Pekin Insurance Health Benefit Plan
Traditional Health Benefits

(Active Employee Plan)

Document and Summary Plan Description

Original Effective Date: January 1, 2017
Restatement Effective Date: January 1, 2020

Table of Contents

ESTABLISHMENT OF THE PLAN 4
ADOPTION OF THE PLAN DOCUMENT AND SUMMARY DESCRIPTION 4
INTRODUCTION AND PURPOSE AND GENERAL PLAN INFORMATION 5
SCHEDULE OF BENEFITS 9
DEFINITIONS 18
ELIGIBILITY AND EFFECTIVE DATE FOR COVERAGE 37
Eligibility for Employee Coverage 37
Effective Date for Employee Coverage 37
Eligibility for Dependent Coverage 37
SPECIAL ENROLLMENT PERIODS 38
Additional Special Enrollment Rights 41
OPEN ENROLLMENT 41
TERMINATION OF COVERAGE 41
Employer Continuation Coverage 42
Continuation During Family and Medical Leave 42
Employees on Military Leave 43
MEDICAL BENEFIT 43
Amount of Benefit for Covered Expense 43
Preventative Care 43
Benefit for Covered Expense Provided by a Preferred Provider 44
Benefit for Covered Expense for Emergency Services 45
Benefit for Covered Expense Provided by a Non-Preferred Provider 45
Use of Non-Preferred Providers 46
Benefits Payable for Covered Expense 46
PRESCRIPTION BENEFIT 53
Amount of Benefit 53
Allowable Covered Prescription Expense 53
How to File a Claim 54
Prescriptions Purchased at a Retail Pharmacy 54
Prescriptions Purchased From the Mail Service Program 54
Prescription Drug Card Limitations and Exclusions 55
MEDICAL BENEFIT LIMITATIONS & EXCLUSIONS 56
PRECERTIFICATION OF SERVICES 60
Services Requiring Precertification by Utilization Review 60
Services Recommended for Precertification by Utilization Review 60
Medical Emergency 60
Making the Call 60
Precertification Process 61

Medical Necessity and Appropriateness ... 61
Right to Appeal ... 61
Failure to Precertify ... 61
CASE MANAGEMENT PRIOR AUTHORIZATION / PREAPPROVAL ... 61
FILING A CLAIM, CLAIM PROCEDURES, APPEAL PROCEDURES ... 62
COORDINATION WITH MEDICARE AND MEDICAID ... 74
COORDINATION OF BENEFITS ... 74
HEALTH INSURANCE CONTINUATION COVERAGE RIGHTS UNDER COBRA ... 75
GENERAL PROVISIONS ... 79
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT ... 81
PLAN ADMINISTRATION ... 86
PARTICIPANT'S RIGHTS ... 88
HIPAA PRIVACY ... 89
WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ... 91
THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 ANNUAL NOTICE TO HEALTH PLAN PARTICIPANTS ... 91

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

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Farmers Automobile Insurance Association (the "Sponsor") as of January 1, 2020 hereby sets forth the provisions of the Pekin Insurance Health Benefit Plan - Traditional Health Benefits (the "Plan").

Effective Date

The Plan Document is effective as of the date first set forth above, and any amendment is effective as of the date set forth in the amendment.

Adoption of the Plan Document

Farmers Automobile Insurance Association, as the settler of the Plan, hereby adopts this Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1 et seq. ("ERISA").

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

Farmers Automobile Insurance Association

By: Kimberly Remmert

Name: Kimberly Remmert

Date: 12/18/19

Title: VP-HR

INTRODUCTION AND PURPOSE AND GENERAL PLAN INFORMATION

Introduction and Purpose

Farmers Automobile Insurance Association has established the Plan for the benefit of employees, in accordance with the terms and conditions described herein. Participants in the Plan may be required to contribute toward benefit coverage.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for medical benefits. The Plan Document is maintained by Farmers Automobile Insurance Association and may be inspected at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:	**Pekin Insurance Health Benefit Plan** **Traditional Health Benefits**
Plan Sponsor/Employer:	**Farmers Automobile Insurance Association** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161**
Plan Administrator: **(Named Fiduciary)**	**Farmers Automobile Insurance Association** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161**
Plan Sponsor ID No.	**37-0268670**
Source of Funding:	**Self-Funded**
Applicable Law:	**ERISA**
Calendar Year/Plan Year:	**January 1 – December 31**
Plan Number:	**510**
Plan Type:	**Welfare Plan**
Original EFFECTIVE DATE:	**January 1, 2017**
Restatement EFFECTIVE DATE:	**January 1, 2020**
Third Party Administrator **Preapproval:**	**Group Plan Solutions Benefit Administration,** **A Division of Pekin Insurance** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 855-545-7165** **Email: inquiry@groupplansolutions.com** **Website:** www.groupplansolutions.com

Case Management Prior Authorization, Precertification and Utilization Review for Medical Conditions and Mental Health and Substance Use Disorder:	**Hines & Associates, Inc.** **14 N Riverside Avenue** **St. Charles, IL 60174**
24-hour Precertification:	**Phone: 888-641-5304** **Website:** www.precertcare.com
Pharmacy Benefit Manager:	**Optum RX** **Customer Service: 844-265-1771** **Website:** www.optumrx.com
Preferred Provider Networks: **Please refer to Your ID card for Your correct network identification. Your network is defined by your location.**	**UnityPoint Health PLUS (formerly First Choice)** **Group Plan Solutions** **P.O. Box 21424** **Eagan, MN 55121** **Phone: 866-510-2922** **HealthLink - Open Access III** **P.O. Box 419104** **St. Louis, MO 63141** **Phone: 800-624-2356** **PHCS** **PO Box 21424** **Eagan, MN 55121** **Phone: 888-955-7427** **HealthEOS by Multiplan** **EDI# 34080** **PO Box 6090** **Depere, WI 54115-6090** **Phone: 800-279-9776** **Travel Network:** **PHCS - Healthy Directions** **EDI# 37086** **P.O. Box 1587** **Pekin, IL 61555-1587**
COBRA Notice:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance** **COBRA** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 855-545-7165** **Email: inquiry@groupplansolutions.com** **Website:** www.groupplansolutions.com

Participating Employers:	**Farmers Automobile Insurance Association** **Tax ID: 37-0268670** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161 ext. 2451**
	Pekin Insurance Company **Tax ID: 37-6028411** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161 ext. 2451**
	Pekin Life Insurance Company **Tax ID: 37-0866596** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161 ext. 2451**
Agent for Service of Process:	**Farmers Automobile Insurance Association** **2505 Court Street** **Pekin, IL 61558** **Phone: 309-346-1161**

Legal Entity and Service of Process

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

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Participant or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Plan Document shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time.

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.

Applicable Law

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

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right:

- to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents
- to make determinations in regards to issues relating to eligibility for benefits
- to decide disputes that may arise relative to a Plan Participant's rights, and
- to determine all questions of fact and law arising under the Plan.

SCHEDULE OF BENEFITS
Effective 1/1/2020
Pekin Insurance Health Benefit Plan - Traditional Health Benefits

Calendar Year Deductible

The amount of the Covered Expenses a Participant is responsible to pay each Calendar Year. The Preferred Provider and Non-Preferred Provider Calendar Year Deductibles are accumulated separately.

	Preferred Providers	Non-Preferred Providers
Individual Deductible (per Calendar Year)	$ 750	$ 1,500
Family Deductible (per Calendar Year)	$ 2,250	$ 4,500

All individual Deductible amounts will satisfy the family Deductible, but no one Participant will be required to pay more than the individual Deductible amount.

Out-of-Pocket Maximum - Medical

The maximum amount of Covered Expenses a Participant must pay per Calendar Year before the Plan will begin to pay benefits for Covered Expenses at 100% for such Calendar Year. The Preferred Provider Out-of-Pocket Maximum and Non-Preferred Provider Out-of-Pocket Maximum are accumulated separately for the Calendar Year.

	Preferred Providers	Non-Preferred Providers
Individual Out-of-Pocket Maximum (per Calendar Year)	$ 4,000	$ 8,000
Family Out-of-Pocket Maximum (per Calendar Year)	$ 8,000	$16,000

All individual Out-of-Pocket amounts will satisfy the family Out-of-Pocket maximum, but no one Participant will be required to pay more than the individual Out-of-Pocket amount.

Out-of-Pocket Maximum includes: annual Deductible, Coinsurance, Copays and Access Fees.

Coinsurance & Benefit Maximums for Covered Expenses per Participant

Preferred Provider and Non-Preferred Provider Coinsurance percentages are the percentages of Covered Expenses paid by the Plan. Benefit Maximum is the limit on the Covered Expenses that the Plan will pay on behalf of any Participants per Calendar Year. Expenses must be eligible under the Plan, Medically Necessary and the most cost-effective medically appropriate care.

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Preventative Care	100% (Deductible Waived)	Not Covered	
Primary Care Physician Office Visit evaluation and management services	$25 Copay (Deductible Waived - 80% coinsurance applies to additional services.)	60%	
Virtual Care Visit with designated telemedicine provider		Not Covered	
Specialist Physician Office Visit evaluation and management services	$40 Copay (Deductible Waived - 80% coinsurance applies to additional services.)	60%	
Hospital Services - Inpatient ***Precertification required***	80%	60%	
Hospital Services – Outpatient **May require Case Management Prior Authorization**	80%	60%	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Serious Mental Health Conditions – Inpatient ***Precertification required***	80%	60%	
Serious Mental Health Conditions – Outpatient **Precertification/Case Management Prior Authorization recommended** – See **PRECERTICATION OF SERVICES** section	80%	60%	
Ambulatory Surgical Facility	80%	60%	
Physician & Surgeon Services	80%	60%	
Emergency Room (Access Fee waived if participant is admitted immediately following the emergency room visit) *No coverage for Non-Emergency Services at an Emergency Room*	80% after $75 Access Fee for Emergency Services	80% after $75 Access Fee for Emergency Services	
Emergency Ambulance Services (ground and air)	80%	80%	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Skilled Nursing Facility **Case Management Prior Authorization required**	80%	60%	90 days per Calendar Year maximum
Outpatient Diagnostic Tests and Laboratory Tests	80%	60%	
Outpatient Non-Emergency High Tech Diagnostic Services. MRI, MRA, CT and PET	80%	60%	
Outpatient Radiation and Chemotherapy ***Case Management Prior Authorization required***	80%	60%	
Outpatient Medical Supplies including Durable Medical Equipment ***Preapproval required***	80%	60%	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Maternity Services – Routine Prenatal	100% (Deductible Waived - 80% coinsurance applies to additional services.)	60%	
Maternity Services-Hospital Inpatient Confinement	80%	60%	
Inpatient Rehabilitation Services ***Precertification/Case Management Prior Authorization required***	80%	60%	
Human Organ or Tissue Transplants ***Precertification required (inpatient) & Preapproval (outpatient)***	100%, After Deductible (at Center of Excellence Transplant Facility)	Non-Center of Excellence 90% of first $100,000, After Deductible No coverage thereafter	See Covered Expenses for complete benefit description
Transplant Service Lodging and Transportation Allowance when Center of Excellence Transplant Facility is used ***Preapproval required***	100%, Deductible Waived, $200 daily maximum, $10,000 lifetime maximum	Not Covered at Non-Center of Excellence	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Substance Use Disorders – Inpatient ***Precertification required - See PRECERTIFICATION OF SERVICES section***	80%	60%	
Substance Use Disorders - Partial Hospitalization and Outpatient Services ***Precertification/Case Management Prior Authorization recommended***– See ***PRECERTICATION OF SERVICES*** section	80%	60%	
Hospice Care ***Case Management Prior Authorization required***	80%	60%	
Home Health Care ***Case Management Prior Authorization required***	80%	60%	90 visits per Calendar Year maximum
Temporomandibular Joint Dysfunction (TMJ) services including diagnostic and surgical treatment Oral Appliances for TMJ ***Preapproval required***	80% 50% for Oral Appliances	60% 50% for Oral Appliances	TMJ benefits limited to $2,500 lifetime maximum allowed Oral Appliances for TMJ limited to one every 3 years, applied to the $2,500 TMJ lifetime maximum allowed

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Oral Appliances for Teeth Grinding ***Preapproval required***	50%	50%	Benefit Limit for Oral Appliances related to Teeth Grinding limited to one every 3 years and $2,500 Calendar Year max allowed
Oral Appliances for Sleep Apnea **Preapproval *required***	50%	50%	Benefit Limit for Oral Appliances related to Sleep Apnea limited to one every 3 years and $2,500 Calendar Year maximum allowed
Therapy – Physical & Occupational	80%	60%	20 visit for each therapy type per Calendar Year, **additional visits require Preapproval**
Speech Therapy ***Preapproval required***	80%	60%	***Preapproval required***

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Therapy – Manipulative (Chiropractic, Osteopathic & Naprapath). Spinal manipulation/adjustment	$25 Copay (After Copay, Deductible Waived - 80% coinsurance applies to additional services.)	60%	20 visits per Calendar Year maximum
Infertility Treatment ***Preapproval required***	80%	60%	3 completed oocytes retrievals per lifetime, see Covered Expenses for complete benefit description
Bariatric Surgery ***Preapproval required***	80%	60%	See Covered Expenses for complete benefit description
Cardiac Rehabilitation Services – Phase I and Phase II	80%	60%	36 treatments per 6 month period
Injectable Medications, administered in an office setting. ***Preapproval required***	80%	60%	

Medical Services and Supplies	**Preferred Provider Coinsurance Percentage Paid by the Plan (after Preferred Provider Deductible)**	**Non-Preferred Provider Coinsurance Percentage Paid by the Plan (after Non-Preferred Provider Deductible)**	**Benefit Maximum per Participant, if any**
Reasonable and Customary Percentile Level	95th	95th	
Retail Prescription Drugs (per drug purchased) 90 day supply, after a 30 day supply is filled. (1 copay for 1-30 day supply, 2 copays 31-60 day supply, 3 copays 61-90 day supply.) No more than a 30 day supply allowed on Specialty drugs and opioids.	Generic Drugs: $20 Copayment Preferred Brand Drugs: $30 Copayment Non-Preferred Brand Drugs: $50 Copayment Specialty Drugs: $100 Copayment	Not Covered	
Mail Order Prescription Drugs (per drug purchased) 90 day supply, after a 30 day supply is filled. No more than a 30 day supply allowed on Specialty drugs and opioids.	Generic Drugs: $60 Copayment Preferred Brand Drugs: $90 Copayment Non-Preferred Brand Drugs: $150 Copayment Specialty Drugs: $100 Copayment	Not Covered	

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; however they may be used to identify ineligible expenses. Please refer to the appropriate sections of the Plan Document for that information. There are also definitions located in other sections of this Plan Document.

