excess Insurance. Except as otherwise provided under the Plan's Coordination of Benefits Article, the following rule applies: a) if at the time of injury or illness there is available, or potentially available, any coverage, the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's Coordination of Benefit Article B). The Plan's benefits shall be excess to the responsible party, its insurer, or any other source on behalf of that party, any first party insurance through medical payment coverage, personal injury protection, No-fault Auto insurance coverage, uninsured or underinsured motorist coverage, any policy of insurance from any insurance company or guarantor of a Third-Party, workers' compensation or other liability insurance company, or any other source, including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

9.4 Severability. In the event that any provision of this Article is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this Article and Plan. The provision shall be fully severable. The Plan shall be construed and provisions enforced as if such invalid or illegal provision had not been inserted in the Plan.

9.5 Verification of Eligibility. Except for Emergency Services, Providers shall confirm Member eligibility before rendering Covered Services. If the Provider obtains such confirmation, Plan shall not retroactively deny payment if Plan later determines that a Member verified as eligible was not in fact a Member.

ARTICLE X
HIPAA PRIVACY AND SECURITY

10.1 Compliance with HIPAA Privacy and Security. Certain Authorized Individuals of the Employer's workforce perform services in connection with administration of the Plan. To perform these services, it is necessary for these Covered Employees from time to time to have access to Protected Health Information ("PHI") as defined below. Under the Standards of Privacy of Individually Identifiable Health Information (45CFR Part 164 the "Privacy Standards"), these Covered Employees are permitted to have such access subject to the following:

General. The Plan shall not disclose PHI to any Covered Individual of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy & Security Article is met. PHI shall have the same definition as set out in the Privacy Standards and generally shall mean individually identifiable health information about the past, present, or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

Permitted Uses and Disclosures for Plan Administration. PHI disclosed to Authorized Individuals of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administration functions. The Plan's administrative functions shall include all Plan payment and heath care operations. The terms "payment" and "health care operations" shall have the same Glossary as set out in the Privacy Standards.

Generally, “payment is defined as any activity undertaken by the Plan to collect money due to it or to determine or fulfill its responsibility for payment of benefits under the Plan. “Health care operations” include activities related to payment and plan administration. Plan administration functions do not include employment-related functions or functions in connection with other benefit plans.

Prohibition on Use or Disclosure of Genetic Information for Underwriting Purposes. Notwithstanding any other provision of the Plan, the Plan shall not use or disclose PHI that is genetic information for underwriting purposes. “Underwriting purposes” means, with respect to the Plan, 1) rules for, or determination of, eligibility (including enrollment and continued eligibility) for, or determination of, benefits under the Plan (including cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program) ; 2) the computation of contribution amounts under the Plan (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); 3) the application of any preexisting condition exclusion under the Plan, coverage or policy; and 4) other activities related to the creation, renewal, or replacement of a contract of health benefits. However, “underwriting purposes” does not include determinations of medical appropriateness where an individual seeks a benefit under the Plan.

Authorized Employees. The Plan shall disclose PHI only to Authorized Individual of the Employer’s workforce who are authorized to receive such PHI, and only to the extent and in the minimum amount necessary for these persons to perform Plan administrative functions. For purposes of this HIPAA Privacy and Security Article, “Authorized Individuals” include the following: Risk Manager, Treasurer, HR manager, Covered Employees in the Information Technology Department who support employee benefits.

Updates Required. The Plan Sponsor shall amend the Plan promptly with respect to any changes in the Authorized Individuals of an Employer’s workforce who are authorized to receive PHI. An Authorized Individual of the Employer’s workforce who receives PHI shall use or disclose the PHI only to the extent necessary to perform his or her duties with respect to the Plan’s administrative functions. In the event that any Authorized Individual of the Employer’s workforce uses or discloses PHI other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach; applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment; mitigating any harm caused by the breach, to the extent practicable, and documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

