WINCO HOLDINGS, INC.
EMPLOYEE BENEFIT PLAN

SERVING AS THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Effective January 1, 2020

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Plan Information and Contract Administrators

Plan Sponsor/Administrator:	WinCo Holdings, Inc. PO Box 5756 Boise, ID 83705 208-377-0110 http://benefits.wincofoods.com
Name of Plan:	WinCo Holdings, Inc. Employee Benefit Plan
Plan Sponsor Tax ID Number:	82-0290448
Plan Number:	501
Agent for Service of Legal Process:	Corporation Service Company 2711 Centerville Road, Suite 400 Wilmington, DE 19808 866-403-5272 Fax: 302-636-5454
Contract Administrator Medical:	Regence Blue Shield of Idaho PO Box 2998 Tacoma, WA 98401-2998 866-240-9580 866-218-9163 Consejeros Program (Spanish Customer Service) www.regence.com Appeals may be submitted in writing to: Regence Blue Shield of Idaho PO Box 2998 Tacoma, WA 98401-2998 Or by fax: 877-663-7526 Verbal requests can be made by calling 866-240-9580
Medical Pre-authorization:	See section 12 for details on pre-authorization for medical and dialysis. Contact Regence Blue Shield of Idaho for a list of medical services and supplies requiring Pre-authorization at 1-866-240-9580 or at https://www.regence.com/web/regence_provider/pre-authorization
Contract Administrator Dental:	Delta Dental of Idaho PO Box 2870 Boise, ID 83702 800-356-7586 www.deltadentalid.com
Contract Administrator Prescription: (Retail)	MedImpact Healthcare Systems Inc. PO Box 509098 San Diego, CA 92150-9098 800-910-4706 https://mp.medimpact.com

Contract Administrator Prescription: (Mail Order & Specialty)	MedImpact Direct PO Box 51580 Phoenix, AZ 85076-1580 855-873-8739 www.medimpactdirect.com
Contract Administrator Prescription: (Mail Order 90 Day Brand Name Only)	CRX PO Box 44650 Detroit, MI 48244-0650 866-488-7874 www.WinCoBenefitsCRX.com
Contract Administrator Vision:	Vision Service Plan (VSP) One Union Square Building, 600 University Street, Suite 2004 Seattle, WA 98101 800-877-7195 www.vsp.com
Contract Administrator Flexible Spending:	ConnectYourCare Claims Department PO Box 622317 Orlando, FL 32862-2317 877-292-4040 www.connectyourcare.com
Contract Administrator COBRA:	ConnectYourCare PO Box 2639 Omaha, NE 68103 855-687-2021 www.connectyourcare.com
Contract Administrator Short-Term Disability:	OneAmerica/American United Life Insurance Company 8101 E Prentice Ave, Suite 625 Greenwood Village, CO 80111 1-855-517-6365 www.oneamerica.com
Contract Administrator Long-Term Disability:	OneAmerica/American United Life Insurance Company 8101 E Prentice Ave, Suite 625 Greenwood Village, CO 80111 1-855-517-6365 www.oneamerica.com
Contract Administrator Group Term Life & AD&D:	OneAmerica/American United Life Insurance Company 8101 E Prentice Ave, Suite 625 Greenwood Village, CO 80111 1-800-553-3522 www.oneamerica.com

Contract Administrator Employee Assistance Program: (EAP)	ComPsych NBC Tower – 13th Floor 455 N Cityfront Plaza Dr Chicago, IL 60611 1-855-387-9727 www.guidanceresources.com
Dialysis Cost Containment Program Administrator: (Repricing, Pre-authorization & Network)	Zelis Healthcare 2 Crossroads Dr Bedminster, NJ 07921 888-311-3505 www.zelis.com Repricing or payment appeals may be submitted in writing to: Zelis Healthcare 2 Crossroads Dr Bedminster, NJ 07921 888-311-3505 Or by fax: 908-658-3511 Dialysis benefit appeals may be submitted in writing to: WinCo Holdings, Inc. Attention: Benefits PO Box 5756 Boise, ID 83705
Telemedicine:	MDLive 888-725-3097 www.mdlive.com/wincobenefits
Travel Insurance:	The Hartford Group Life Claims P.O. Box 14299 Lexington, KY 40512-4299 Fax: 1-866-954-2621 E-Mail: gbclaimcslife@thehartford.com

General Plan Information

This document is a description of the WinCo Holdings, Inc. Employee Benefit Plan (Plan). No oral interpretations can change the Plan. The purpose of the Plan is to provide certain health care and welfare benefits for Eligible Employees of WinCo and their eligible Dependent(s). This document sets forth the provisions that constitute the Plan, including terms and conditions of benefits, and serves as a Plan Document and Summary Plan Description (SPD). Please read it carefully and keep it for future reference.