ACCESS FEE

Means the amount You must pay each time You incur Covered Expense for Emergency Services provided in a Hospital emergency room. The amount is shown on the Schedule of Benefits. This amount must be paid anytime You receive Emergency Services in a Hospital emergency room, and are not directly admitted to the Hospital as an Inpatient. This amount is in addition to any deductible and coinsurance amounts.

ADVERSE BENEFIT DETERMINATION

Means 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

Means a review of an adverse benefit determination by the Third Party Administrator, as required under this Plan's claims and internal appeals procedures.

Once an authorized representative is appointed, the Third Party Administrator will direct all information and notification regarding the claim to the authorized representative. You will be copied on all notifications regarding decisions, unless You provide specific written direction otherwise.

APPROVED CLINICAL TRIAL

Means a phase I, phase II, phase III, or phase IV Clinical Trial:

- Conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition or disease; and
- Is one of the following:
    - Federally funded trials;
    - The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
        1. The National Institutes of Health;
        2. The Centers for Disease Control and Prevention;
        3. The Agency for Health Care Research and Quality;
        4. The Centers for Medicare & Medicaid Services;
        5. A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses 1) through 4) above;
        6. The Department of Defense; or
        7. The Department of Veterans Affairs.

- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants in any of the following clauses below if the following conditions are met:
  - The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer reviews of studies and investigations used by the National Institutes of Health and assures unbiased reviews of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review:
    - The Department of Veterans Affairs;
    - The Department of Defense;
    - The Department of Energy; or
  - The study or investigation is conducted under an investigational new drug application review by the Food and Drug Administration; or
  - The study or investigation is a drug trial that is exempt from the investigational new drug application requirements.

Life-Threatening Condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualified Individual

A Participant who meets the following conditions:

- The Participant is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Condition or disease.
- Either:
  - the referring health care provider has concluded that the Participant's participation in the clinical trial would be appropriate based upon the Participants meeting the conditions described in paragraph above; or
  - the Participant provides medical and scientific information establishing that participation in such trial would be appropriate based upon the Participants meeting the conditions described above.

Routine Patient Costs

All items and services that are typically covered by the Plan for a Qualified Individual who is not enrolled in a clinical trial. Routine patient costs do not include:

- the investigational item, device, or service, itself;
- items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Clinical Trial participation requires Case Management Prior Authorization.

APPROVED TRANSPLANT SERVICES

Means services and supplies for organ transplants when provided at or arranged by a Transplant Center of Excellence. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement and tissue typing, and ancillary services related to the organ transplant.

AUTHORIZED REPRESENTATIVE

Means:

- a person to whom You have given express written consent to represent You in an external review, and includes Your health care provider, or
- a person authorized by law to provide substituted consent for You, or
- Your health care provider when You are unable to provide consent.

An Appointment of Authorized Representative form may be obtained from the Third Party Administrator. The completed form must be submitted to the Third Party Administrator at:

Group Plan Solutions
2505 Court Street
Pekin, IL 61558
FAX # 855-545-7165
Email Address: healthclaimappeal@groupplansolutions.com

An assignment for purposes of payment does not constitute appointment of an authorized representative under these claim procedures.

BENEFITS ELIGIBLE EMPLOYEE

Means a person employed by Farmers Automobile Insurance Company or a Participating Employer on a regular full-time basis. The person must work at least 30 hours per week. Members of the Inactive Class are not eligible under this Plan.

BENEFIT PERIOD

Means the 12 month period during which deductible and coinsurance amounts apply. It begins on January 1 of a year and ends on December 31 of the year.

CASE MANAGEMENT PRIOR AUTHORIZATION

Means the process of determining benefit coverage prior to service being rendered to a Participant. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the Participant. This Participant-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

CHILD, CHILDREN

Means the Benefits Eligible Employee or the Benefits Eligible Employee's Spouse's:

- natural born child;
- legally adopted child or child in the custody of the Benefits Eligible Employee or Benefits Eligible Employee's Spouse while adoption proceedings are pending with respect to that child; or
- any other child that has been declared the legal responsibility of the Benefits Eligible Employee or Benefits Eligible Employee's Spouse.

The child must be under 26 years of age.

It also means the Benefits Eligible Employee or Benefits Eligible Employee's Spouse's child who is 26 years of age or older, if the child meets the definition of Total Disability. The child must have become Totally Disabled before the child became 26 years of age.

CIVIL UNION

Means a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act or any other U.S. state civil union law.

CLAIM

Means any request for a Plan benefit or benefits made in accordance with the claim procedures. A communication regarding benefits that is not made in accordance with the claim procedures will not be treated as a claim.

CLAIMANT

Means a Participant person who makes a request for a Plan benefit or benefits in accordance with the claim and appeals procedures. Any reference to claimant in the section titled Filing a Claim, Claim Procedures, and Appeal Procedures for medical benefits also refers an authorized representative of the Participant person.

CLEAN CLAIM

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

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

COINSURANCE

Means the designated percentage the Plan will pay per Participant per benefit period in excess of any applicable deductible for a Covered Expense. The applicable percentages are shown on the Schedule of Benefits. For Covered Expenses, the Preferred Provider Coinsurance amount applies to Covered Expenses provided by a Preferred Provider and the Non-Preferred Provider Coinsurance amount applies to covered services provided by a Non-Preferred Provider.

COMPLICATIONS OF PREGNANCY

Means a pregnancy complicated by concurrent disease or abnormal conditions significantly affecting usual medical management, such as, but not limited to:

- extra-uterine pregnancy;
- severe toxemic disorders;
- severe puerperal sepsis;
- spontaneous miscarriage;
- severe hemorrhage;
- any complications of pregnancy requiring delivery by cesarean section.

Complication of pregnancy does not include:

- false labor;
- occasional spotting;
- physician prescribed rest;
- morning sickness;
- induced abortion;
- elective cesarean section;
- maternal age;
- repeat cesarean section, unless necessary because of existing medical complications.

CONCURRENT CARE CLAIM

Means a Claim where an ongoing course of treatment that has been approved will be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims:

a. where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; or
b. where an extension is requested beyond the initially approved period of time or number of treatments.

COPAY

Means the specific dollar amount a Participant is required to pay towards Covered Expenses. Copay amounts vary based on the service and are shown on the Schedule of Benefits.

COVERED CHILD(REN)

Means a Child who is covered for benefits under this Plan.

COVERED DEPENDENT

Means a Dependent who is covered for benefits under this Plan.

COVERED EMPLOYEE

Means a Benefits Eligible Employee who is covered for benefits under this Plan

COVERED EXPENSE(S)

Means the Medically Necessary, Regular, Reasonable & Customary charges for medical services and supplies that are incurred:

- by a Participant while this coverage is in force;
- before this coverage ends; and
- for the treatment of an illness or injury, except for Preventive Care as outlined in MEDICAL BENEFITS Preventive Care.

In determining whether an expense is a Covered Expense the Plan will consider:

- the definitions, provisions, limitations and exclusions in the Plan;

- clinical coverage guidelines and medical policies as posted on the public website of the Third Party Administrator;
- standardized billing procedures; and
- medical peer reviews and recommendations provided by nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

COVERED PERSON

Means a Covered Employee, Covered Spouse and/or Covered Child(ren).

COVERED SPOUSE

Means a Spouse who is covered for benefits under this Plan.

CUSTODIAL CARE

Means care which is primarily for the purpose of meeting personal needs. It can be provided by persons without professional skills or training. Examples are help in walking, getting in and out of bed, bathing, eating, dressing, and taking medicine. Custodial care also includes supervision of the patient for safety reasons. It also includes Durable Medical Equipment that does not treat a condition, but is used to facilitate activities of daily living, such as but not limited to hoyer lifts, electric wheelchairs, bath chairs, and raised toilet seats.

DENTAL

Means any care or treatment or surgery relating to the teeth or gums, including but not limited to preventative dental care, extractions, restorations, endodontics, periodontics, prosthodontics, oral surgery for any condition which is caused by or related to a problem of the teeth, medications, or any appliances which rest upon or are attached to the teeth. For the purposes of this Plan, all care, surgery, or treatment of this type will be considered dental treatment or surgery, regardless of the origin of the condition which caused the treatment or surgery unless specifically listed as covered under the Plan. If an expense is eligible under both this Plan and the Employer's dental plan, this Plan will pay primary.

DENTAL SERVICES

Means care and treatment of the teeth and gums, or any services rendered by a dentist or dental surgeon. If an expense is eligible under both this Plan and the Employer's dental plan, this Plan will pay primary.

DENTIST

Means a person licensed to practice dentistry by the state in which he or she is practicing. He or she must be practicing within the scope of their license.

DEPENDENT

Means the Spouse and the Child or Children of the Benefits Eligible Employee, who are not themselves, Covered Employees under this Plan.

DURABLE MEDICAL EQUIPMENT

Means medical equipment:

- which is Preapproved as required by the Plan;
- is used repeatedly;
- serves a medical purpose;
- would not be useful to a person without an injury or illness;

- is appropriate for treating an illness or injury in the home; and
- is the standard model equipment that meets the patient's needs.

The following items are not considered Durable Medical Equipment, and are not covered under the Plan:

- Expenses for Durable Medical Equipment that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a Physician) and certain medical devices including, but not limited to:
    - common household items including air purifiers or cleaners, air conditioners, humidifiers, dehumidifiers, vaporizers, heaters, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, heating pads, heat lamps, ice bags, or cold pack pumps;
    - personal hygiene equipment including tub chairs used in a tub or shower, and raised toilet seats, or supplies;
    - personal comfort items including cervical pillows, gravity lumbar reduction, TENS units, translift chairs, and transfer equipment;
    - exercise equipment of any type, swimming pools, hot tubs, whirlpools, spas or saunas;
    - any equipment which provides comfort or convenience;
    - structure or vehicle alterations, ramps, or elevators;
    - duplicate equipment;
    - similar types of items or equipment;
    - expense in excess of the cost for the standard model of equipment that is attributable to purchasing a more advanced model of equipment than what is covered under the Plan;
    - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
    - Medical equipment including blood pressure monitoring devices, unless prescribed by a Physician for preventive services and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension, PUVA lights and stethoscopes;
    - Computers or computer systems and related equipment or similar items or equipment;
    - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

EFFECTIVE DATE

Means the Effective Date of this Plan, January 1, 2020, or the date the Participant is effective under this Plan as described in the section "ELIGIBILITY AND EFFECTIVE DATE FOR COVERAGE" if after January 1, 2020.

EMERGENCY SERVICES

Means Covered Expenses for those medical and health services provided:

- to treat a medical condition, manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part;

or

- When a Physician instructs You to go to an emergency room or other emergency facility immediately to treat an emergency medical condition.

With respect to an emergency medical condition, a medical screening examination that is within the capability of the medical facility including ancillary services routinely available to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available, such further medical examination and treatment as is required to stabilize the patient.

It does not mean Covered Expense for services provided by a Non-Preferred Provider once a referral can be made to safely transfer the patient to the care of a Preferred Provider.

EQUIVALENT GENERIC DRUG

Means a drug that the Pharmacy Benefit Manager has classified as safe, equivalent to, and as effective as the brand name drug that would otherwise have been prescribed.

EVALUATION AND MANAGEMENT SERVICES

Means those services properly assigned a CPT (American Medical Association Current Procedural Terminology) evaluation and management services code.

EXPERIMENTAL/INVESTIGATIONAL

Means any drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of an injury or illness if one or more of the following criteria apply. The drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted; or
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
- is subject to review and approval of an Institutional Review Board or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

It also means any service, supply, or treatment that is not commonly and customarily recognized by the physician’s profession and within the United States as appropriate treatment of the patient’s diagnosed illness or injury and determined to be of proven effectiveness by the appropriate National Scientific Organization related to the diagnosed illness or injury.

It also means any procedures, drugs, or devices with unproven efficacy. Unproven efficacy means that the procedures, drugs, or devices have not been used with sufficient frequency or have not achieved the requisite success rates to establish their safety and efficacy in the medical community. A procedure, drug, or device may be considered experimental/investigational for certain diagnoses and conditions, and considered established therapies for other diagnoses and conditions.

A medical treatment, procedure, drug or device that is not considered an Approved Clinical Trial will be considered experimental or investigational if reliable evidence shows it is the subject of ongoing phase I II, or III clinical trials or under study to determine its safety, efficacy, or its efficacy as compared with the standard means of treatment or diagnosis, and reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis, and/or approval has not been given by the United States Food and Drug Administration at the time it is furnished.

The fact that a procedure, drug, or device is the only available treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to this definition.

GROUP TYPE PLAN

Means any of the following:

- Group or blanket insurance coverage;
- Prepayment plans (including Blue Cross – Blue Shield)
- Union Welfare plans;
- Plans growing out an employee-employer relationship;
- Any statutory plans;
- The medical benefits coverage in group automobile contracts, in group or individual automobile "no-fault" contracts, and in traditional "fault" type contracts;
- Uninsured or underinsured motorist coverage.

HABILITATIVE SERVICES

Means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by the Participant's treating Physician pursuant to a treatment plan to enhance a Child to function with a congenital, genetic, or early acquired disorder. A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a Child prior to that Child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, or early acquired disorder may include but are not limited to autism, Autism Spectrum Disorders, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

HEALTH INSURANCE COVERAGE

Means benefits consisting of medical care under any hospital or medical service plan or certificate, hospital or medical service contract, or health maintenance organization contract offered by a health insurance issuer.

HOME HEALTH CARE

Means care and treatment of a Participant under a plan of care established by the Participant's physician. The plan must be submitted to the Third Party Administrator in writing, and Case Management Prior Authorization is obtained, as required by the Plan. The plan of care must be reviewed at least every two months by the Participant's Physician.

It consists of the medically necessary services for:

- part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);
- part-time or intermittent home health aide services, which solely consist of caring for the patient, and which are provided under the supervision of a R.N. or medical social worker;
- physical, inhalation/respiratory, occupational or speech therapy;
- nutrition counseling provided by or under the supervision of a registered dietician;

- evaluation and development of a home health plan by a R.N., physician extender or medical social worker, when approved or requested by the primary care physician;
- medical equipment, medical social services, medical supplies, oxygen and equipment for its administration, parenteral and enteral nutrition, prescription drugs and medicines administered in the vein or muscle, prosthetic devices and braces;
- home health aide services – when provided in conjunction with a Medically Necessary skilled service also received in the home.