10.2 Certification of Employer. The Employer must provide certification to the Plan that it agrees to not use or further disclose PHI other than as permitted or required

by the Plan documents or as required by law; ensure that any agent or subcontractor to whom it provides PHI agrees to the same restrictions and conditions that apply to the Employer with respect to such information; not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer; report to the Plan any use of disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law; make available PHI to individual Plan Covered Individuals in accordance with article 164.524 of the Privacy Standards; make available PHI for amendment by individual Plan Covered Individual and incorporate any amendments to PHI in accordance with Article 164.52 of the Privacy Standards; make available PHI required to provide any accounting of disclosures to individual Plan Covered Individual in accordance with Article 164.528 of the Privacy Standards; make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards; if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible, and ensure the adequate separation between the Plan (including Authorized Individuals of the Employer's workforce) and the Employer, as required by Article 164.504(f)(2)(iii) of the Privacy Standards.

10.3 Compliance with HIPAA Security Standards. If the Employer creates, receives, maintains, or transmits any electronic PHI on behalf of the Plan (other than enrollment/disenrollment information, summary health information, and information disclosed pursuant to a HIPAA compliant authorization, which are not subjects to these restrictions), the Employer will: implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan; ensure that the adequate separation between the Plan and Employer (i.e. the firewall) described in Section 15.1 is supported by reasonable and appropriate security measures; ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and report to the Plan any security incident of which it becomes aware, as follows: Employer will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy electronic PHI or to interfere with systems operations in an information system containing electronic PHI; in addition, Employer will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of electronic PHI or interference with systems operations in an information system containing electronic PHI. "Electronic PHI" means Protected Health Information that is transmitted by or maintained in electronic media.

ARTICLE XI
PLAN ADMINISTRATION

11.1 Responsibilities of the Plan Administrator. The Plan Administrator is the Company. The Plan must be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or a committee may be appointed by the Company to carry out actions of the Plan Administrator as agents of the Plan Administrator.

11.2 Discretionary Authority of the Plan Administrator. The Plan Administrator shall perform its duties and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination, or other action of the Plan Administrator shall be subject to reversal only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with, and consent to, any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section. The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

11.3 Powers and Duties of the Plan Administrator. The Plan Administrator will have the powers and duties of the general administration of this Plan, including the following: to administer the Plan in accordance with its terms; to determine all questions of eligibility, status, and coverage under the Plan; to interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed items; to make factual findings; to decide disputes which may arise relative to a Covered Individual's rights and/or availability of benefits; to prescribe procedures for filing a claim for benefits, to review claim denials and Appeals relating to them and to uphold or reverse such denials; to keep and maintain the Plan documents and all other records pertaining to the Plan; to appoint and supervise a Claims Administrator to pay Claims to perform all necessary reporting as required by ERISA; to establish and communicate procedures to determine whether a medical child support order is a QMCSO; to delegate to any person or entity such powers, duties, and responsibilities it deems appropriate; to establish one or more committees to assist in administration of the Plan; and to perform each and every function necessary for or related to the Plan's administration.

It shall be the principal duty of the Plan Administrator to see that the terms of the Plan are carried out for the exclusive benefit of persons entitled to participate in the Plan. In connection with its administration of the Plan, except as may be otherwise provided herein and in addition to the powers specifically given to the Plan Administrator elsewhere

in the Plan, the powers and duties of the Plan Administrator shall include (without being limited thereto) the following powers and duties:

1. To construe and interpret the terms of the Plan and to determine all questions arising under the Plan, including the power to determine the rights or eligibility of Eligible Employees or Eligible Dependents under the Plan and the amount, manner and timing of their benefits hereunder, and to remedy ambiguities, inconsistencies and omissions.

2. To adopt such rules of procedure and regulations as in its opinion may be necessary for the proper and efficient administration of the Plan and as are consistent with the Plan, and to enforce the Plan according to its terms and rules and regulations adopted by the Plan Administrator as above.

3. To prescribe forms to be used in the administration of the Plan.

4. To make a determination as to the right of any person to a benefit and to afford any person dissatisfied with such determination the right to appeal such determination.

5. To receive from the Employer and from Covered Employees and Covered Dependents such information as shall be necessary for the proper administration of the Plan.