The Plan Sponsor and Administrator for the Plan is WinCo. The plan in not grandfathered under ACA guidelines. The Administrator's duties are more fully described in this document.

Method of Funding

Except for long-term disability insurance described in Section 19 and group term life and accidental death and dismemberment (AD&D) insurance described in Section 20, Plan benefits are self-funded and are provided directly from the general assets of the Plan Sponsor. The Plan Sponsor is responsible for the financing and administration of the Plan. A third-party or Contract Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Contract Administrator for each benefit offered under the Plan is listed under Plan Information and Contract Administrators.

The long-term disability and group term life and AD&D benefits under the Plan are fully insured. The Insurer for these benefits is responsible for and assumes the financial risk and obligation of payment of benefits under insurance policies issued under the Plan. The Employer's responsibilities are limited to obtaining the policy of insurance and contributing required insurance Premiums for Participants.

The Employer may require that Participants contribute toward the cost of providing Plan benefits, whether self-funded or insured. The amount of such contributions will be determined by the Employer and may be changed by the Employer from time to time. The Employer will deduct such contributions on a regular basis from the wages or salary of Eligible Employees who receive coverage under the Plan.

Plan Benefits

The Plan provides medical, dental, Prescription Drug, vision, short-term disability, and flexible spending benefits to Eligible Employees and their eligible Dependent(s) as applicable. These benefits require the Eligible Employee to enroll in coverage. Long-term disability (full-time salaried exempt Employees only), group term life and AD&D, and employee assistance program (EAP) benefits are available to Eligible Employees and eligible Dependent(s) as applicable without enrollment.

Administration Expenses

In addition to being used for Premiums and/or payment of benefits, contributions may also be used to pay administrative expenses of the Plan in accordance with the terms and conditions of the administrative service agreement signed by the Plan Sponsor and the Contract Administrator. To the extent contributions do not cover administrative expenses of the Plan, the Employer will pay the administrative expenses.

Premium Only Plan

Under Section 125 of the Internal Revenue code, the Plan has been established as a premium only plan (POP) or Cafeteria Plan. This allows Eligible Employees to pay certain qualified expenses, such as Premiums, on a pre-tax basis. This reduces the Employee's taxable income and increases the take-home income. Employees will be automatically enrolled pre-tax unless an after-tax deduction is designated.

Plan and Benefit Year

The Plan Year is the 12-month fiscal period for the Plan beginning January 1 and ending December 31, which is used for the purpose of IRS tax filing. The benefit year begins January 1st and ends December 31st of each year.

Summary of Notice of Privacy Practices

This summary is provided to assist the Participant in understanding the Plan's Privacy Practices with respect to health information protected under HIPAA (the Health Insurance Portability and Accountability Act).

Uses and Disclosures of Health Information. The Plan will use and disclose the Participant's health information in order to assist health care Providers in treating the Participant. The Plan will also use and disclose the Participant's health information in order to make payment for health care services or to allow insurance companies to process insurance claims for services rendered to the Participant. Finally, the Plan may disclose the Participant's health information for certain operational activities such as administration of the company's dental coverage plan and health risk assessment program.

Uses and Disclosures Based on the Participant's Authorization. The Plan will not use or disclose the Participant's health information without the Participant's written authorization except as stated in the Privacy Notice. This is required for all family members or close friends who are involved in the Participant's health care.

Uses and Disclosures Not Requiring the Participant's Authorization. In the following circumstances, the Plan may disclose the Participant's health information without the Participant's written authorization:

- For certain limited research purposes; for purposes of public health and safety;
- To Government agencies for purposes of audits, investigations and other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Plan Participant Rights. A Plan Participant has the following rights:

- To have access to and/or a copy of the Participant's health information;
- To receive an accounting of certain disclosures the Plan has made of the Participant's health information;
- To request restrictions as to how the Participant's health information is used or disclosed;
- To request that the Plan communicate with the Participant in confidence;
- To request that the Plan amend the Participant's health information;
- To receive notice of the Plan's privacy practices.

Questions and Complaints

If the Participant wants more information about the Plan's privacy practices or if the Participant has questions or concerns, contact the Plan using the information below. To request a copy of the privacy notice, please contact the WinCo Benefits Department by phone at 800-341-6543 or by email at benefits@wincofoods.com.