The home health care services must be provided or coordinated by a state-licensed or Medicare-certified home health agency or rehabilitation agency.

HOSPICE

Means an agency that provides a coordinated program of home and inpatient care for the special physical, psychological, and social needs of terminally ill persons and their families. The hospice agency must:

- Be certified or licensed as a hospice by the state in which they are operating;
- Operate under the direct supervision of a physician;
- Provide services 24 hours a day, seven days a week; and
- Maintain medical records on each patient.

HOSPICE CARE

Means care and treatment provided by a Hospice for a terminally ill person and the immediate family members of the person if they are covered under the Plan.

HOSPITAL

Means a place which:

- is legally operated for the inpatient care and treatment of ill or injured persons;
- is mainly engaged in providing medical and diagnostic services;
- has continuous 24 hour nursing services; and
- has a staff of one or more physicians available at all times except when the facility meets the definition of Residential Treatment Facility in this Plan.

It does not mean:

- a rest, nursing, or convalescent home;
- a facility or institution mainly for the treatment of alcoholics or drug addicts except when the facility meets the definition of Residential Treatment Facility in this Plan;
- a facility primarily affording custodial or educational care for persons suffering from mental diseases or disorders except when the facility meets the definition of Residential Treatment Facility in this Plan; or
- a freestanding ambulatory surgical facility that arranges for overnight stays within the facility.

ILLNESS

Means any condition, disease, or sickness which causes loss and affects normal bodily function, other than a condition caused by injury.

It also means:

- a pregnancy or complication of pregnancy;
- a congenital defect or birth abnormality for a child.

IMMEDIATE FAMILY

Means the Participant’s spouse, children, parents, brothers and sisters.

INACTIVE CLASS

Means an individual who is a:

- Retiree;
- Disabled Employee prior to January 1, 2014;
- Dependent(s) of Retirees and Disabled Employees prior to January 1, 2014; or
- Surviving Dependent(s).

INFERTILITY TREATMENT

Means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if Your Physician determines a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

INJURY

Means bodily injury caused by an accident.

INPATIENT

Means a confinement in a hospital that results in the hospital making a room and board charge. An overnight stay in an observation unit of a hospital or licensed ambulatory surgical facility will be considered an inpatient stay for Precertification purposes.

INTENSIVE CARE

Means a separate area in a hospital for the inpatient care of patients who are critically ill which:

- Provides constant nursing care which is not usual in other rooms and wards; and
- Has special lifesaving equipment which is immediately available at all times; and
- Has at least one R.N. on duty at all times.

LOSS OF ELIGIBILITY OF COVERAGE

Means a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions toward such coverage were terminated. It also means a loss of coverage under the COBRA continuation provision the Participant was covered under because the period of time allowed for coverage under COBRA has been exhausted. It does not mean loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause, such as fraud or intentional misrepresentation.

MAIL ORDER PRESCRIPTION COPAY AMOUNT

Means the amount the participant must pay for each prescription order obtained through the mail service program.

MANIPULATIVE THERAPY

Means treatment consisting primarily of manipulation, heat, ultrasound, diathermy or similar types of treatment including Osteopathic, Chiropractic, and Naprapathic Services regardless of the medical degree of the person providing the treatment.

MATERNITY SERVICES

Means:

- Prenatal and postnatal care, delivery, including Complications of Pregnancy.
- Maternity Services include a minimum of:
  - 48 hours of Inpatient care (in addition to the day of delivery) following a vaginal delivery, or
  - 96 hours of Inpatient care (in addition to the day of delivery) following a cesarean section.

The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable. If the Inpatient Hospital stay is shorter, coverage includes a follow-up postpartum home visit by an approved provider competent to perform postpartum care.

For a covered pregnancy of a Participant mother under the Plan, expenses incurred for a well Newborn Child's initial Hospital confinement will be considered a Covered Expense under the Participant mother's coverage. In the case of other insurance coverage for the mother, normal Coordination of Benefits will apply as if the charges for the well Newborn are for the mother. No benefits are provided for the well Newborn initial Hospital confinement when the mother is not covered under the Plan. Mother and well Newborn will be considered one Participant until discharge from the initial Hospital confinement and therefore the Mother must be Eligible for coverage for the Newborn's initial Hospital confinement to be eligible. In the case of a non-well Newborn with an Illness or Injury, all usual provisions of the Plan apply.

MAXIMUM ALLOWABLE AMOUNT

Means the cost of a procedure, drug, or device that would adequately accommodate treatment of a Participant's condition.

MEDICALLY NECESSARY

Means 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.

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.

MEDICARE

Means Title XVIII of the Social Security Act as amended.

MEDICAID

Means Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act as amended.

MINOR

Means a person who is under the legal age of competence.

MORBID OBESITY

Means:

(1) A body mass index of at least thirty-five (35) kilograms per meter squared, with comorbidities or coexisting medical conditions such as cardiovascular disease, Type 2 diabetes, cardiopulmonary disease, sleep apnea, a history of cardiomyopathy; or
(2) A body mass index of at least forty (40) kilograms per meter squared without co morbidity.

For purposes of this section, body mass index is equal to weight in kilograms divided by height in meters squared.

NAPRAPATH

Means a provider of Naprapathic Services duly licensed to legally perform such services.

NAPRAPATHIC SERVICES

Means treatment by a Naprapath, within the scope of the applicable license, including manipulation of connective tissues and adjoining structures and by dietary measures to facilitate the body's recuperative and regenerative process.

NEWBORN CHILD

Means a Dependent Child born to a Benefits Eligible Employee.

NEVER EVENT

Means any occurrence on a United States list of inexcusable outcomes in a health care setting compiled by the National Quality Forum. They are defined as "adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability."

NON-PREFERRED PROVIDER

Means a medical provider who has not entered into a written agreement to provide services to the Plan Participants in the Plan at a negotiated rate.

NON-PREFERRED PROVIDER COINSURANCE

Means the amount of Covered Expense that a Participant must pay for services provided by a Non-Preferred Provider in a Calendar Year, after the Plan has paid the Non-Preferred Coinsurance amount. Non-Preferred Coinsurance share does not include:

- any Deductible amounts;
- any Copay amounts;
- any Access Fee;
- any penalty for noncompliance with plan requirements;
- any Transplant Amount;

- any Preferred Provider coinsurance;
- any non-covered services.

The Non-Preferred Coinsurance share amount is shown on the Schedule of Benefits.

NON-PREFERRED PROVIDER DEDUCTIBLE

Means the amount of Covered Expense for services provided by a Non-Preferred Provider that must be incurred in a Calendar Year by a Participant before any Covered Expense is paid by the Plan. It is equal to the lesser of:

- the amount specified under the Non-Preferred Provider Individual Deductible amount shown on the Schedule of Benefits ;
- the amount needed to satisfy the Non-Preferred Provider Family Deductible amount shown on the Schedule of Benefits.

Preferred Provider Deductible, Coinsurance, Copay and Access Fees, Non-Preferred Provider Coinsurance and Access Fee amounts will not be used to satisfy the Non-Preferred Deductible Amount.

NON-PREFERRED PROVIDER FAMILY DEDUCTIBLE

Means the amount of deductible a covered family must pay in a Calendar Year for services provided by Non-Preferred Providers. This amount is shown on the Schedule of Benefits. The Non-Preferred Provider Family Deductible may be satisfied by combining all amounts applied to Non-Preferred Provider Individual Deductibles for the Covered Employee and the Covered Employee’s Dependents for the Calendar Year. No one Participant will be required to satisfy more than the applicable Individual Non-Preferred Deductible. However, only Covered Expense that is incurred in a Calendar Year and applied to that same Calendar Year’s Non-Preferred Individual Deductible can be used to satisfy the Non-Preferred Family Deductible.

NON-PREFERRED PROVIDER INDIVIDUAL DEDUCTIBLE

Means the maximum amount of deductible that an individual participant must pay in a Calendar Year for services provided by Non-Preferred Providers.

NON-PREFERRED PROVIDER OUT-OF-POCKET MAXIMUM

Means any share of a Covered Expense the Participant is required to pay for Non-Preferred Provider Covered Expenses. This maximum includes any Non-Preferred Provider Deductible and Non-Preferred Provider Coinsurance amounts applied to covered services and Non-Preferred Provider Access Fees. No one Participant will be required to satisfy more than the applicable Individual Non-Preferred Provider Deductible. Non-covered services and benefit reductions are not included in this Maximum.

OUT-OF-POCKET MAXIMUM

Means the maximum amount of Covered Expenses the Participant will incur in a Calendar Year. The Out-of-Pocket Maximum includes applicable Copays, Deductibles, Coinsurance share and Access Fees. The Out-of-Pocket Maximums are shown on the Schedule of Benefits for Preferred Providers and Non-Preferred Providers. After the applicable Out-of-Pocket Maximum is reached, the Plan will pay the remainder of the Covered Expenses incurred by a Participant during the rest of the year for that type of Provider. Non-covered services and benefit reductions are not included in this Maximum.

ORAL SURGERY

Means only for the following services:

- surgical removal of complete boney impacted teeth;
- excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

- surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses);
- treatment of fractures of facial bone;
- external incision and drainage of cellulitis;
- incision of accessory sinuses, salivary glands or ducts;
- reduction of dislocation of, or excision of, the temporomandibular joints caused by Temporomandibular Joint Dysfunction and Related Disorders (TMJ) when Case Management Prior Authorization is obtained.

Anesthesia (general) and Hospital or ambulatory surgical facility services related to covered Dental Services if:

- a Covered Child is age 6 or under;
- a Participant has a chronic disability; or
- based on determination by a licensed dentist and the Participant‛s treating Physician, the Participant has one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary Dental treatment or surgery if not rendered in a Hospital or ambulatory surgical facility.

If an expense is eligible under both this Plan and the Employer's dental plan, this Plan will pay primary.

PARTICIPANT

Means any Benefits Eligible Employee or Benefits Eligible Employee's Dependent who is covered for benefits under this Plan.

PERIOD OF COVERAGE

Means the Plan Year, with the following exceptions: (a) for Covered Employees and Covered Dependents who first become Participants, it shall mean the portion of the Plan Year following the date participation commences; and (b) for Participants who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates. A different Period of Coverage (e.g., a calendar month) may be established by the Administrator and communicated to Participants.

PERMITTED ELECTION CHANGE

Means:

- change in legal marital status (marriage, divorce, death of a spouse, and annulment);
- change in number of Dependents (birth, adoption, placement for adoption and death);
- change in employment status that affects eligibility under the benefit plan;
- Dependent satisfies or cease to satisfy Dependent eligibility requirements;
- residence change if it affects the Benefits Eligible Employee's eligibility for coverage;
- eligibility to enroll in an Exchange (Marketplace) special or annual open enrollment period.

PHYSICIAN

Means a practitioner of the healing arts, licensed by the state the practitioner practices in. The practitioner must be performing only those services the practitioner is licensed to perform.

PREAPPROVAL

Means a review by the Plan to determine the benefit coverage of Medically Necessary services. The Plan will provide benefits for the covered service if approved by the Plan prior to receiving the services.

PRECERTIFICATION

Means the process required to obtain prior approval for Inpatient Hospital admissions and other select Hospital services.

PREFERRED PROVIDER

Means a medical provider who has entered into a written agreement to provide services to the Plan Participants in the Medical Benefit section of the Plan at a negotiated rate. The General Plan Information section indicates the name of the Preferred Provider Networks. The Plan recommends that You verify that the provider You are using or considering is currently a Preferred Provider.

In addition, covered services obtained from a Non-Preferred Provider, pathologist, anesthesiologist, radiologist, or emergency room Physician (other Physicians providing one source services to Preferred Provider Hospital/Facility are also included) shall be considered to be provided by a Preferred Provider if the services are rendered as part of treatment rendered at a Preferred Provider Hospital.

It also means a provider who is a member of the Preferred Provider travel network if the treatment being provided is for an unexpected illness or injury while traveling outside the Participant's primary Preferred Provider Network. It also means a provider who is a member of the Preferred Provider travel network if the treatment is for an eligible Dependent who is living outside of the primary PPO 's service area and is receiving services outside of the primary Preferred Provider network service area. The General Plan Information section indicates the name of the travel network in addition to other Preferred Provider Networks. Please refer to Your ID card for correct network identification. The travel network may also be found on Your ID card.

It also means a provider accessed under the qualification outlined in Benefit for Covered Expense Provided by a Non-Preferred Provider or Benefit for Covered Expense for Emergency Services Provided in a Hospital Emergency Room. However, rates for reimbursement will be at the Regular, Reasonable & Customary rate due to lack of a negotiated Preferred Provider.

It also means a Non-Preferred Provider if the nearest Preferred Provider is more than 50 miles from the Participant's residence. Consideration of covering services of a Non-Preferred Provider as Preferred must be approved. However, rates for reimbursement will be at the Regular, Reasonable & Customary rate due to lack of a negotiated Preferred Provider direct contract.

PREFERRED PROVIDER COINSURANCE

Means the amount of Covered Expense that a participant must pay for services provided by a Preferred Provider in a Calendar Year, after the Plan has paid the coinsurance amount. Preferred Provider Coinsurance does not include:

- any Deductible amounts;
- any Copay amounts;
- any Access Fee;
- any penalty for noncompliance with Plan requirements;
- any Transplant amount;

- any Non-Preferred Coinsurance;
- any non-covered services.

PREFERRED PROVIDER DEDUCTIBLE

Means the amount of Covered Expense for services provided by a Preferred Provider that must be incurred in a Calendar Year by a Participant before any Covered Expense is paid by the Plan. It is equal to the lesser of:

- the amount specified under the Preferred Provider Individual Deductible amount shown on the Schedule of Benefits ;
- the amount needed to satisfy the Preferred Provider Family Deductible amount shown on the Schedule of Benefits.

Non-Preferred Provider Deductible and Preferred Provider or Non-Preferred Provider Coinsurance amounts, Access Fees or Copays will not be used to satisfy the Preferred Provider Deductible amount.

PREFERRED PROVIDER FAMILY DEDUCTIBLE

Means the maximum amount of deductible a covered family must pay for Covered Expense in a Calendar Year for services provided by Preferred Providers. This amount is shown on the Schedule of Benefits. The Preferred Provider Family Deductible may be satisfied by combining all amounts applied to Preferred Provider Individual Deductibles for covered Participants for the Calendar Year. No one Participant will be required to satisfy more than the applicable Preferred Provider Individual Deductible. However, only Covered Expense that is incurred in a Calendar Year and applied to that same Calendar Year's Preferred Provider Individual Deductible can be used to satisfy the Preferred Provider Family Deductible.