6. To prepare and distribute information necessary for the administration of the Plan.

7. To furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate.

8. To employ agents, attorneys, accountants, actuaries or other persons and allocate or delegate them such powers, rights and duties as the Plan Administrator may consider necessary or desirable to properly carry out the administration of the Plan, provided that such allocation or delegation, and the acceptance thereof by such agents, attorneys, accountants, actuaries, or other persons, shall be in writing.

9. To adopt such rules and procedures as in its opinion may be necessary or appropriate for the proper and efficient administration of medical child support orders.

Notwithstanding the foregoing, the Plan Administrator may designate other organizations or persons (who also may be employed by an Employer) to carry out specific fiduciary or non-fiduciary responsibilities of the Plan Administrator in administering the Plan, including, but not limited to, the following:

1. Pursuant to an administrative services agreement or claims administration agreement, the responsibility for administering and managing any part of the Plan, including the processing and payment of claims under the Plan and recordkeeping related thereto;

2. The responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to Eligible Employees or other persons entitled to benefits under the Plan; and

3. The responsibility to review Claims or Claim denials under the Plan to the extent an insurer, Claims Administrator or Appeals Fiduciary is not empowered with such responsibility under the terms of this Plan, in accordance with section 2719 of the Public Health Service Act.

11.4 Plan Administrator Compensation. The Plan Administrator serves without compensation.

11.5 Fiduciary. A person is a "fiduciary" with respect to the Plan to the extent that the person: exercises any discretionary authority or discretionary control respecting management of the Plan or exercises any authority or control respecting management or disposition of Plan assets; renders investment advice for a fee or for any other compensation, direct or indirect, or has any authority or any responsibility to do so; or has discretionary authority or discretionary responsibility in the administration of the Plan.

11.6 Fiduciary Duties. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to Covered Individuals, and defraying reasonable expenses of administering the Plan. These are duties which must be carried out with care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation; by diversifying the investments of the Plan so as to minimize the risk of large losses unless under the circumstances it is clearly prudent not to do so; and in accordance with the Plan documents to the extent that they agree with ERISA. Any individual or entity that serves as a fiduciary of this Plan may serve in more than one fiduciary capacity with respect to the Plan. Further, a fiduciary may employ one or more individuals or entities with regard to any responsibility that the fiduciary has under the Plan.

11.7 Named Fiduciary. A "named fiduciary" is the fiduciary named in the Plan. A Named Fiduciary can appoint others to carry out fiduciary responsibilities under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the Named Fiduciary allocates its responsibility to other persons, the Named Fiduciary shall not be liable for any act or omission of such person unless either the Named Fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or the Named Fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA. The Named Fiduciary of this Plan is the Plan Administrator. The Third-Party Administrator is not a fiduciary of this Plan.

11.8 Release of Medical Information. The Plan Administrator and Claims Administrator are entitled to receive information reasonably necessary to administer this Plan, subject to all applicable confidentiality requirements as defined in this Plan and as

required by law, from any Health Care Provider of services to a Covered Individual. By accepting coverage under this Plan, Covered Individuals authorize any Health Care Provider that has attended or treated them, to release to the Plan Administrator and Claims Administrator upon request, any and all information, records or copies of records relating to attendance, examination or treatment rendered to Covered Individuals. If the Covered Individual inhibits the Plan Administrator and/or Claims Administrator from getting necessary information to pay Claims, this Plan has no obligation to pay Claims.

11.9 Payment to Health Care Providers and Assignment of Benefits. When a Covered Individual receives Covered Services from an Out-of-Network Health Care Provider, this Plan pays the Health Care Provider, unless the Covered Individual provides this Plan with satisfactory proof that the Covered Individual has already paid the Health Care Provider for the Covered Services. The amount of such payment shall be consistent with the benefits available under the terms of the Plan. Claims for services received by a Covered Individual from an unapproved Out-of-Network Health Care Provider that are not Covered Services will not be paid. A Covered Individual who has paid an unapproved Out-of-Network Health Care Provider outside of the Plan will not receive any reimbursement for such payments if the claim relates to services that are not Covered Services.