If the Participant believes that the Plan may have violated the Participant's privacy rights, or the Participant disagrees with a decision the Plan made about access to the Participant's protected health information or in response to a request the Participant made, the Participant may submit a complaint using the contact information below. The Participant also may submit a complaint in writing to the U.S. Department of Health and Human Services. The Plan will provide the Participant with the address to file a complaint with the U.S. Department of Health and Human Services upon request.

The Plan supports the Participant's right to protect the privacy of protected health information. The Plan will not retaliate in any way if the Participant chooses to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Name of Contact Person:	**Manager, Employee Benefits**	**Telephone:**	**208-377-0110**
Address:	**650 N. Armstrong Place, Boise, Idaho 83704**	**Fax:**	**208-672-2025**

Section 1 – Introduction

1.1 This Summary Plan Description (SPD)

As a Participant of the Plan, your rights and benefits are determined by the provisions of the Plan. This booklet describes those rights and benefits. **PLEASE READ THIS BOOKLET CAREFULLY**. It outlines what must done to be covered. It explains how to file claims. It is the Participant's explanation booklet of coverage under the Plan.

In addition to the limitations with respect to benefits mentioned elsewhere in the Plan, nothing contained herein shall be construed as a guarantee of payment.

PLEASE NOTE:

Failure to follow the eligibility or enrollment requirements may result in delay of coverage or no coverage at all. Reimbursement of medical or other benefits from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, obligation to repay, subrogation, exclusions, timeliness of COBRA elections, Pre-authorization or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage. These provisions are explained in this document.

A Participant should contact the applicable Contract Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of Plan benefits or requirements. Please start with a review of the terms listed in Section 26. Terms which have a special or technical meaning begin with a capital letter and are explained in the Section 26. The Plan provisions described in this document govern the administration and payment of claims.

1.2 Contract Administrators

The Plan Sponsor has contracted with third-party Contract Administrators (see page 3 for a complete list of Contract Administrators) to provide claims administration and other specified services under the Plan. The Contract Administrators may be affiliated with a Provider network as deemed necessary to provide access to adequate Providers, but is a separate company. The Contract Administrators' agreements with the Plan does not involve those companies used to provide access to Providers, or their officers or Employees.

1.3 Managed Care

The Plan provides medical benefits through managed healthcare. Such management necessarily limits some choices of Providers and Facilities. The management features and procedures are described by this SPD. The Plan's medical benefits are intended to meet basic healthcare needs, but not necessarily to satisfy every healthcare need or every desire a Participant may have for services.

1.4 Agreement

As a condition to enrollment and to receiving benefits, the Participant and every Dependent enrolled through the Participant's coverage agree to the medical managed care features that are a part of the Plan and to all of the other terms and conditions of the Plan that apply to benefits the Participant elects or receives under the Plan.

1.5 Right to Terminate or Change the Plan

The Participant is only entitled to receive benefits while the Plan is in effect and the Participant and the Participant's Dependent(s), if applicable, are properly enrolled. The Participant does not have any permanent or vested interest in any benefits under the Plan. Benefits may change at any time as the Plan is renewed or modified from year to year. Unless otherwise expressly stated in this SPD, all benefits end when the Plan ends.

1.6 Administration

The Contract Administrators establishes reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of benefits. The Participants are subject to these administrative practices when receiving benefits, but they do not change the express provisions of the Plan.

1.7 Notices

Any notice required of the Plan will be sufficient if mailed to the address of the Participant and/or Dependent(s) appearing on the records of the Administrator as applicable. It is the Participant's responsibility to notify the Administrator of address changes or changes in other contact information. Notices by Participants will be

sufficient if mailed to the Administrator unless the Plan contains different mailing instructions. All required notices must be sent by at least first class mail.

1.8 Nondiscrimination

The Plan will not discriminate against any Participant based on race, sex, religion, national origin, or any other basis forbidden by law. The Plan will not terminate or refuse to enroll any Participant because of the health status or the healthcare needs of the Participant or because the Participant exercised any right under the Plan's complaint resolution system.

1.9 Timely Filing

The Plan has a timely filing requirement of one year. A Participant (or a health care provider on the Participant's behalf) must submit a claim with the applicable Contract Administrator in order to receive benefits for Covered Services. A claim not filed in a timely manner will be denied unless it can be demonstrated it could not have been filed timely. The denial may be appealed in accordance with the appeal process.

1.10 Questions

If there are questions about benefits, call the applicable Contract Administrator's customer service number provided on the ID card or listed in the Plan Information and Contract Administrators Section. The Contract Administrators offer foreign language assistance.