PREFERRED PROVIDER INDIVIDUAL DEDUCTIBLE

Means the maximum amount of deductible that an individual participant must pay for Covered Expense in a Calendar Year for services provided by Preferred Providers.

PREFERRED PROVIDER OUT-OF-POCKET MAXIMUM

Means any share of a Covered Expense the Participant is required to pay for Preferred Provider Covered Expenses. This Maximum includes any Preferred Provider Deductible, Preferred Provider Coinsurance, and Copay amounts applied to covered services and Preferred Provider Access Fees. All pharmacy and drug Copay amounts apply towards the Preferred Provider Out-of-Pocket Maximum. Non-covered services and benefit reductions are not included in this Maximum.

No one Participant will be required to satisfy more than the applicable Individual Preferred Provider Deductible.

Non-Preferred Provider Deductible and Coinsurance amounts will not be used to satisfy the Preferred Provider deductible amount.

PRESCRIPTION COPAY

Means the amount the Participant must pay for each prescription order obtained at a retail pharmacy. It is shown on the Schedule of Benefits.

PROOF OF LOSS

Means:

- a properly completed claim form; and
- any other information the Plan needs to process the Claim.

REGULAR, REASONABLE & CUSTOMARY

Means the lesser of:

- the actual charge;
- what the provider will accept for the same service or supply in the absence of insurance;
- the amount the provider has agreed to charge under a Preferred Provider agreement with the Plan;
- the amount the provider has agreed to accept under the terms of a negotiated agreement with the Plan;
- an amount determined by the Plan by comparing charges made by other medical professionals and/or facilities with similar credentials, for similar services and supplies, adjusted to the geographic locale, and based upon the Regular, Reasonable & Customary percentile level deemed appropriate by the Plan;
- an amount based on the level and/or method of reimbursement used by the Centers of Medicare and Medicaid Services for the same services or supplies; or
- an amount based on accepted industry standard or a commercially available database using factors such as, but not limited to the:
    - complexity or severity of the treatment;
    - level of skill and experience required for the treatment;
    - cost and quality data;
    - comparable fees and costs for the treatment;
    - reimbursement amounts paid by Centers for Medicare and Medicaid Services for the same services or supplies;
    - generally accepted billing practices; and/or
    - industry standard cost, reimbursement, and utilization data.

Regular, Reasonable & Customary for certain surgical charges will be determined as follows:

- for multiple surgical procedures performed at the same operative session, the Plan will allow up to 100% of the Regular, Reasonable & Customary amount for the first surgical procedure, 50% of the Regular, Reasonable & Customary amount for the second surgical procedure, and 25% of the Regular, Reasonable & Customary amount for each additional surgical procedure;
- for charges by an assistant surgeon, the Plan will allow up to 20% of the amount allowed for the primary surgical procedure when an assistant is deemed Medically Necessary.

The Plan Administrator reserves the right to take into consideration all of the above means of determining the Regular, Reasonable & Customary rate and in some instances an allowable amount may not be the lesser of.

RESIDENTIAL TREATMENT CENTER

Means a facility, licensed as such under applicable law, whose primary function is offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure.

Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with mental health conditions, serious mental health conditions and/or Substance Use Disorders.

It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

RETIREE

Means an individual who: (a) was enrolled in this Plan on the date of their retirement as an Employee; (b) qualifies for benefits under terms and definitions set forth by the Farmers Automobile Insurance Association Retirement Plan as of their retirement date; and (c) was not terminated for gross misconduct.

SCHEDULE OF BENEFITS

Means a list which states those benefits that the Plan Administrator has decided to provide to participants under the Plan.

SKILLED NURSING FACILITY

Means a legally operated institution or a part of an institution for the treatment of inpatients. Treatment must be under the supervision of a Physician. The facility must provide 24 hour nursing service under the supervision of a R.N. It must maintain daily medical records of each patient. This definition does not include:

- a rest home or home for the elderly;
- an institution, nor a unit of an institution, used for custodial or educational care;
- an institution, nor a unit of an institution, used for the treatment of alcoholics, drug addicts, or the mentally ill.

SPOUSE

Means a party to a legal marriage or civil union.

STABILIZE

Means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

SUBSTANCE USE DISORDER

Means the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

- substance use disorders;
- substance dependence disorders;
- substance induced disorders; and
- alcoholism.

SURVIVING DEPENDENT

Means any person who was covered under any group health plan sponsored by the Employer or Participating Employer as a Dependent at the time of death of one of the following classes of participants:

(a) a Covered Employee;
(b) a Disabled Employee prior to January 1, 2014; or
(c) a Retiree.

and the person described in (a), (b) or (c) above, had at least 9 years of service on his/her date of death.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TERMINALLY ILL PERSON

Means a person who has been diagnosed by a physician as having a life expectancy of six months or less.

TOTAL DISABILITY

Means an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may require, in its sole discretion.

TRANSPLANT CENTER OF EXCELLENCE

Means a facility which has entered into an agreement through a national organ transplant network to render approved transplant services to the Plan's Participants. The Transplant Center of Excellence facility may or may not be located within the Participant's geographic area. A list of Transplant Center of Excellence facilities upon request will be made available to the participants.

URGENT CARE

Means medical care for an Illness or Injury serious enough that a reasonable person would seek care right away, but not so severe as to require Hospital emergency department care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

URGENT CARE CENTER

Means a licensed facility that provides Urgent Care.

YOU, YOUR

Means a Plan Participant.

ELIGIBILITY AND EFFECTIVE DATE FOR COVERAGE

Eligibility for Employee Coverage

All Benefits Eligible Employees of Farmers Automobile Insurance Company or a Participating Employer are eligible to become covered under the Plan once they have completed 30 consecutive days as a Benefits Eligible Employee of Farmers Automobile Insurance Company or a Participating Employer.

Effective Date for Employee Coverage

For coverage under this Plan to become effective all Benefits Eligible Employees who meet the eligibility requirements above must follow the enrollment procedures required by the Employer within 30 days of their eligibility date. If the Benefits Eligible Employee completes the enrollment procedures on a timely basis the coverage under the Plan will become effective on the day following the day the Benefits Eligible Employee completes the eligibility period above.

Eligibility for Dependent Coverage

A Benefits Eligible Employee's Dependents are eligible to be covered under the Plan on the earliest of the following dates:

- The date the Benefits Eligible Employee becomes covered under the Plan;
- The first date the Benefits Eligible Employee has an eligible Dependent.

The Benefits Eligible Employee must enroll any eligible Dependents within 30 days of the date they are first eligible for them to become covered as a Dependent under the Plan.

A person cannot be covered as both a Dependent and a Benefits Eligible Employee under the Plan. A Dependent Child cannot be covered as a Dependent of more than one Covered Employee.

Newborn Children

A newborn child is covered from the moment of birth. In order for coverage to extend beyond the first 30 days after birth, You must submit an enrollment form for the newborn within 30 days after the newborn's birth.

A well newborn's initial hospital confinement will only be considered Covered Expense if the Plan is paying benefits for the mother's pregnancy under this benefit. The mother and well newborn will be considered one Participant until discharged from the initial Hospital confinement. In the case of a non-well newborn with an illness or injury, all usual Plan provisions apply.

SPECIAL ENROLLMENT PERIODS

For Persons Who Previously Declined Coverage

A person who previously declined coverage because they were covered under Health Insurance Coverage or other Group Type Plan may have a 30 day special enrollment period if they lose that coverage.

The 30 day special enrollment period will begin for that person on the day the person experiences a Loss of Eligibility of Coverage. The person must follow the special enrollment procedures required by the Employer for the Plan. Coverage will become effective on the date of the event.

Due to a Permitted Election Change

A person will have a 30 day special enrollment period to apply for coverage beginning on the date a Permitted Election Change occurs. The person must follow the special enrollment procedures required by the Employer for the Plan. Coverage will become effective on the date of the event.

In the case of a Permitted Election Change due to marriage, coverage will become effective on the date of the marriage, after the special enrollment procedures required by the Employer for the Plan are completed, as long as enrollment occurs within the 30 day special enrollment period.

In the case of a Permitted Election Change due to the birth of a Dependent child, coverage will begin on the child's date of birth, after the special enrollment procedures required by the Employer Plan are completed, as long as enrollment occurs within the 30 day special enrollment period.

In the case of a Permitted Election Change due to adoption or placement for adoption, coverage will begin on the date of the adoption or placement for adoption, after the special enrollment procedures required by the Employer for Plan are completed, as long as enrollment occurs within the 30 day special enrollment period.

Exchange Enrollment

A Participant who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for coverage the Plan, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have

enrolled or intend to enroll in new Exchange coverage that is effective beginning no later than the day immediately following the last day of coverage under the Plan.

Reduction of Hours

A Participant who was reasonably expected to average 30 hours of service or more per week and experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election for Medical Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform for coverage that is effective no later than the first day of the second month following the month that includes the date the Medical Plan coverage is revoked.

Election changes made pursuant to this provision will become effective no earlier than the first day following the date that the election change request is filed (as determined by the Plan Administrator, election changes may become effective later to the extent that the other coverage commences later), and shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event recognized under IRS regulations or other guidance allows for a further election change.

Qualified Medical Child Support Order

The Plan Administrator will enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a Qualified Medical Child Support Order ("QMCSO") if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

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

Medical Child Support Order means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

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

National Medical Support Notice or "NMSN" means a notice that contains the following information:

- Name of an issuing State agency;
- Name and mailing address (if any) of a Covered Employee who is a Participant under the Plan;
- Name and mailing address of one or more alternate recipients; and
- Identity of an underlying child support order.

Qualified Medical Child Support Order or "QMCSO" is a medical child support order that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO,

it must clearly specify the following:

- The name and last known mailing address (if any) of the Participant and the name and mailing address of each such alternate recipient covered by the order;
- A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of this Plan.

In addition, a NMSM shall be deemed a QMCSO if it:

- Contains the information outlined in the definition of National Medical Support Notice;
- Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and Plan Administrator will assume that all are designated;
- Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any);
- Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

  However, such an order need not be recognized as qualified if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible plan participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1098 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

- Notify the Participant and each alternate recipient covered by the Order in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
- Make an administrative determination if the order is a QMCSO and notify the Participant and each alternate recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
  - Whether the child is covered under the Plan; and
  - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

- Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
- Permit any alternate recipient to designate a representative for receipt of copies of the notices that are sent to the alternate recipient with respect to the Order.

Additional Special Enrollment Rights

Benefits Eligible Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances;

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

OPEN ENROLLMENT

Once annually Benefits Eligible Employees will have a choice of enrolling in the Plan. Benefits Eligible Employees will be notified in advance when the open enrollment period is to begin and how long it will last. If a Benefits Eligible Employee declined coverage at the time they were initially eligible for coverage, the Benefits Eligible Employee will be able to enroll during the open enrollment period. If a Benefits Eligible Employee and a Benefits Eligible Employee's Dependents enroll during an open enrollment period, the Benefits Eligible Employee's coverage and Benefits Eligible Employee's Dependent's coverage will be effective on January 1st following the end of the open enrollment period.

TERMINATION OF COVERAGE

Termination Dates of Covered Employee Coverage

The coverage of any Covered Employee under the Plan will end on the earliest of the following dates:

- The date this entire Plan terminates or with respect to a specific benefit, the date the specific benefit is terminated;
- The date the Covered Employee requests coverage be terminated, as long as the request is made on or before the date requested and the Covered Employee is voluntarily canceling it because of change in status, special enrollment or at annual open enrollment periods;
- The last day of the period for which the Covered Employee has made a contribution, if the Covered Employee fails to make a required contribution for coverage when it is due;
- The date the Covered Employee ceases to be eligible for coverage under the Plan;
- The date the Covered Employee's employment is terminated;
- Immediately after a Covered Employee or a Covered Employee's Covered Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information;
- The date the Covered Employee becomes a member of the Inactive Class*; or
- The date of the Covered Employee's death.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Covered Employee who are covered under this Plan will end on the earliest of the following dates:

- The date this entire Plan terminates or with respect to a specific benefit, the date the specific benefit is terminated;
- The date coverage for Dependents is discontinued under this Plan;
- The date coverage terminates under this Plan for the Covered Employee upon whom the Dependent depends for eligibility*;
- The period for which the Covered Employee has made a contribution, if the Covered Employee fails to make a required contribution for Dependent coverage when it is due;
- The date the Covered Employee requests coverage for a Dependent be terminated, as long as the request is made on or before the date requested and the Covered

Employee is voluntarily canceling it because of change in status, special enrollment or at annual open enrollment periods;

- The date such person ceases to be a Dependent as defined in this Plan, except as may be provided for in other areas of this section;
- In the case of a Child age 26 or older, for whom coverage is being continued due to Total Disability, the earliest of:
  - the date of cessation of such Total Disability;
  - the date proof of the uninterrupted continuance of Total Disability is not provided, including failure to submit to any requested examination; or
  - the date the Child is no longer dependent on the Covered Employee for support;
- Immediately after a Covered Employee or a Covered Employee's Covered Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information; or
- The date of the Covered Dependent's death.

*Medical benefits for Participants who become members of the Inactive Class are provided under the Farmers Automobile Insurance Association Medical and Dental Benefit Plan.

Employer Continuation Coverage

In the event of an Employer approved leave of absence, coverage for Covered Employees and their Covered Dependents will continue for up to a maximum of 26 weeks (including any FMLA, workers comp and ADA leave) in a 12 month period as long as the Covered Employee continues to pay the required contributions.

Continuation During Family and Medical Leave

In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), continuation coverage under the Plan is available to Participants under certain specified conditions.