11.10 Amending and Terminating the Plan. As the settlor of the Plan, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending the benefits under the Plan. Because amendments are made by the Plan Sponsor in its settlor capacity (and not as Plan Administrator), they are not subject to ERISA's fiduciary standards. The procedure for amending the Plan is for the Plan Sponsor's Board of Directors (or its delegate) to adopt a resolution approving the amendment. However, the Plan Sponsor's Director of Employee Benefits has authority to adopt legal, technical, compliance, and administrative amendments to the Plan without the need for Board of Directors approval. If the Plan is terminated, the rights of the Covered Individuals are limited to Covered Charges incurred before the Plan's termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for Covered Charges incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding Claims and all expenses of Plan termination. To the extent that any Plan assets remain, they will be used for the benefit of Covered Individuals and Covered Employees in accordance with ERISA. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

11.11 Non-Discretionary Administration. Day-to-day administration of the Plan may be performed (or overseen, to the extent performed by a Third-Party) by employees of the Plan Sponsor. To the extent that these Covered Employees perform non-discretionary administrative functions, they are acting as agents of the Company and not as Plan fiduciaries.

11.12 Indemnification. In its capacity as settlor of the Plan, the Plan Sponsor will indemnify its officers and employees from any and all personal liability arising out of any

actions taken by them in good faith and in the course and scope of their employment and responsibilities with respect to the Plan. Indemnification shall not apply in the case of intentional misconduct, gross negligence, self-dealing, or conflict-of-interest transactions involving any officer or employee.

11.13 Funding. For each Coverage Year, the Employer will determine the amount of contributions that Covered Individual or any subgroup of Covered Individual will be required to pay for coverage under this Plan. The portion of the cost of coverage for which the Covered Individual is responsible may be paid by the Covered Employee on a pre-tax basis through a cafeteria plan of the Employer if such a plan is made available by the Employer and the Covered Employee meets the eligibility requirements of, and enrolls in, the cafeteria plan. The Employer will be responsible for any amounts under the Plan in excess of the contributions by Covered Individuals. Operating expenses may be paid either out of Employer/Employee contributions, if any, or directly be the Employer. The Plan Sponsor intends for this Plan to be an unfunded contractual obligation, with benefits paid from the Employer's general assets and Employee contribution. To the extent this Plan has Plan assets, such assets shall be used for the sole and exclusive purpose of providing benefits under this Plan and defraying reasonable administrative costs of this Plan (including disposition of Plan assets upon termination of this Plan).

ARTICLE XII
GENERAL PROVISIONS

12.1 Applicable Law. This is a self-insured benefit plan governed by ERISA. As such, Federal law and jurisdiction may preempt State law and jurisdiction regarding certain types of claims brought under the Plan. To the extent not preempted by federal law, the laws of the State of Illinois shall apply.

Exhaustion of Administrative Procedures Required. To the fullest extent permitted under applicable law, the right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. Failure to exhaust administrative procedures may preclude you from bringing an action in court.

12.2 Conformity with Governing Law. If any provision of this Plan is contrary to any law to which it is subject, such provisions are hereby amended to conform thereto.

12.3 Not a Contract of Employment. This Plan document and any amendments constitute the terms and provisions of benefits available through this Plan. Nothing in this Plan document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Employer with the bargaining representatives of any Employees.

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

12.5 Making a Claim for Benefits. In order for a Covered Charge to be paid by the Plan, a Claim must be properly and timely submitted in accordance with the claims procedures set forth in Article XIII: Claim and Appeal Procedures. If a Claimant does not agree with the initial Claim decision made by the Plan, the Claimant has a right to Appeal that decision and have it reviewed. Under certain circumstances expedited review may be requested. If the Claimant does not agree with the Claim decision on Appeal, the Claimant has the right, in many cases, to request an External Review. For more information, see Addendum 1. For purposes of the Plan's Claim procedure (and Appeal procedures described in Claims and Appeals Procedures appearing later in this document, and Authorized Representative may act on a Claimant's behalf with respect to any aspect of a Claim. Once an Authorized Representative has been recognized by the Plan, the Plan will direct all information, correspondence, notifications and other communications regarding the Claim to the Authorized Representative, unless and until the Claimant provides written direction to the Claims Administrator otherwise.

12.6 Non-Discrimination Policy. This Plan will not discriminate against any Covered Individual based on race, color, religion, national origin, disability, gender, sexual orientation, or disability.