1.11 Disclaimer

The Contract Administrators' employees often respond to inquiries regarding coverage as part of their job responsibilities. These employees do not have the authority to extend or modify the benefits provided by the Plan.

A. In the event of a discrepancy between information given by a Contract Administrators' employee and the written terms of the Plan, the terms of the Plan will control.
B. Any changes or modifications to benefits must be provided in writing.
C. Administrative errors will not invalidate benefits otherwise in force or give rise to rights or benefits not otherwise provided by the Plan.

Section 2 – Administrator

2.1 Authority of the Administrator

The Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including determinations regarding eligibility for benefits, construction of the terms of the Plan, and resolution of possible ambiguities, inconsistencies, or omissions. All determinations of the Administrator with respect to any matter on which it has the power, duty, and/or authority to act shall be made by it in its sole discretion and shall be conclusive and binding on all persons.

In addition, the Administrator may:

A. Prescribe such forms, procedures, and policies as may be necessary for efficient Plan administration.

B. Designate other persons to carry out any of its duties or powers and employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan.

2.2 Delegation of Claims Review Fiduciary Authority

The Plan Sponsor has delegated to the designated Contract Administrator its discretionary authority with respect to making and reviewing benefit claims determinations. As a claims review Fiduciary, the Contract Administrator has sole discretionary authority to determine the availability of benefits and to interpret, construe, and administer the applicable terms of the Plan. Its determinations shall be conclusive and binding subject to the Appeals process set forth in Section 23.

Section 3 – Eligibility

3.1 Eligibility

3.1.1 Salary Exempt

A full-time salaried exempt Employee's coverage begins the 1st day of the month following his/her hire date for medical, dental, vision, prescription, short-term disability, and long-term disability benefits. Eligibility begins date of hire for group term life and AD&D insurance and the employee assistance program (EAP).

3.1.2 Hourly/Non-exempt

An hourly Employee becomes eligible to participate in the Plan after having been employed as an hourly Employee for **three full consecutive calendar months in which the Eligible Employee worked a minimum of 100 hours in each calendar month.** Hourly Employee's coverage begins the 1st day of the month following the month in which they have met all eligibility requirements for medical, dental, vision, prescription, and short-term disability benefits. Eligibility begins date of hire for group term life and AD&D insurance and the employee assistance program (EAP).

3.1.3 Contract/Temporary

Contract/temporary Employees are not eligible for any of the benefits listed in this document.

3.1.4 Look-back Period

The Plan uses a standard measurement period to determine the protection of healthcare coverage for an existing benefit Eligible Employee.

The measurement period will include a three month look-back period and a six month stability period. The Plan will review the prior three months (look-back period), and if the Employee has a minimum of 300 hours, the Employee will remain eligible for coverage for the next six calendar months regardless of hours worked in those months (stability period). The measurement of the look-back period will take place monthly. If an Employee is not eligible for coverage at the end of one look-back period, eligibility will be re-examined at the end of the next month.

3.2 Dependent Eligibility

To qualify as an eligible Dependent under the Plan, a person must be and remain one of the following:

3.2.1 Dependent

A properly enrolled person who is a Participant's lawful spouse or a child that is a legal resident of the United States. Dependent includes:

A. Children - The children (by birth or adoption, and children placed for adoption or under legal guardianship through testamentary appointment or court order, but not under temporary guardianship or guardianship for school residency purposes) of the Employee or the Employee's lawful spouse, who are younger than age 26.

B. Disabled Children - Dependent children who meet all of the Eligibility requirements may enroll or remain enrolled as Dependent(s) after reaching age 26 as long as they:

1. Are unable to engage in substantial gainful employment to the degree they can achieve economic independence due to medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than 12 months or result in death;
2. Are chiefly dependent upon the Employee or the Employee's lawful spouse for support and maintenance since they reached age 26; and
3. Employee provides proof of dependent's incapacity and dependency within 31 days of the last day of the month in which the child reaches age 26 to the Contract Administrator.

C. Incarcerated Dependents - Despite otherwise qualifying as described above, a person incarcerated in a prison, jail, or other correctional facility is not a Dependent.

D. Court-Ordered Dependent Coverage - When the Employee is required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in the Employee's family coverage only to the minimum extent required by applicable law.

E. Qualified Medical Child Support Order (QMCSO) - A QMCSO can be issued by a court of law or by a state or local child welfare agency. In order for the medical child support order to be qualified, the order must specify the following:
   1. The Employee’s name and last known mailing address (if any) and the name and mailing address of each alternate recipient covered by the order;
   2. A reasonable description of the type of coverage to be provided, or the manner in which the coverage will be determined; and
   3. The period to which the order applies.