A Covered Employee who takes a leave of absence under applicable provisions of FMLA is entitled to continued coverage under the Plan for the Covered Employee and the Covered Employee's Covered Dependents. Benefits under the Plan are available to the same extent as if the Covered Employee had been actively at work during the entire leave period, subject to the following terms and conditions:

- Coverage shall cease for a Covered Employee (and the Covered Employee's Covered Dependents) for the duration of the leave if at any time the Covered Employee is more than 30 days late in paying any required contribution.
- A Covered Employee who declines coverage during the leave or whose coverage is terminated as a result of the Covered Employee failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.
- If a Covered Employee who is a key employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from the Covered Employee's reinstatement, the key employee's entitlement to Plan benefits continues unless and until the Covered Employee advises the Employer that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.
- Any portion of the cost of coverage which had been paid by the Covered Employee prior to the leave must continue to be paid by the Covered Employee during the leave. If the cost is raised or lowered during the leave, the Covered Employee shall pay the new rates. If the leave is unpaid, the Covered Employee and the Employer shall negotiate a reasonable means for paying the Covered Employee's portion of the cost.
- If the Employer provides a new health plan or benefits or changes the health benefits or Plan while the Covered Employee is on leave, the Covered Employee is entitled to the new or changed Plan and benefits to the same extent as if the Covered Employee were not on leave.
- The Employer may recover its share of the cost of benefits paid during a period of

unpaid leave if the Covered Employee fails to return to work after the Covered Employee's leave entitlement has been exhausted or expires, unless the reason the Covered Employee does not return to work is due to:
    - The continuation, recurrence, or onset of a serious health condition which would entitle the Covered Employee to additional leave under the FMLA, or
    - Other circumstances beyond the Covered Employee's control.

If a Covered Employee fails to return to work because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the Employer from recovering its share of the cost of benefits paid on the Covered Employee's behalf during a period of unpaid leave, the Employer may require medical certification of the Covered Employee's or the Covered Dependent's serious health condition. The Covered Employee is required to provide medical certification within thirty days from the date of the Employer's request. If the Employer requests medical certification and the Covered Employee does not provide such certification in a timely manner, the Employer may recover the costs of benefits paid during the period of unpaid leave.

Employees on Military Leave

Covered Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to Covered Employees and Covered Dependents who were covered under the Plan before leaving for military service.

- The maximum period of coverage of a person under such an election shall be the lesser of:
    - The 24 month period beginning on the date on which the person's military leave begins, or
    - The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Covered Employee's share, if any, for the coverage.
- An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not be terminated because of service. However, an exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

MEDICAL BENEFIT

Amount of Benefit for Covered Expense

Preventative Care

The Plan will pay 100% of the Regular, Reasonable & Customary charge for Covered Expense incurred for preventive services, but only when provided by a Preferred Provider unless there is no Preferred Provider that can perform the services. Non-Preferred Provider must be Preapproved to qualify for Preferred Provider coverage. The deductible will not apply to this benefit.

Non-Preferred Provider laboratory tests and professional pathology laboratory services ordered by a Preferred Provider at a covered preventative care visit will be covered and treated as Non-Preferred Provider regular medical services and be covered subject to the applicable deductible and coinsurance as shown on the Schedule of Benefits.

Preventive Services means:

- Items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force including those regarding breast cancer

screening, mammography, and prevention, other than those issued on or around November 2009;

- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for the person receiving the immunization;
- Preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents;
- Preventive care and screenings for women as provided for by the Health Resources and Services Administration;
- It includes:
    - Colorectal cancer examination and screening as recommended by the American Cancer Society;
    - Shingles vaccine for Participants 50 years of age or older;
    - Human papilloma virus vaccines;
    - Screening mammography and clinical breast exams;
    - Pap test for cervical cancer;
    - Digital rectal examination and a prostate-specific antigen test;
    - CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination for Participants having a family history of one or more first-degree relatives with ovarian cancer, or with clusters of women relatives with breast cancer, or a family history of nonpolyposis colorectal cancer, or a positive BRCA1 or BRCA2 mutation test;
    - Blood Profile;
    - Urinalysis;
    - CBC;
    - EKG;
    - Chest X-Ray;
    - TSH (thyroid);
    - Lipid Profile;
    - Hematocrit;
    - Any other preventative care as outlined on the Schedule of Benefits.

It does not mean similar services when prescribed to monitor or diagnose a Participant who is having current symptoms or who has been diagnosed with an illness.

Benefit for Covered Expense Provided by a Preferred Provider

The Plan will pay according to the Schedule of Benefits for the Covered Expense for evaluation and management services provided by a Preferred Provider.

After the applicable office visit Copay, the plan will pay 100% of Covered Expenses for the office visit charge made by a Preferred Provider for treatment of an illness or injury. The office visit Copay amounts are shown on the Schedule of Benefits. It applies to each office visit charge by a Preferred Provider.

If, during an office visit, a Preferred Provider performs and bills for x-ray or laboratory tests, the Plan will waive the Preferred Provider Deductible amount, and pay the Covered Expense for those x-ray or laboratory tests at the applicable Preferred Provider Coinsurance percentage. The Preferred Provider Coinsurance percentage amounts are shown on the Schedule of Benefits.

Except as stated above, payment of any benefit for services by a Preferred Provider will be considered Covered Expenses for services by a Preferred Provider and must equal the applicable Preferred Provider Deductible during a Calendar Year. After meeting the Calendar Year Preferred Provider Deductible the Plan will pay benefits for Covered Expenses provided by the Preferred Provider at the applicable Preferred Provider Coinsurance percentage as outlined on the Schedule of Benefits. If the amount of Covered Expense paid by the Participant for Preferred Provider Deductible and Preferred Provider Coinsurance, Copays and Access Fees during a Calendar Year equals the Preferred Provider Out-of-Pocket Maximum, the Plan will pay the Covered Expenses for those services at 100% for the remainder of the Plan Year subject to any limitations outlined in the Plan or Schedule of Benefits.

Benefit for Covered Expense for Emergency Services

When You incur Covered Expense for Emergency Services provided in a hospital emergency room, You must pay an emergency room Access Fee (refer to Schedule of Benefits). This amount must be paid anytime You receive Emergency Services in a hospital emergency room, and are not directly admitted to the hospital as an inpatient. This amount is in addition to any deductibles and coinsurance share amounts. If You are directly admitted to the hospital as an inpatient following an emergency room visit, the emergency room Access Fee will not apply.

Emergency Services provided by a Preferred Provider or a Non-Preferred Provider will be considered to be services from a Preferred Provider and will be paid as outlined above in the section titled "Benefit for Covered Expense Provided by a Preferred Provider."

If the Emergency Services were provided by Non-Preferred Providers, once it has been established the Participant is stabilized and a safe transfer to a Preferred Provider can be made and the Participant chooses to continue to receive care from Non-Preferred Providers, benefits for Covered Expense from Non-Preferred Providers will be paid as outlined below in the section titled "Benefit for Covered Expense Provided by a Non-Preferred Provider."

Benefit for Covered Expense Provided by a Non-Preferred Provider

Before the Plan pays any benefits for services by a Non-Preferred Provider, Covered Expenses equal to the Non-Preferred Provider Deductible must be incurred in a Calendar Year. The Plan will then pay benefits for Covered Expenses provided by the Non-Preferred Provider that are in excess of the Non-Preferred Provider Deductible for the remainder of the Calendar Year. These benefits will be paid at the Non-Preferred Provider Coinsurance percentage shown on the Schedule of Benefits. If the amount of Covered Expenses the participant pays for Non-Preferred Provider Deductible and Coinsurance and Non-Preferred Provider Access Fees during a Calendar Year equals the Non-Preferred Provider Out-of-Pocket Maximum, the plan will then pay Covered Expenses for these services at 100% for the remainder of the Calendar Year.

If there is no Preferred Provider of the required specialty, the Plan will consider Covered Expenses by the Non-Preferred Provider to be considered as if services were provided by a Preferred Provider. Use of a Non-Preferred Provider due to convenience, physician preference or patient/family preference does not qualify for extension of Preferred Provider coverage. All Covered Expenses from other providers resulting from use of a Non-Preferred Provider under this provision will be considered Non-Preferred Provider unless there are no Preferred Providers available for use by the Non-Preferred Provider. Consideration of covering Non-

Preferred Provider services as Preferred Provider must be Preapproved as required by the Plan.

Use of Non-Preferred Providers

When You use a Non-Preferred Provider:

- The amount of payment is based upon a reduced allowable amount, and not the actual billed charge; and
- You may be expected to pay a larger portion of the bill, even after the Plan has paid the percentage of eligible expense provided under the Plan.

Benefits Payable for Covered Expense

Covered Expense means the medically necessary, Regular, Reasonable & Customary charges for medical services and supplies that are incurred:

- By a Participant while this Plan is in force;
- Before coverage ends; and
- For the treatment of an illness or injury.

In determining whether an expense is a Covered Expense under this Plan, the Plan may take into consideration:

- The definitions, provisions, limitations, and exclusions in the Plan, including the Schedule of Benefits, attachments and amendments;
- Any clinical coverage guidelines or medical coverage policies as posted on the Third Party Administrator's website;
- Medical peer reviews and recommendations provided by nationally recognized public and private organizations that review the medical effectiveness of health care services and technology;
- If proper Preapproval, Case Management Prior Authorization or Precertification has occurred as outlined in the Plan or Schedule of Benefits.

Covered Expenses are charges:

- By a Hospital for:
    - Semiprivate room and board;
    - Care in the Intensive Care Unit;
    - Hospital services and supplies which are to be used while in the hospital;
    - Emergency Services in a hospital emergency room;
    - Outpatient medical care and treatment.
- For outpatient surgery performed in a licensed ambulatory surgical facility;
- By a physician for:
    - Office visits;
    - Hospital care;
    - Surgical services, including postoperative care following inpatient or outpatient surgery; for multiple surgical procedures performed during the same operative session, Covered Expense will include 100% of the Regular, Reasonable & Customary amount for the first surgical procedure, 50% of the Regular, Reasonable & Customary amount for the second surgical procedure, and 25% of the Regular, Reasonable & Customary amount for each additional surgical procedure;
    - Services of an assistant surgeon when medically necessary to perform the surgery, but no more than 20% of the primary provider's allowable fee;

- Injections and medication that must be consumed at the physician's office when Preapproval is obtained, as required by this Plan and outlined in the Schedule of Benefits except for items excluded under Medical Benefit Limitations & Exclusions;
  - An additional surgical opinion following recommendation for elective surgery limited to one consultation and related diagnostic services by a physician (if You request, benefits will be provided for an additional consultation when the need for surgery, in Your opinion, is not resolved by the first arranged consultation);
  - Oral Surgery, as defined herein, including anesthesia and related charges;
  - Dental Services rendered by a Dentist or physician which are required as a result of accidental injury to the jaws, teeth, mouth, or face;
  - Professional pathology laboratory services which are required to physically analyze a specimen and make a diagnosis, including laboratory tests which do not require the physician to make a personal interpretation as in the case of automated clinical pathology tests;
  - Designated telemedicine provider Virtual Care visits.
- For other services and supplies for:
  - Medically Necessary local ground ambulance transportation to the nearest Preferred Provider Hospital able to provide the care;
  - Medically Necessary air ambulance transportation to the nearest Preferred Provider Hospital able to provide the care;
  - Anesthesia and its administration;
  - X-rays;
  - High tech diagnostics services such as MRI, MRA, CT, and PET scanning procedures;
  - Radiation therapy, Case Management Prior Authorization is required;
  - Chemotherapy, or similar treatment, provided in the office, hospital, or the home, but the Covered Expense for chemotherapy provided through a hospital or physician's office will not exceed the Regular, Reasonable & Customary fees for home chemotherapy when Case Management Prior Authorization is obtained as required by the Plan;
  - Wigs or hair prosthesis (Limited to $100 per Participant per lifetime), when required due to hair loss resulting from chemotherapy and/or radiation therapy;
  - Laboratory tests;
  - Blood, blood plasma, and its administration;
  - Ostomy supplies when Preapproval is obtained as required by the Plan;
  - Allergens dispensed by a physician;
  - Durable Medical Equipment for the purchase or rental when Preapproval is obtained as required by the Plan;
  - Outpatient diabetes self–management training, education and medical nutrition therapy if these services are rendered by a physician, or duly certified, registered or licensed health care professional with expertise in diabetes management;
  - Insulin Pumps when Preapproval is obtained as required by the Plan;
  - Initial purchase of artificial eyes and larynx when Preapproval is obtained as required by the Plan;
  - Crutches;
  - Orthopedic braces when Preapproval is obtained, as required by the Plan except for items excluded under Medical Benefit Limitations & Exclusions;

    - Custom foot orthotics when Preapproval is obtained as required by the Plan except for items excluded under Medical Benefit Limitations & Exclusions up to a maximum allowable of $200 per Calendar Year;
    - The standard prosthetic limb that meets Your needs as determined by the Plan; Initial purchase, fitting and adjusting of the limb; repair, refitting and/or replacement of a prosthetic limb as long as it has been properly maintained and not subjected to abuse or misuse, and when not covered by product warranty when Preapproval is obtained as required by the Plan;
    - The purchase of one pair of the following while covered:
        - One pair of orthopedic shoes;
        - One support stocking for each leg;
        - One article of similar apparel- type item;
- For Home Health Care visits when Case Management Prior Authorization is obtained as required by the Plan, not to exceed:
    - The number of visits shown on the Schedule of Benefits during one Calendar Year; and
    - The cost for such care in an inpatient facility;
- For care in a licensed Skilled Nursing Facility when Case Management Prior Authorization is obtained as required by the Plan, but not for longer than the number of days shown on the Schedule of Benefits during one Calendar Year;
- For Hospice Care when Case Management Prior Authorization is obtained, as required by the Plan;
- For expense incurred for outpatient physical therapy, outpatient occupational therapy and only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time when Preapproval is obtained, as shown on the Schedule of Benefits and as required by the Plan;
- For expense incurred for outpatient speech therapy by a licensed or certified speech therapist to restore speech loss or correct impairment due to a congenital defect for which corrective surgery has been performed, or an injury or illness will be considered Covered Expense when Preapproval is obtained, as shown on the Schedule of Benefits and as required by the Plan;
- For expense incurred for inpatient stay in an inpatient rehabilitation facility, but only when the patient is able to participate in intensive therapy and treatment of at least 3 hours per day, and there is documented measureable improvement occurring as a result of the therapy, treatment, and stay when Precertification is obtained, as required by the Plan;
- For expense incurred for visits for Phase I and Phase II outpatient cardiac rehabilitation services if a Participant has a history of any of the following: acute myocardial infarction, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty, heart valve surgery, heart transplantation, stable angina pectoris, compensated heart failure or trans myocardial revascularization, but only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. Benefits are limited to the number of visits shown on the Schedule of Benefits during a six month period and must be performed at a Preferred Provider;
- For expense incurred for visits for outpatient pulmonary rehabilitation, but only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time;
- For expenses incurred for manipulative therapy (Osteopathic, Chiropractic, Naprapathic Services) See Schedule of Benefits;
- Injections for contraceptive purposes, including Depo-Provera and Norplant;
- Contraceptive devices which require a written prescription before dispensing;