12.7 Mental Health Parity. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with Mental Health Parity. Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost-sharing restrictions and treatment duration limitations.

12.8 Newborns' and Mothers' Health Protection Act (NMHPA). Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with NMHPA. Federal law requires the following statement be included in the Plan document: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

12.9 Women's Health and Cancer Rights Act of 1998 (WHCRA). Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with WHCRA. Specifically, the Plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

12.10 Genetic Information Nondiscrimination Act of 2008 (GINA). Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with GINA.

12.11 Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with USERRA. The Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by USERRA.

12.12 Michelle's Law. Notwithstanding any provision of the Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with Michelle's Law. Generally, if coverage for a Dependent child is based on the child's status as a student and the child is no longer enrolled as a student due to a serious injury or illness, the Plan will continue coverage for a limited period of time.

ARTICLE XIII
FILING A CLAIM, CLAIM PROCEDURES, APPEAL PROCEDURES

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

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

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

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

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

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

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

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

Pre-service Claims

- A "pre-service non-urgent claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

- A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Concurrent Claims

- A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or

- The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

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

Post-service Claims

- A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

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

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third-Party Administrator in accordance with the Plan's procedures. If the resulting post-service claim for benefits is not filed within 180 days of the date the service was incurred the claim will be denied.

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

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

Pre-service Urgent Care Claims

- If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

- If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.

- The Participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:

  - The Plan's receipt of the specified information; or

  - The end of the period afforded the Participant to provide the information.

If there is an Adverse Benefit Determination, a request for an expedited Appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

Pre-service Non-Urgent Care Claims

- If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

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

Concurrent Claims

- *Plan Notice of Reduction or Termination*. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments the Participant will be notified 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. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

- *Request by Participant Involving Urgent Care*. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Participant makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

- *Request by Participant Involving Non-Urgent Care*. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

- *Request by Participant Involving Rescission*. With respect to rescissions, the following timetable applies:

  - Notification to Participant: 30 days

  - Notification of Adverse Benefit Determination on Appeal: 30 days

Post-service Claims

- If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

- If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

Extensions – Pre-service Urgent Care Claims

No extensions are available in connection with Pre-service urgent care claims.

Extensions – Pre-service Non-Urgent Care Claims

This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims

This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods

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

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

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

- A reference to the specific portion(s) of the Plan provisions upon which a denial is based;

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

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's internal Appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the Appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;

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

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

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

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and Appeals and external review processes; and

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

13.5 Appeal of Adverse Benefit Determinations.

Full and Fair Review of All Claims

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

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to Appeal the determination;

- Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and Appeals process;

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

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

- That, in deciding an Appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of any such individual;

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

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

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

Requirements for Appeal

The Participant must file the Appeal in writing (although oral Appeals are permitted for pre-service urgent care claims) within [180] days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally Appeal, the Participant may telephone:

Group Plan Solutions Benefit Administration,
A Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

To file an Appeal in writing, the Participant's Appeal must be addressed as follows and mailed or faxed as follows:

Group Plan Solutions Benefit Administration,
A Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

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

- The name of the employee/Participant;
- The employee/Participant's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the Appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the Appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

- *Pre-service Urgent Care Claims*: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Appeal.

- *Pre-service Non-urgent Care Claims*: Within a reasonable period of time appropriate to the medical circumstances; but not later than 30 days after receipt of the Appeal.

- *Concurrent Claims*: The response will be made in the appropriate time period based upon the type of claim; pre-service urgent, pre-service non-urgent or post-service.

- *Post-service Claims*: Within a reasonable period of time, but not later than 60 days after receipt of the Appeal.

Manner and Content of Notification of Adverse Benefit Determination on Review

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

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

- A reference to the specific portion(s) of the Plan provisions upon which a denial is based;

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

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of available internal Appeals and external review processes, including information regarding how to initiate an Appeal;

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

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;

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

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

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

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

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Review

If, for any reason, the Participant does not receive a written response to the Appeal within the appropriate time period set forth above, the Participant may assume that the

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

13.6 External Review Process.

A. Scope

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

2. The Federal external review process applies only to:

(a) An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and

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

B. Standard External Review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

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

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

(a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(b) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

(c) The claimant has exhausted the Plan's internal Appeal process unless the claimant is not required to exhaust the internal Appeals process under the interim final regulations; and

(d) The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

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

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

13.7 Expedited External Review.

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

(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal Appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the

claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal Appeal; or

(b) A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

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

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

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and Appeals process.