F. National Medical Support Notice (NMSN) - An NMSN is a QMCSO issued by a state or local child welfare agency to withhold from the Employee’s income any contributions required by the Plan to provide health insurance coverage for an Eligible child.

G. Duration of Coverage **-** Court-ordered coverage for a Dependent child will be provided to the age of 26.

Section 4 – Enrollment

4.1 Initial Enrollment Provisions

Employees must enroll in medical, dental, vision, prescription, and short-term disability coverage within 31 days of their eligibility date. When the hourly Employee's enrollment and eligibility requirements are met, the coverage begins on the first day of the month following three (3) full, consecutive, calendar months in which he/she has worked at least 100 hours in each qualifying month. When the salaried Employee's enrollment and eligibility requirements are met, the coverage begins the first day of the month following the hire date. If an Employee does not enroll during this initial enrollment period, the Employee is considered late and will not be allowed to enroll in the Plan until the next Open Enrollment period, unless the Employee experiences a Life Event.

If the Employee wants medical, dental, vision and/or Prescription Drug coverage for current Dependent(s), Dependent(s), if eligible, must be enrolled at the same time (or at the time of a later Life Event, or during a later Open Enrollment period) and documentation of the relationship must be provided. Coverage for Dependent(s) enrolled at the same time as the Employee begins the date the Employee's coverage begins.

Long-term disability and group term life and AD&D benefit are company-provided benefits. Enrollment is automatic once an Employee meets the eligibility conditions.

4.2 Life Events

If an Employee is enrolled in the Plan and experiences a Life Event, the Employee has 31 days to add or remove Dependent(s) according to the Life Event. If the Employee gains a Dependent through a legally valid marriage, birth, adoption, placement for adoption, or under legal guardianship with the Employee or the Employee's lawful spouse, then the Employee may enroll the Dependent (and the Employee, if applicable) in the Plan. In the case of birth, adoption or placement for adoption of a child, the Employee may also enroll the Employee's eligible spouse, even if he or she is not newly eligible as a Dependent. However, this Special Enrollment Right is only available by enrolling within 31 days of the marriage, birth, adoption, or placement for adoption. An Employee cannot remove coverage for themselves or Dependent(s) outside an Open Enrollment period unless a Life Event occurs. An Employee has 60 days to add or remove coverage when related to Medicare, CHIP, and Medicaid only.

The following are examples of Life Events:

- Birth, adoption, gain legal guardianship
- Marriage
- New Hire
- Newly Eligible
- Gain or loss of other qualified group coverage
- Death of a Dependent
- Divorce, legal separation or annulment
- Dependent ceases to satisfy the eligibility requirement
- Loss of Coverage from Government plans/programs
- Loss of CHIP or Medicaid eligibility; gaining CHIP or Medicaid subsidy eligibility (60 days)

An Employee must enroll the new Dependent(s) within 31 days of the Life Event (marriage, birth, adoption, etc.). Coverage begins the first day a Dependent is legally acquired if properly enrolled. The covered Employee's biological newborn will be enrolled at birth provided the Employee completes the Plans' application. Failure to submit the application within 31 days will result in denial of claims for the newborn. If an Employee does not enroll eligible Dependent(s) during initial enrollment period or within 31 days of the date they acquire them, the Employee's Dependent(s) are considered late and will not be allowed to enroll into the Plan until the next Open Enrollment period, unless a Life Event occurs. Once a Dependent has been added, he/she may not be removed from the Plan without a Life Event.

If the Employee properly enrolls under this Special Enrollment Right, coverage will be effective:

- As of the date of marriage;
- As of the date of birth;
- As of the date of adoption or when the child is placed in the Employee's home for adoption;
- If the child is more than 31 days old when adopted or placed for adoption, as of the child's date of placement.
- As of the later of:
    - The effective date of the guardianship court order or testamentary appointment; or
    - The date the guardianship court order or testamentary appointment is received by the Plan.

An Employee must cancel coverage for a Dependent who is no longer qualified for coverage (i.e. divorce, etc.) within 31 days or as soon as practically possible. Failure to notify the WinCo Benefits Department of changes in eligibility status may result in the Employee being subject to immediate termination of employment and/or termination of health care coverage on the basis of dishonesty, willful misrepresentation and/or fraud. If claims are submitted for payment on an ineligible Dependent, the Employee is responsible for reimbursing the Plan.