- Elective sterilization surgery;
- Medically Necessary expense incurred for Maternity Services;
- Medically Necessary expense incurred for a well or ill newborn, but only if Dependent coverage has been added for the newborn within 30 days following the newborn's birth;
- Medically Necessary expense incurred for the diagnosis and treatment of all mental illnesses, psychiatric conditions, and alcoholism and Substance Use Disorder, including:
  - Medically Necessary individual outpatient mental health or rehabilitation care visits to qualified physicians, licensed clinical psychologists or clinical social workers as may be necessary and appropriate for evaluation, short-term treatment and crisis intervention services, Precertification is recommended by the Plan (Provider office visits do not require Precertification);
  - Medically Necessary inpatient mental health or rehabilitation care at an inpatient facility, Residential Treatment Center or Hospital when Precertification is obtained, as required by the Plan;
  - Partial Hospitalization, Precertification is recommended by the Plan;
  - Intensive Outpatient Treatment (day treatment), Precertification is recommended by the Plan;
  - Opiate replacement therapy and psychotherapy, Precertification is recommended by the Plan;
  - Nursing services provided in the home, Precertification is recommended by the Plan;
  - Detoxification (sub-acute/non-medical);
  - Diagnosis, detoxification and treatment of the medical complications of the use of or addiction to alcohol or drugs on either an inpatient basis, Precertification is required, or outpatient basis, Precertification is recommended by the Plan;
- For Approved Clinical Trials Covered Expenses includes routine patient costs incurred by a Qualified Individual who participates in an Approved Clinical Trial. A Qualified Individual who wishes to participate in an Approved Clinical Trial must obtain Case Management Prior Authorization and use a Preferred Provider if a Preferred Provider is participating in the trial and the Preferred Provider accepts the Qualified Individual as a participant in the trial. However, if the Approved Clinical Trial is either conducted outside the state in which the Qualified Individual resides by a Non-Preferred Provider or there is no Preferred Provider conducting the Approved Clinical Trial and accepting the Qualified Individual in the individual's state of residence, then routine patient costs will be covered as if provided by a Preferred Provider and subject to Regular, Reasonable & Customary when Case Management Prior Authorization is obtained, as required by the Plan;
- The treatment of injuries to whole natural teeth. The treatment must be performed during the first 12 months after the date of injury;
- Treatment of congenital defects and birth abnormalities, including cleft palate or cleft lip, for a child;
- Hearing examinations, but only to test or treat hearing loss related to illness or injury;
- Bone anchored Hearing aids, osseointegrated auditory implants, when Preapproval is obtained, as required by the Plan;
- Examination and testing of sexual criminal assault victim (services covered with no cost share);
- Diagnosis and Treatment of Autism Spectrum Disorder(s) including the following care when prescribed, provided or ordered for an Participant diagnosed with an Autism Spectrum Disorder by (a) a Physician or a Psychologist who has determined that such care is Medically Necessary, or (b) a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such

care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:
  - Psychiatric care, including diagnostic services;
  - Psychological assessments and treatments;

  Preapproval is recommended by the Plan;

- Habilitative services for Participants under age 19 years of age with a congenital, genetic, or early acquired disorder if all of the following conditions are met:
  - A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder;
  - Treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, Physician, licensed nurse, optometrist, licensed nutritionist, clinical social worker, or Psychologist upon the referral of a Physician; and
  - Treatment must be Medically Necessary and therapeutic and not Experimental/Investigational.

  Preapproval is recommended by the Plan;

- Non-experimental, Medically Necessary surgical treatment of Morbid Obesity when bariatric surgery is performed for the treatment of Morbid Obesity. Bariatric surgery is Medically Necessary for Morbid Obesity when ALL of the following medical criteria are met:
  - Completion of a comprehensive multidisciplinary bariatric evaluation proximate to surgery which would include:
    - Physical exam with surgical history with discussion of the specific procedure to be performed; and
    - Clinically appropriate lab data with diagnostics; and
    - Nutritional consultation with counseling/education, which includes a reduced calorie diet program supervised by a dietician or nutritionist; and
    - Mental health evaluation and clearance;

    A physician's summary letter is not sufficient documentation. Documentation must include medical records documenting compliance with the physician's plan of care and the patient's progress throughout the course of treatment including medical documentation supporting body mass index (BMI) and comorbidities;
  - The Participant is over the age of 21 or if the Participant is under 21 and
    - Two (2) authorized physicians determine that the surgery is necessary to:
      - Save the life of the Participant; or
      - Restore the Participant's ability to maintain a major life activity;

        and
      - Each physician must document in the Participant's medical record the reason for the physician's determination;

  Bariatric surgery requires Preapproval. See the Third Party Administrator website to obtain a list of covered bariatric surgeries and current clinical coverage guidelines or medical coverage policies;

- Genetic molecular testing (specific gene identification) and related counseling when both of the following requirements are met:
  - the insured is an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.);
  - the outcome of the test is expected to determine a covered course of treatment or prevention and is not merely informational;

- Inpatient treatment following a covered mastectomy for the length of time determined to be appropriate by the attending physician;
- One breast prosthesis per breast or reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance; replacement breast prosthesis once every two years;
- Three post-mastectomy surgical bras every six months, limited to the standard model;
- Treatment of physical complications of a mastectomy, including lymphedema;
- Breast reduction surgery when performed in conjunction with reconstructive surgery following a mastectomy;
- Breast reduction surgery that is preapproved and where the Plan determines it to be Medically Necessary:
    - Medical Necessity at minimum will require ALL of the following to be met:
        - Patient is over the age of 18;
        - At least 2 of the areas listed below are documented as directly attributed to macromasia and have affected daily activities for at least 1 year:
            - Headaches
            - Pain in neck
            - Pain in shoulders
            - Pain in upper back
            - Pain, ulceration and grooving of the shoulder caused by bra straps
            - Severe soft tissue infection from overlying breast tissue;
        - Minimum of a 3 months trial of conservative treatments such as:
            - Use of muscle relaxants and/or analgesic/NSAIDs
            - Physical therapy, Chiropractic care and/or exercising
            - Use of proper bra support such as wide strap bars
            - Medically supervised weight loss program
            - Medical evaluation of spinal pain;
        - Physical exam documenting breast hypertrophy;

  Proposed surgery that removes less than 1 kg may require additional supporting documentation for Medical Necessity to be considered;
- Obstructive sleep apnea diagnosis treatments including custom made oral and dental splints and appliances for the treatment of documented obstructive sleep apnea. See Schedule of Benefits, CPAP or similar machines and oral and dental splints and appliances require Preapproval. Sleep studies require Case Management Prior Authorization;
- Temporomandibular Joint Dysfunction (TMJ) including custom made oral and dental splints and appliances for the treatment of documented TMJ. Benefits are limited to the amount shown on the Schedule of Benefits. Oral and dental splints and appliances require Preapproval;
- Oral and dental splints and appliances for teeth grinding. Benefits are limited to the amount shown on the Schedule of Benefits. Oral and dental splints and appliances require Preapproval;
- Infertility Treatment
    - Initial diagnosis of Infertility and/or Infertility Treatment when Preapproval is obtained as required by the Plan;
    - Diagnostic testing including but not limited to In-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination,

gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection;

Benefits for treatments that include oocyte retrievals will be provided only when You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate Infertility Treatments; however, this requirement will be waived if You or Your partner has a medical condition that makes such treatment useless.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to You. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals and the subsequent procedure to transfer the oocytes or sperm that are eligible for coverage under this Plan in Your lifetime is three. Following the third completed oocyte retrieval and transfer, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to You. Thereafter, You will have no benefits for Infertility Treatment.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

- Medically Necessary expense incurred for an organ or bone marrow transplant, but only when performed at a facility designated as a Transplant Center of Excellence facility, and Preapproval is obtained, as required by the Plan.
  Transplant Benefits including Preapproved organ transplants according to the following schedule:
  - Transplant Center of Excellence Facility
    - 100% of Approved Transplant Services after the Preferred Provider Deductible has been met;
    - Organ Procurement and acquisition covered in full;
    - Travel/Lodging Benefit outlined below.
  - Non - Transplant Center of Excellence Facility
    - 90% of the Covered Expense in excess of the Non-Preferred Provider deductible for hospital charges, physician charges, tissue typing and other ancillary services related to the organ transplant. Once the Participant has paid 10% of $100,000 of Covered Expense for the transplant services listed above, then there is no coverage thereafter under the Plan for the transplant;
    - No coverage for organ procurement and acquisition;
    - No coverage for transportation and lodging.
  - Travel/Lodging Benefit for Transplants performed at Center of Excellence Facility.
    - When a covered organ transplant is performed at a Transplant Center of Excellence facility, the Plan will provide:
      - Transportation for the Participant patient and one member of the Participant patient's immediate family to accompany the Participant patient to and from the Transplant Center of Excellence; and

- Lodging at or near the Transplant Center of Excellence for the family member who accompanied the Participant patient, while the Participant is confined at the Transplant Center of Excellence.

The Plan will authorize the transportation and lodging at no cost to the Participant patient, except that the daily maximum benefit the Plan will pay for food and lodging for the family member who accompanied the Participant is $200 with a total maximum of $10,000. The Plan Administrator must be provided with itemized bills for all transportation, food and lodging expenses.

PRESCRIPTION BENEFIT

The prescription benefit under this Plan provides benefits for Covered Expense incurred for drugs which require a written prescription, and which are dispensed by a licensed pharmacist. The program also provides benefits for expense for insulin, syringes for administration of insulin and glucagon emergency kits, when prescribed by a Physician and dispensed by a licensed pharmacist.

This prescription drug card benefit is administered by the prescription drug card company, hereafter referred to as the Pharmacy Benefit Manager.

Amount of Benefit

The Participant must pay a drug Copay amount each time a prescription is ordered. The amount of the Copay will vary by the type of medication purchased, and the place of purchase.

Allowable Covered Prescription Expense

A prescription drug order is a request for each separate prescription drug and/or each authorized refill, if ordered by a Physician.

Expense incurred for a prescription drug order for the following items will be considered allowable covered prescription expense:

- Injectable and non-injectable legend drug;
- Insulin and epipens on prescription;
- Disposable insulin needles/syringes;
- Test strips for glucose monitors;
- Lancets for diabetic blood monitoring and other supplies for testing and monitoring diabetes;
- Glucagon emergency kits;
- Tretinoin, all dosage forms (Retin-A), when Medically Necessary;
- ADD/ADHD medications when Medically Necessary (PBM prior authorization may be required);
- Oral contraceptives and female contraceptive devices;
- Medications ordered in conjunction with a covered Infertility Treatment plan as defined in Amount of Benefit for Covered Expense, Infertility;
- Evidenced-based preventative oral medications that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (at no Cost-Share);
- Erectile dysfunction medications but limited to 6 pills per month;
- Any medication containing nicotine or other smoking deterrent medications as required by law;
- Compound medications if at least one ingredient is a legend drug;
- Any other oral drug which, under the applicable state laws, may be only dispensed upon a written prescription of a Physician or other lawful prescriber.

How to File a Claim

To file a prescription claim at a retail pharmacy, a Participant should present the prescription drug card to the participating pharmacy. The pharmacist will use the information on Your card to electronically file a claim with the Pharmacy Benefit Manager.

To file a claim under the Mail Service Program, a Participant must submit the original prescription and the necessary forms to the Pharmacy Benefit Manager Mail Service Program. The necessary forms and instruction brochures can be obtained from the Third Party Administrator website, www.groupplansolutions.com or by calling the Third Party Administrator.

Prescriptions Purchased at a Retail Pharmacy

Up to a 90 day supply of prescription medication can be obtained from a retail pharmacy after a 30 day supply has been covered under the Plan. Specialty drugs and opioids may not be purchased in quantities larger than a 30 day supply. You must pay the applicable Retail Prescription Copay amount designated for the type of medication purchased as outlined on the Schedule of Benefits and the Pharmacy Benefit Managers formulary tiers, and then the Plan will pay the rest of the Covered Expense at 100%. The retail Copay tiers are outlined in the Schedule of Benefits. All drug classifications are determined by the Pharmacy Benefit Manager.

- The "generic prescription Copay amount" must be paid anytime You purchase a generic medication;
- The "preferred brand prescription Copay amount" must be paid anytime You purchase a preferred brand medication listed on the preferred brand medication list and for which an equivalent generic drug is not available;
- The "brand prescription Copay amount" must be paid anytime You purchase a brand medication that is not on the "preferred brand medication list" and for which an equivalent generic drug is not available;
- The "specialty prescription Copay amount" must be paid anytime You purchase a specialty medication listed on the PBMs specialty medications list.

When purchasing a qualified medication, You must pay the applicable Retail Prescription Copay according to the schedule below:

- 1 copayment for a 1 - 30 day supply;
- 2 copayments for a 31 - 60 day supply;
- 3 copayments for a 61 - 90 day supply.

The Plan will not allow more than the price the Plan has negotiated with the Pharmacy Benefit Manager for a prescription, less the prescription Copay amount for a prescription.

The Plan will not pay the difference in charge between a brand drug and a generic drug, if the generic drug has been designated a generic equivalent.

Prescriptions Purchased From the Mail Service Program

Up to a 90 day supply of medication can be obtained from mail service program after a 30 day supply has been covered under the Plan. Specialty drugs and opioids may not be purchased in quantities larger than a 30 day supply. You must pay the applicable Mail Order Prescription Copay amount designated for the type of medication purchased as outlined on the Schedule of Benefits and the Pharmacy Benefit Managers formulary tiers, and then the Plan will pay the rest of the Covered Expense at 100%. The Copay will vary based on if the drug is Generic, Brand, Preferred Brand or Specialty. The mail order Copay tiers are

outlined in the Schedule of Benefits. All drug classifications are determined by the Pharmacy Benefit Manager.

- The "generic mail order prescription Copay amount" must be paid anytime You purchase a generic medication;
- The "preferred brand mail order prescription Copay amount" must be paid anytime You purchase a preferred brand medication listed on the preferred brand medication list and for which an equivalent generic drug is not available;
- The "brand prescription mail order Copay amount" must be paid anytime You purchase a brand medication that is not on the "preferred brand medication list" and for which an equivalent generic drug is not available;
- The "specialty mail order prescription Copay amount" must be paid anytime You purchase a specialty medication listed on the PBMs specialty medications list.

The Plan will not pay more than the price the Plan has negotiated with the Pharmacy Benefit Manager, less the mail order Copay amount for a prescription.

The Plan will not pay the difference in charge between a brand drug and a generic drug, if the generic drug has been designated a generic equivalent.