4. Notice Of Final External Review Decision. The Plan's (or Third-Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

ARTICLE XIV
ERISA INFORMATION

14.1 Administrative Information. The following table summarizes important administrative information about the Plan:

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Pedigree Ovens Inc as of August 1, 2018, hereby sets forth the provisions of the Pedigree Ovens Inc. Health and Welfare Benefit Plan (the "Plan").

Name of Plan: Pedigree Ovens Inc. Employee Health Plan.
Plan Sponsor's Employer Identification Number:26-2894155
Plan Number: 3
Plan Year: 2018-2019
Type of Plan: Group Health Plan
Type of Administration: The Plan is administered by the Company in its discretion. The Company may enter into an administrative services contract with a third-party administrator for the payment of claims for benefits.
Plan Administrator, Plan Sponsor, Agent for Legal Service, Named Fiduciary: Pedigree Ovens Inc., 495 Comanche Circle, Harvard, IL 60033-3110 **Claims Administrator:** Group Plan Solutions, 2505 Court Street, Pekin, IL 61558 This Plan is self-insured, meaning that benefits are paid from the general assets of the Plan Sponsor and are not guaranteed under an insurance policy or contract. The cost of the Plan is paid with contributions by the Plan Sponsor and participating employees. The Plan Sponsor determines the amount of contributions to the Plan, based on estimates of claims and administration costs.

14.2 Statement of ERISA Rights. A Covered Individual under this Plan is entitled to certain rights and protections under ERISA. ERISA provides that all Covered Individuals shall be entitled to:

- **Receive Information About this Plan and Benefits.**
  - Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing this Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if required to be filed by this 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 this Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of this Plan's annual financial report, if an annual financial report is required. The Plan Administrator may make a reasonable charge for the copies. The Plan Administrator is required by law to furnish each Covered Individual with a copy of this summary annual report.

- Continue health care coverage for the Employee, Spouse or Dependents if there is a loss of coverage under this Plan as a result of a Qualifying Event. Covered Individuals may have to pay for such coverage. Review the COBRA Notice of Rights in this document and the Plan rules governing COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under this Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion under another plan in accordance with applicable law.

- **Prudent Actions by Plan Fiduciaries**. In addition to creating rights for plan Covered Individuals, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Individuals. No one may fire an employee or otherwise discriminate against an employee in any way to prevent them from obtaining a welfare benefit or exercising rights under ERISA.

- **Enforce Your Rights**. If a claim for a welfare benefit is denied or ignored a Covered Individual 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 Covered Individuals can take to enforce the foregoing rights. For instance, if a Covered Individual requests a copy of

Plan documents or the latest annual report from this Plan and does not receive them within thirty (30) days, the Covered Individual 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 Individual up to $110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Covered Individual has a Claim for benefits which is denied or ignored the Covered Individual may file suit in a state or Federal Court after exhausting the Appeal procedures provided in this Plan. In addition, if a Covered Individual disagrees with this Plan's decision or lack thereof concerning the qualified status of a medical child support order, the Covered Individual may file suit in Federal Court. If it should happen that Plan fiduciaries misuse this Plan's money, or if a Covered Individual is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Covered Individual is successful, the court may order the person they sued to pay these costs and fees. If the Covered Individual loses, the court may order the Covered Individual to pay these costs and fees, for example, if it finds the claim to be frivolous.

- **Assistance with Questions.** For questions about this Plan, contact the Plan Administrator. For questions about this statement or about a Covered Individual's rights under ERISA or if a Covered Individual needs assistance in obtaining documents from the Plan Administrator, 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. A Covered Individual may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Execution of Plan Document

IN WITNESS, WHEREOF, this Plan Document is executed pursuant to proper authority:

By: _____

Name: Kurt Stricker

Title: President

Date: July 27, 2018