4.3 Dual Coverage

When two Employees are legally married or have a parent/child relationship and are Eligible Employees with the Employer, both may elect single coverage through the Plan, or one may elect to be covered as a Dependent of the other, but may not also elect single coverage. When both are enrolled for coverage as Employees under the Plan, Dependent(s) can be covered under either Employee's coverage, but not both.

If two legally married Employees or Employees who have a parent/child relationship are covered as Employees under the Plan and one of them terminates employment, the terminating Employee and any of his/her covered Dependent(s) will be permitted to immediately enroll under the remaining Employee's coverage, provided written application is made and received within 31 days of loss of coverage. Such coverage shall be deemed a continuation of prior coverage and any previous benefit limitations, maximums, or waiting periods applied prior to the change in enrollment will be applied under the replacement coverage.

4.4 Enrollment

The Employee is responsible for obtaining and submitting to the Employer evidence of eligibility and all other information required by the Plan in the enrollment process on applications specified by the Employer. The Employee enrolls his/herself and any Dependent(s) by completing, signing, and submitting these forms and any other required enrollment materials to the Employer. Employees are also responsible for paying any changes in Premiums due to coverage changes. Failure to meet the 31 day deadline will cause benefits to be denied, and the Employee will have to wait until Open Enrollment, unless a Life Event occurs, to add coverage. Questions on enrollment should be direct to the WinCo Benefits Department at benefits@wincofoods.com or at 1-800-341-6543.

4.5 Open Enrollment Period

Open Enrollment is the one time during the year as designated by the Administrator, when Employees will be allowed to make changes to certain benefits under their Plan without having a qualifying Life Event (marriage, divorce, birth of a child, see Section 4.2). Employees can enroll in medical, dental, vision, prescription, and short-term disability coverage, cancel coverage, or add or drop Dependent(s). Changes made during Open Enrollment go into effect on January 1st of the next Calendar Year or the first of the month eligibility requirements are met. See Section 3.1.

4.6 Qualified Medical Child Support Orders

Notwithstanding any other Plan provision, upon receipt of a Qualified Medical Child Support Order (QMCSO), the Plan will provide benefits in accordance with Section 609 of ERISA. Dependent child(ren) of a covered Employee, named in a Qualified Medical Child Support Order (QMSCO), shall become covered under the Plan on the date the Employee is eligible for coverage or the date QMSCO specifies that coverage shall commence. The Plan Sponsor will establish written procedures for determining (and shall have sole discretion to determine) whether a QMCSO is qualified and for administering the provision of benefits under the Plan pursuant to a QMCSO. The Plan Sponsor may seek clarification and modification of the order, including the right to seek a

hearing before the court or agency which issued the order.

4.7 Uniformed Services Employment and Reemployment Rights Act

Notwithstanding any other Plan provision, the Plan will provide benefits in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

4.8 Family and Medical Leave Act

All Plan provisions are intended to be in compliance with the Family and Medical Leave Act of 1993 as amended (FMLA). To the extent the FMLA applies to the Employer, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted and the Employee continues to pay Premiums. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA.

4.9 Genetic Information Nondiscrimination Act (GINA)

The Plan shall not request, require or purchase genetic information (as that term is defined by GINA) with respect to any person prior to such person's enrollment under the Plan or coverage in connection with such enrollment. No Employee will be discriminated against with respect to the Employee's rights under the Plan on the basis of genetic information relating to the Employee. Further, the Plan Sponsor will not request, require or purchase genetic information with respect to any Employee or a family member of the Employee except as authorized by the Employee in connection with a wellness program in accordance with the requirements of Section 202(b) of GINA and all applicable regulations.

4.10 Children's Health Insurance Program Reauthorization Act (CHIPRA)

Eligible Employees and their otherwise eligible Dependent(s) may enroll for coverage under the Plan upon (1) termination of the individual's coverage under a Medicaid plan or under a state child health plan, or (2) the individual becomes eligible for assistance with respect to coverage under the Plan under a Medicaid plan or a state child health plan, if the Eligible Employee requests coverage under the Plan by completing an application form and submitting it to the Contract Administrator within sixty (60) days of the termination of such coverage or determination of eligibility for assistance, as the case may be. Such enrollment shall be governed by the provisions of CHIPRA and any applicable regulations or other guidance issued pursuant to CHIPRA.

For additional CHIPRA information, contact the State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov.