Prescription Drug Card Limitations and Exclusions

A prescription drug order does not include and no benefit will be payable for the following, regardless of the reason for which prescribed:

- The amount of expense for a medication that is in excess of the amount agreed upon between the Pharmacy Benefit Manager and the Plan Administrator;
- The difference between the cost of a Brand name drug and an equivalent generic drug, if the generic drug has been designated an equivalent generic drug by the Pharmacy Benefit Manager;
- For duplicate prescriptions or prescriptions refilled more frequently than the prescribed dosage indicates (a prescription (other than opioids) purchased at retail pharmacy cannot be refilled until the patient has used 75% of the medication as prescribed; a prescription (other than opioids) purchased at mail order cannot be refilled until the patient has used 60% of the medication as prescribed; a prescription for opioids purchased at retail pharmacy cannot be refilled until the patient has used 80% of the medication as prescribed; or a prescription for opioids purchased at mail order cannot be refilled until the patient has used 80% of the medication as prescribed);
- Prescriptions not purchased from a Preferred Provider (in-network) pharmacy as determined by the Pharmacy Benefit Manager;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, Skilled Nursing Facility, convalescent care facility, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Drugs dispensed by a physician;
- Fluoride supplements;
- Hematinics;
- Immunization agents, refer to Amount of Benefit for Covered Expense; Preventative Care;
- Biological sera, refer to Amount of Benefit for Covered Expense;

- Blood or blood plasma;
- Minerals;
- Minoxidil (Rogaine) or other similar medications for the treatment of alopecia;
- Anorexiants (any drugs used for purposes of weight control);
- Non-legend drugs, other than insulin;
- Vitamins, singly or in combination, except for legend prenatal vitamins and folic acid;
- Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed under Allowable Covered Prescription Expense;
- Charges for the administration or injection of any drug;
- Prescriptions which an eligible person is entitled to receive without charge under any Worker's Compensation law;
- Drugs labeled "Caution-limited by federal laws to investigational use", or experimental/investigational drugs, even though a charge is made to the individual Except as outlined in Amount of Benefit for Covered Expense, Clinical Trials;
- Any charge for a prescription drug when the drug does not meet the step therapy requirements of the Pharmacy Benefit Manager;
- Any charge for more than a 90 day supply of a prescription drug at a retail pharmacy;
- Any charge for more than a 90 day supply of a prescription drug at the mail order pharmacy;
- Any charge for a prescription drug dosage that exceeds the Pharmacy Benefit Manager's optimum dosage limits;
- For prescriptions refilled in excess of the number ordered by the physician;
- For prescriptions refilled after one year from the physician's original order;
- For prescriptions to replace lost or damaged prescriptions;
- For prescriptions for the treatment of Infertility or in vitro fertilization except as outlined in Amount of Benefit for Covered Expense, Infertility;
- Drugs used primarily for cosmetic purposes, regardless of intended use;
- Any charge for a prescription drug that does not meet preauthorization requirements established by the Pharmacy Benefit Manager. The Plan can allow a one-month fill for a prescription drug that a Participant has been taking continuously in the past;
- Convenience packaging when the cost exceeds the cost of the drug when purchased in its normal container;
- Drugs abused or otherwise misused by a Participant;
- Most prescription and non-prescription nutritional and dietary supplements are not Covered Expenses under this benefit.

MEDICAL BENEFIT LIMITATIONS & EXCLUSIONS

The following exclusions apply to the Medical Benefit section of this plan.

The Medical Benefit section of this plan does not cover loss caused by:

- Claims arising out of, caused by or contributed to war declared or undeclared, civil war, hostilities or invasion;
- Service in the armed forces;
- Complications arising from excluded treatment;

- Commission of a felony or illegal activities. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

This Plan does not pay any benefit for expense for:

- Services that aren't medically necessary;
- Services for which no benefit is defined or described in this Plan;
- Incidental appendectomies;
- Treatment of educational, training problems, or learning disorders, marital counseling, or social counseling, except as outlined in the Amount of Benefit for Covered Expense;
- Services provided by an employee of a school district, or a person contracted to provide services for a school district, or services available through a school system;
- Any experimental/investigational service, supply, or treatment;
- The use of any services or facilities of a federal, Veteran's administration, state, county or municipal hospital, except where the Plan or the Participant are legally required to pay the expenses;
- Treatment of an injury or illness caused by or resulting from an illness or injury of the Participant, if the illness or injury is recognized as a compensable loss by the provisions of any worker's compensation act, employer liability laws, occupational disease law, or any similar law of a state or federal government, or other governmental subdivision, under which the person is or could be protected on a mandatory basis, whether or not such protection is afforded; or would have been recognized had the Participant made claim within the appropriate time limits. If the worker's compensation type coverage has denied a claim, but the Participant is still pursuing coverage with the worker's compensation type coverage through a state or federal commission or agency, or other legal entity, benefits will not be payable under this Plan until the Participant certifies the Participant no longer intends to pursue coverage through the worker's compensation type coverage;
- Bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription;
- Hearing aids except as outlined in Amount of Benefit for Covered Expense;
- Contact lenses, Eye glasses, Eye examinations for the correction of vision or fitting of glasses or contact lenses; Vision therapy or orthoptics treatment (eye exercises);
- Any dental treatment, dentures, dental surgery, or extractions, except as outlined in Amount of Benefit for Covered Expense;
- Any orthodontic procedure or appliance except as outlined in Amount of Benefit for Covered Expense;
- Any service or supply not recommended or approved by a licensed medical practitioner;
- Any treatment or surgery that results in the improvement of appearance, except for that which is the result of breast reconstruction following a mastectomy or when determined Medically Necessary, or treatment of congenital defects and birth abnormalities, including cleft lip or cleft palate repair, or which is the result of an injury. The treatment must be performed during the first 12 months after the date of injury;
- Services or supplies that are not for the diagnosis or treatment of an existing illness or injury, except as provided under the section titled "Preventive Care";
- Immunizations or vaccinations, including Synagis or similar immunization agents, except as provided under the section titled "Preventive Care";
- Abortions, except where the mother's life is threatened;
- Amniocentesis, except for the diagnosis or treatment of an existing complication of pregnancy;
- Reversal of sterilization procedures;
- Nonmedical services and supplies;

- Durable Medical Equipment unless the purchase or rental of the equipment has been Preapproved as required by the Plan.
- Any service or supply that the Participant is not legally required to pay for, including any forgiveness of Deductible, Coinsurance, Copay, or Access Fee by a provider or any write off of an outstanding balance by a provider;
- Any surgery for the correction of a refractive error;
- Treatment received in an emergency room of a hospital except when Emergency Services are being rendered;
- The replacement of a piece of Durable Medical Equipment or a prosthesis unless Preapproved as required by the Plan;
- Custodial care;
- Services furnished by the Covered Employee or a member of the Covered Employee's or the Covered Employee's Spouse's immediate family, or by a person who regularly lives in the Covered Employee's home;
- Any medical treatment, weight reduction program, membership dues, or clinic fees for the treatment of obesity or morbid obesity, except where required by law or allowed for under the Amount of Benefit for Covered Expense;
- Any surgical procedure to remove excess tissue caused by weight loss;
- Nutritional supplements;
- Treatment related to the restoration of fertility or promotion of conception including in vitro fertilization except as outlined in Amount of Benefit for Covered Expense;
- Animal to human organ transplants;
- Replacement of human organs by artificial or mechanical devices;
- Treatment of caffeine, gambling, computer or similar addictions;
- Services provided by a midwife, except where specifically licensed by the state to practice midwifery;
- By a registered nurse (RN) for private duty professional nursing services;
- Sclerotherapy for varicose veins;
- Devices used specifically as safety items or to affect performance primarily in sports-related activities;
- Medical or surgical treatment of upper or lower jaw alignment conditions or malformations, including orthognathic surgery, expect for direct treatment of acute traumatic injury or cancer except as provided in the Amount of Benefit for Covered Expense;
- Wigs or hair prosthesis; except as provided in the Amount of Benefit for Covered Expense;
- Routine foot care related to corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain, except that routine foot care for patients with diabetes will be covered when Preapproval has been obtained as required by the Plan;
- Shoe inserts;
- Physical conditioning programs such as athletic training, body-building exercises, fitness and flexibility programs;
- Physical therapy, occupational therapy, manipulative therapy, or speech therapy services if an expectation for practical improvement in the level of functioning within a reasonable period of time does not exist. Any charge for therapy where the same equipment could be utilized at a health club or gym;
- Physical therapy, occupational therapy, manipulative therapy, or speech therapy when the service being provided is supervised exercise, or when the service being provided does not require a license to be performed;
- The services of a massage therapist, athletic trainer, or masseuse; acupuncture or acupressure treatment;
- Ambulance usage when another type of transportation or another level of ambulance service could have been used without endangering the patient's health;
- Any charge that does not meet the definition of Regular, Reasonable & Customary for an otherwise Covered Expense;

- Any charge for a service that exceeds the maximum allowable amount;
- Care required while incarcerated in a federal, state or local penal institution or while in custody of federal, state, or local law enforcement authorities, unless otherwise required by law or regulation;
- Court ordered testing or care unless medically necessary or unless otherwise required by law or regulation;
- Surrogate parenting;
- Breast reduction surgery, except when performed in conjunction with reconstructive surgery following a mastectomy or when Medically Necessary;
- Treatment performed outside the United States, except when an emergency;
- Removal of breast implants that were implanted solely for cosmetic reasons;
- Growth hormone treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to growth hormone deficiency, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Participant's condition;
- Removal and/or replacement of a defective or recalled implant or device, or expense incurred as a result of medical malpractice;
- Expense that exceeds any maximum allowable amount;
- Self-injected prescription medications, except as may be provided under the Prescription Medication Benefit;
- Any oral medication intended to be self-administered except as may be provided under the Prescription Medication Benefit;
- Over the counter medications except as may be provided under the Prescription Medication Benefit;
- Expenses for complications arising from an expense not covered by the Plan;
- Injuries associated with or resulting from act of chewing except as outlined in Amount of Benefit for Covered Expense;
- Maxillary or mandibular tooth implants (osseointegration);
- Certain disorders related to early childhood, such as academic underachievement disorder;
- Communication disorders, such as stuttering and stammering;
- Sexual identification or gender disorders;
- Sexual transformation procedures, treatments, or studies;
- Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from You will be covered if You choose to use a surrogate;
- Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term;
- Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance;
- Non-medical costs of an egg or sperm donor;
- Travel costs for travel within 100 miles of Your home or travel costs not Medically Necessary or required by the Claim Administrator;
- Infertility Treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists;
- Infertility Treatment rendered to Your Dependents under age 18;
- A Never Event;

- Any treatment that does not meet the clinical coverage guidelines or medical coverage policies as posted on the Third Party Administrator's website;
- Third Party Recovery, Subrogation, and/or Reimbursement of an Injury or Sickness not payable by virtue of the Plan's Third Party Recovery, Subrogation, and/or Reimbursement provisions.

PRECERTIFICATION OF SERVICES

This Plan includes a utilization review program. The purpose of this program is to:

- Promote the efficient utilization of quality health care services;
- Assure the patient and payer that health care benefits are used for quality, medically necessary services;
- Assure that all services are provided in the most cost effective, appropriate setting; and
- Minimize the risk of retrospective payment denials.

Services Requiring Precertification by Utilization Review

You must call the applicable Precertification number if:

- You are being admitted as an inpatient to a Hospital or Residential Treatment Center, including overnight observation or inpatient Physical Therapy, Speech Therapy, or Occupational Therapy;
- You are being admitted as an inpatient to a hospital for Childbirth/Delivery and Your inpatient stay exceeds:
  - 48 hours following a vaginal delivery (not including the day of delivery); or
  - 96 hours following a cesarean birth (not including the day of delivery).

Services Recommended for Precertification by Utilization Review

It is recommended that You call the Precertification number if You are going to receive any of the following medically necessary services for the treatment of mental health and Substance Use Disorders:

- Day treatment, intensive outpatient services, partial hospitalization services:
- Opiate replacement therapy and psychotherapy and nursing services provided in the home.

Provider office visits do not require Precertification.

Non-Emergency Hospitalization and Inpatient Treatment

You must call the applicable Precertification number listed in the General Plan Information section at least 3 business days before You are scheduled for a non-emergency inpatient admission to a Hospital, Residential Treatment Center or other facility, inpatient surgery, or inpatient physical, speech or occupational therapy.

Medical Emergency

You must call the applicable Precertification number listed in the General Plan Information section of this Plan within 2 business days (or as soon as reasonably possible if Your condition prevents You from calling within that time frame) after Your emergency inpatient admission.

Making the Call

You can make the phone call, or You can have a relative or Your Physician make the phone call. You are responsible for making sure that someone calls the applicable Precertification, Case Management Prior Authorization or Preapproval number, for either a Medical Condition or a Mental Health and Substance Use Disorder condition, on a timely basis. These numbers can be found in the General Plan Information section of the Plan.

When the call is made, the following information should be available:

- the patient's name, date of birth, sex, and the member number and plan name;
- the proposed (or actual) date and reason for admission, surgery, treatment or scanning procedure;
- the name and phone number for the Hospital, Residential Treatment Center and ordering physician.

Precertification Process

When a call is made to the Medical Condition or Mental Health and Substance Use Disorder Conditions Precertification telephone numbers found in the General Plan Information section, the caller will be given a Precertification number. A review determination will be made to verify Medical Necessity and appropriateness only.

The Precertification process does not confirm that a provider is a Preferred Provider. It does not guarantee benefits for a service. If a Participant wants to know if a service approved by Precertification will be covered under the plan, or if a provider is a Preferred Provider, they must call the phone number for Group Plan Solutions found in the General Plan Information section of the Plan.

Medical Necessity and Appropriateness

No benefit will be payable for any hospitalization or Medical Condition or Mental Health and Substance Use Disorder Conditions treatment listed above if it is not approved as Medically Necessary and appropriate by the reviewer.

Right to Appeal

You or Your physician may, at any time, initiate a request for reevaluation or extension of a reviewer's decision by calling the applicable Precertification or Case Management Prior Authorization number. You may also file an appeal with the Third Party Administrator.

Failure to Precertify

If the Participant fails to Precertify any service requiring Precertification, the Participant will be responsible for a penalty equal to the first $500 of the total Covered Expense for services received but in no event will the penalty exceed 50% of the total charges. The Precertification penalty does not apply to Participants that Medicare pays primary including ESRD. The Participant will also be responsible for any non-covered, medically unnecessary expenses resulting from the non-certified stay.

It is the responsibility of the Participant to ensure Precertification has been obtained.