4.11 Extensions of Benefit Coverage

Coverage continues under the following leave provisions that are in addition to coverage available under optional continuation coverage (Consolidated Omnibus Budget Reconciliation Act (COBRA):

A. Family Medical Leave (FMLA) and state family medical leave laws - If an eligible person qualifies for an approved leave of absence (as defined in the Family Medical Leave Act of 1993 or as defined by an applicable state family medical leave law), eligibility may continue for the duration of the leave if the Employee pays any required contributions toward the cost of the coverage. The Employer has the responsibility to provide the Employee with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 31 days of the due date established by the Employer may result in the termination of coverage. Subject to certain exceptions, if the Employee fails to return to work after the leave of absence, the Employer has the right to recover from the Employee any contributions toward the cost of coverage made on his/her behalf during the leave, as outlined in the FMLA. If contributions are not received by the Employer within the time frame set forth, the Employer will retroactively terminate coverage to the date the contributions were last applied.
B. Military Leave - Employees on active National Guard and reserve training leave that lasts less than 31 days will continue to receive their health care benefits if they are actively enrolled at the time the leave begins. Employees who take more than 30 days leave will be offered continued coverage through COBRA. Employees returning from military service will be reinstated on the health insurance benefit Plan immediately with no waiting period. If an Employee has not had coverage immediately preceding military leave, eligibility for coverage, for the purpose of hours worked, will be based on the most recent three (3) month hour average prior to Employee's military leave, assuming all other eligibility criteria are met.

4.12 Reinstatement of Coverage

If the hour requirements are not met, coverage terminates and coverage will be reinstated in the Plan once the Employee has met the look-back criteria outlined in Section 3.1.4. Coverage will be automatically reinstated based on eligibility criteria once an Employee works three consecutive calendar months with a minimum of 300 hours unless the Employee cancels coverage in writing to the benefits office. Should reinstatement occur during the same Calendar Year as the coverage termination date, the Deductible and Out-of-pocket Maximums will be credited.

Section 5 – Employee Responsibilities

5.1 As a condition to receiving benefits, the Employee is required to do the following:

A. Payment
Pay applicable contributions to the Employer, and with respect to medical benefits, pay the Coinsurance, Copay, and/or Deductible amounts listed in the Schedule of Benefits to Provider(s) and/or Facilities.

B. Changes in Eligibility or Contact Information
Notify the Employer when there is a change in the Employee's situation that may affect eligibility, the eligibility of Dependent(s), or if the Employee's contact information (including address) changes.

C. Other Coverage
Notify the Plan if the Employee or if the Employee's Dependent(s) obtain other healthcare coverage. This information is necessary to accurately process and coordinate claims.

D. Information/Records
Provide the Plan all information necessary to administer the Employee's coverage, including proof of relationship, social security number(s), and if requested, the medical history and records for the Employee and the Employee's Dependent(s).

E. Notification of Participants
Notify the Employee's enrolled Dependent(s) of all benefit and other Plan changes.

F. Pre-authorization
Contact the applicable Contract Administrator for services requiring Pre-authorization.

Section 6 – Termination

6.1 Plan Termination

Coverage under the Plan for Participants will terminate when the Plan terminates. The Plan Sponsor may terminate the Plan at any time, in any manner, regardless of the health status of any Participant.

If a Participant ceases to be an eligible person or the Participant does not remit the required contribution or fees, the Participant's coverage and the coverage of any and all enrolled eligible Dependent(s) will terminate on the last day of the last month for which payment was made.

A. Except as provided in this paragraph, coverage under the Plan will terminate on the date a Participant no longer qualifies as a Participant, or the last day of the month the Participant no longer qualifies, as defined in Sections 3 and 4. Coverage will not terminate because of age for a Participant who is an unmarried Dependent child incapable of self-sustaining employment by reason of mental handicap or physical handicap, who became so incapable prior to reaching the age limit, and who is solely dependent on the Participant for support and maintenance, provided the Participant, within 31 days of when the Dependent child reaches the age limit, has submitted to the Plan at the Participant's expense, a Physician's certification of such Dependent child's incapacity.
B. Termination or modification of the Plan automatically terminates or modifies all of the Participants' coverage and rights hereunder. It is the responsibility of the Employer to notify all of its Participants of the termination or any modification of the Plan, and the Contract Administrators' notice thereof to the Participant, upon mailing or any other delivery, shall constitute complete and conclusive notice to the Participants.
C. Except as otherwise provided in the Plan Document, no benefits are available to a Participant for Covered Services rendered after the date of termination of a Participant's coverage.
D. The Employer may terminate or retroactively rescind a Participant's coverage under the Plan for any willful misrepresentation, omission or concealment of fact by, concerning, or on behalf of any Participant that was or would have been material to the Administrator's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, or for fraud.
E. Prior to legal finalization of an adoption, the coverage provided in the Plan for a child placed for adoption by court order with a Participant shall continue as it would for a naturally born child of the Participant until the first of the following events occurs:
    1. The date the child is removed permanently from placement and the legal obligation terminates,
    2. The date the Participant rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility, or
    3. The date the court terminates the pending adoption.