CASE MANAGEMENT PRIOR AUTHORIZATION / PREAPPROVAL

The Plan requires that certain services have Preapproval or Case Management Prior Authorization. Before obtaining these services, You must receive Preapproval or Case Management Prior Authorization from the Plan. The phone numbers to call are listed in the General Information section.

Services requiring Preapproval are:

- Injectable medications (except for insulin and its administration) administered in a physician's office;
- Insulin Pumps;

- Customized orthotics including foot orthotics, purchase, refitting, or replacement of orthotics;
- Prosthetic devices; including but not limited to artificial eyes, limbs, larynx;
- Durable Medical Equipment;
- Cranial Molding Helmets;
- Ostomy supplies;
- CPAP or similar machines; oxygen equipment;
- Most covered medical supplies;
- Outpatient Speech therapy;
- Outpatient Occupational therapy visits in excess of 20 visits per Calendar Year;
- Outpatient Physical therapy visits in excess of 20 visits per Calendar Year;
- Genetic Testing;
- Infertility Treatment;
- Bariatric Surgery;
- Habilitative Services;
- Organ Transplants;
- Bone anchored hearing aids;
- Oral or dental splints and appliances.

Services requiring Case Management Prior Authorization are:

- Home Health Care;
- Infusions whether taken at home or administered in a physician's office;
- Hospice Care;
- Clinical Trials;
- Skilled Nursing stays;
- Radiation Therapy;
- Chemotherapy;
- Sleep Studies;
- Dialysis.

Not all services above may be covered under the Plan. Refer to the Schedule of Benefits, Amount of Benefit for Covered Expense section and Medical Benefit Limitations & Exclusions section.

If a Participant is faced with a serious illness or long-term health concern, the Plan utilizes case management service to provide assistance to manage the person's healthcare benefits more effectively.

Upon the advice of a case management professional, the Plan Administrator has the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result can be achieved without a sacrifice to quality of care for the patient.

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.

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. An annual information statement (or other insurance form) must be completed each year by the Participant and properly signed as required by the Plan Administrator. The completed form must be submitted to the Plan Administrator. 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 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 <u>require</u> the Participant to obtain approval of a medical service <u>prior</u> 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.

- <u>Post-service Claims</u>. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed with the Third Party Administrator within 12 months of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

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

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

Timing of Claim Decisions

The Plan Administrator shall notify the 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:

- <u>Pre-service Urgent Care Claims</u>:

  - 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.

- <u>Pre-service Non-urgent Care Claims</u>:
  - 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).
- <u>Concurrent Claims</u>:
  - 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.

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.

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: 855-545-7165**
> **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: 855-545-7165**
> **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.**

External Review Process

A. Scope

1. The Federal external review process does <u>not</u> 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 benefit; 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.

C. 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.

COORDINATION WITH MEDICARE AND MEDICAID

MEDICARE

The Plan Administrator will determine if Medicare is primary payer based upon Medicare regulations and the status of the Participant on the date a Covered Expense is incurred. Generally, this Plan will pay primary to Medicare for active Covered Employees and the Covered Employee's Covered Spouse and Covered Children except in some cases when a participant has End-Stage Renal Disease (ESRD) per Medicare regulations.

When Medicare is primary payer, the Plan will coordinate the Plan benefits with Medicare in accordance with the "Coordination of Benefits" provision in this Plan.

If a Covered Person is eligible for Medicare as primary payer, but does not enroll or apply for it on time, the Plan will estimate what Medicare would have paid if the Covered Person had made timely application.

MEDICAID

Payment for Expenses Incurred with respect to a Covered Person or Covered Dependent under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Covered Persons or Covered Dependent as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act. In enrolling or in determining or making any payments for Expenses Incurred of a Covered Person or Covered Dependent, the fact that the Covered Person or Covered Dependent is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make payment for the Expenses Incurred constituting such assistance, payment for the Expenses Incurred under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Covered Person or Covered Dependent to such payment for such Expenses Incurred.

COORDINATION OF BENEFITS

When the Plan is the secondary plan, the plan will determine the Regular, Reasonable, and Customary Charge. After the primary plan pays, the Plan will either pay what is left of the Regular, Reasonable and Customary Charge or the regular benefit, whichever is less. The Plan will not pay more than the Regular, Reasonable and Customary Charge amount. The secondary plan pays a reduced amount, which when added to the benefits paid by the primary plan, will normally equal 100% of the allowable expense. The benefits payable under the secondary plan cannot exceed the benefit that would be payable if there was no other group-type plan.

If an expense is eligible under both this Plan and the Employer's dental plan, this Plan will pay primary.

RULES FOR ORDER OF PAYMENT

The primary plan is:

- The plan which does not coordinate its benefits with any other plan.
- The plan which covers the person as an employee or student, rather than as a dependent. However, if a person is also a Medicare beneficiary, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent, for example a retired employee.
- The plan of the parent whose birthday (excluding year of birth) occurs earlier in a Calendar Year, if both parents are living together. If both parents have the same birthday, the plan that has covered a parent the longest is primary. If the other plan does not have this provision in their policy, then the plan which covers the father as an employee will be primary, rather than the plan which covers the mother as an employee.
- The plan of the parent with custody of the child, if the parents are divorced or separated. The secondary plan will be the plan of the spouse of the parent with custody. The final plan will be the plan of the parent without custody.
- If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, then the plan of the parent who has responsibility will be primary over the other parent or stepparent's plan. This provision does not apply until the Plan has been informed of the terms of the court decree. Any benefits paid prior to the Plans knowledge of the terms of the court decree will be subject to the other sections of this provision.
- If the specific terms of a 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, then the plan of the parent whose birthday occurs earlier in the Calendar Year is primary.
- The plan which covers a person as an active employee, rather than the plan which covers the person as a laid-off or retired employee. The primary plan is the plan which covers the person as a dependent of an active employee, rather than the plan which covers the person as a dependent of a laid-off or retired employee.
- The plan which covers the person as an employee, or the dependent of an employee, rather than the plan which covers the person under any continuation coverage. If the other plan does not have a rule regarding continuation coverage, and as a result, the plans do not agree on which plan is primary, then this rule will be ignored.
- If none of the above rules apply, then the plan which has covered the Participant the longest is the primary plan. The length of time a person has been covered under a plan is measured from the claimant's first date of continuous coverage under the Plan.

REIMBURSING THE OTHER PLAN

If another plan has paid their benefit in error according to this provision, the Plan can make payment directly to them to satisfy the intent of this provision. Any payment made by the Plan for this reason will fully discharge the Plan Administrator of any liability under this plan.

HEALTH INSURANCE CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under certain circumstances, you have the right to temporarily extend your health coverage under this plan under a federal continuation provision called COBRA. COBRA

continuation coverage is a continuation of health coverage when coverage would otherwise end because of a life event known as a "qualifying event". After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under this plan is lost because of a qualifying event.

The health coverage that will be extended is the same coverage that is provided to active covered employees.

Qualified beneficiaries who elect COBRA continuation coverage must pay the premiums for COBRA continuation coverage.

WHEN YOU BECOME A QUALIFIED BENEFICIARY

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under this plan because of one of the following qualifying events:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct.

If you are the Covered Spouse of an employee, you will become a qualified beneficiary if you lose your coverage under this plan because any of the following qualifying events happen:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his/her gross misconduct
- Your spouse becomes entitled to Medicare benefits under Part A, Part B, or both
- You become divorced or legally separated from your spouse.

A Covered Dependent child will become a qualified beneficiary if he/she loses coverage under this plan because any of the following qualifying events happen:

- The covered employee parent dies
- The covered employee parent's hours of employment are reduced
- The covered employee parent's employment ends for any reason other than his/her gross misconduct
- The covered employee parent becomes entitled to Medicare benefits under Part A, Part B, or both
- The parents become divorced or legally separated
- The child no longer meets the definition of a dependent child under this plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan Administrator, or the Plans designated representative, will notify you of your right to continue coverage under COBRA once the Plan has been notified that a qualifying event has occurred. The Plan Administrator will be aware when the qualifying event is end of employment or reduction of hours of employment, death of the employee.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For all other qualifying events, you must notify the Plan Administrator, or the Plan's designated representative, in writing of the qualifying event within 60 days after the event occurs. If the Plan Administrator, or the Plan's designated representative, is not

notified within this time frame, COBRA continuation cannot be offered. In order to take advantage of the disability extension, you must also notify the Plan within sixty days of a determination by Social Security that you or a dependent are disabled. It is important for each Covered Person and Covered Dependent to timely provide the Employer with his current mailing address.

THE PLAN ADMINISTRATORS NOTIFICATION RESPONSIBILITIES

Once the Plan Administrators, or the Plans designated representative, receive notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children.

COBRA ELECTION PERIOD

You or your dependents have the responsibility to notify the Plan, or the Plan Administrator's designated representative, of your desire to continue coverage within sixty days from the later of the date of notification or loss of coverage. Upon acceptance, you or your dependent will be notified of any enrollment forms that must be completed. Qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date termination from the Plan would have occurred.

If a Covered Person decides to continue this coverage, the first premium payment is due 45 days following the date he/she returns the election form. Coverage is provided only when the full premium for the applicable period is received. The Covered Person must pay any premiums after that within 30 days of the date the premium is due. Premium payments must be made to the Plan, or the Plan Administrators designated representative. Coverage is not in force for any period for which premium is not paid.

If you or a Covered Dependent experience a qualifying event and do not receive a qualifying event notification in a timely fashion, you should contact the Plan, or the Plan Administrator's designated representative, immediately.

LENGTH OF CONTINUATION

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the Plan in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the social security Administration determination must be provided to the Plan Administrator within 60 days of the date of the determination and prior to the end of the 18th month of continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Covered Spouse and Covered Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

PERSONS WHO CANNOT CONTINUE

A Covered Person cannot continue this coverage under the COBRA continuation provision if at the time of his/her termination, the Covered Person is a nonresident alien with no earned income from sources within the United States, or is the dependent of such person.

COBRA TERMINATION

Although COBRA continuation coverage has a maximum time frame, you may voluntarily terminate coverage at any time by notifying the Plan, or the Plan Administrator designated representative, in advance. In addition, COBRA states that continuation coverage will end for one or more of the following reasons:

- The date the maximum continuation period has been exhausted
- The date the employer ceases to maintain any group health plan for any employee
- The date the Covered Person is covered by another group health plan which does not include a preexisting condition clause or which would have the preexisting condition limitation period reduced by qualifying previous coverage
- The date the Covered Person becomes covered by Medicare Part A and/or Part B
- The date any premium that is due is not paid within the time allowed.

A Covered Person's continuation under this Plan will terminate anytime this Plan is terminated.

GENERAL PROVISIONS

RIGHT TO RECOVERY

If the Plan made a payment in error, the Plan can recover the Plan's payment from another plan, the Participant, or anyone else to whom the Plan has made payment.

PHYSICAL EXAMINATIONS

The Plan Administrator reserves the right to have a Physician of the Plan's choosing examine any Participant whose condition, illness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

AUTOPSY

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

PAYMENT OF BENEFITS

All benefits under this Plan are payable to the covered employee whose illness or injury, or whose Covered Dependent's illness or injury, is the basis of a claim. In the event of the death or incapacity of a covered employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan, is or was providing the care and support of such Employee.

ASSIGNMENTS

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

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

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

RECOVERY OF PAYMENTS

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

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

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

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

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

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

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

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

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

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. The Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Participant shall be a trustee over those Plan assets.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Participant(s) fails to so pursue said rights and/or action.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

- 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 coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or
- any other source including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

PLAN PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

1. Any Plan Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Participant understands that he/she is required to:

    a) notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

b) instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
c) in circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Plan Participant disputes this obligation to the Plan under this section, the Plan Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

EXCESS INSURANCE

1. If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

   a) the responsible party, its insurer, or any other source on behalf of that party;
   b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c) any policy of insurance from any insurance company or guarantor of a third party;
   d) worker's compensation or other liability insurance company; or
   e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the

Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

OBLIGATIONS

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
    c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
    f) to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
    g) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage;
    h) to instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
    i) in circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft;
    j) to make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Participant over settlement funds is resolved.

2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

OFFSET

If timely repayment is not made, or the Plan Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the Plan. This provision applies even if the Plan Participant has disbursed settlement funds.

MINOR STATUS

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

Plan Administrator

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

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator have maximum legal discretionary authority to:

- construe and interpret the terms and provisions of the Plan;
- to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental/Investigational);
- to decide disputes which may arise relative to a Participant's rights; and
- to decide questions of Plan interpretation and those of fact relating to the Plan.

The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include 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 terms;
- to make factual findings;
- to decide disputes which may arise relative to a participant'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 Third Party 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 as it deems appropriate; and
- to perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settler 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.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Other Provisions

Notwithstanding anything else in the Plan to the contrary, the maximum cost sharing imposed under the Plan shall not exceed the maximum set forth in 42 U.S.C. §300gg-6(b).

Notwithstanding anything in the Plan to the contrary, the Plan shall not discriminate against providers in violation of 42 U.S.C. §300gg-5.

PARTICIPANT'S RIGHTS

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

Receive Information About the Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

HIPAA PRIVACY

Right to Receive and Release Information

The Third Party Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan Administrator or Third Party Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, *et seq.*, or other applicable law, the Plan Administrator or Third Party Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Third Party Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

(a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

(b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make available protected health information in accordance with 45 C.F.R. 164.524;

(g) Make health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

(i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, *et seq.*;

(j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, *et seq*. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998 ANNUAL NOTICE TO HEALTH PLAN PARTICIPANTS

The Women’s Health and Cancer Rights Act (WHCRA) requires group health plans to provide participants with notices of their rights under WHCRA, to provide certain benefits in connection with a mastectomy, and to provide other protections for participants undergoing mastectomies.

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance amounts applicable to other medical and surgical benefits provided under this health plan.

Please keep this information with Your other group health plan documents. If You have any questions about the Plan’s coverage of mastectomies and reconstructive surgeries, please call Group Plan Solutions at 888-301-0747.

THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996 ANNUAL NOTICE TO HEALTH PLAN PARTICIPANTS

The Newborns’ and Mothers’ Health Protection Act of 1996 prohibits group health plans from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth:

- Following a normal vaginal delivery to less than 48 hours; and
- Following a cesarean section, to less than 96 hours.

The Plan may not require that a provider obtain authorization from the Plan for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, the Plan may not:

- Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage;
- Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage;
- Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage require a mother to give birth in a hospital;
- Restrict benefits for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan’s regular deductible and copay. For further details, refer to Your Summary Plan Description.