    If one of the foregoing events occurs, coverage shall terminate on the last day of the calendar month in which such event occurs.
F. Coverage under the Plan will terminate as follows:
    Employee's Coverage ends the earliest of:
    - The end of the month in which the Employee's employment with the Employer ends;
    - The end of the month for which the full amount of any required contribution was not made;
    - The end of the month in which the Employee is no longer eligible to participate in the Plan;
    - The end of the month the Employee fails to meet the look-back period requirements (Section 3.1.4); or
    - The date the Employee becomes an active member of the United States armed forces unless contrary to federal law.

    Coverage for the covered Employee's Dependent(s) ends the earliest of:
    - The date the Employee's coverage ends;
    - The end of the month in which a Dependent no longer meets the eligibility requirements;
    - The end of the month for which the full amount of any required contribution was made; or
    - The date the Dependent becomes an active member of the armed forces of any country.

Section 7 – Continuation Coverage (COBRA)

7.1 COBRA Qualifying Events

As mandated by federal law, the Plan offers optional continuation coverage (also referred to as COBRA coverage) to the Employee and/or the Employee's eligible Dependent(s) for medical, Prescription Drug, dental and vision benefits if such coverage would otherwise end due to one of the following qualifying events:

A. Termination of the Employee's employment for any reason except gross misconduct. Coverage may continue for the Employee and/or the Employee's eligible Dependent(s);
B. A reduction in hours. Coverage may continue for the Employee and/or the Employee's eligible Dependent(s);
C. Death. Coverage may continue for the Employee's eligible Dependent(s);
D. Divorce or legal separation. Coverage may continue for the Employee's eligible Dependent(s);
E. Covered Dependent child's ceasing to be a Dependent child under the Plan. Coverage may continue for that Dependent.

Note: To choose this continuation coverage, an individual must be covered under the applicable benefits program under the Plan on the day before the qualifying event. In addition, the Employee's newborn child or child placed for adoption with the Employee during a period of continuation coverage will remain eligible for continuation coverage for the remaining period of coverage even if the Employee and/or the Employee's spouse terminate continuation coverage following the child's birth or placement for adoption.

7.2 Notification Requirements

The Employee or the applicable Dependent(s) have the responsibility to inform the Administrator, in writing, within 60 days of a divorce or legal separation or of a child losing Dependent status under the Plan. Failure to provide this written notification within 60 days will result in the loss of continuation coverage rights. The Employee or the applicable Dependent(s) also have the responsibility to inform the Administrator in writing of Disability as explained Section 7.4. The Employee or the applicable Dependent(s) also have the responsibility to notify the Administrator in writing if the Employee /Dependent(s) are no longer Disabled.

The Employer has the responsibility to notify the Administrator of the Employee's death, termination of employment, or reduction in hours within 31 days of the qualifying event.

Subject to the Administrator being informed in a timely manner of the qualifying events described in the above paragraphs, the Plan will notify the Contract Administrator. The Contract Administrator will promptly notify the Employee and other qualifying individuals of their continuation coverage rights. The Employee and any applicable Dependent(s) must elect continuation coverage within 60 days after Plan coverage would otherwise end, or, if later, within 60 days of the notice of continuation coverage rights. Failure to elect continuation coverage within this 60-day period will result in loss of continuation coverage rights.

7.3 Notice of Unavailability of Continuation Coverage

If the Contract Administrator receives a notice of a qualifying event from the Employee or the Employee's Dependent(s) and determines that the Employee or the Employee's Dependent(s) is not entitled to continuation coverage, the Administrator will provide to the individual an explanation as to why the person is not entitled to continuation coverage. This notice will be provided within the same time frame that the Contract Administrator would have provided the notice of right to elect continuation coverage.

7.4 Maximum Period of Continuation Coverage

The maximum period of continuation coverage is 36 months from the date of the qualifying event, unless the qualifying event is the Employee's termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event.

However, if a qualifying individual is Disabled (as determined under the Social Security Act) at the time of the Employee's termination or reduction in hours or becomes Disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-Disabled eligible

Dependent(s) who are also entitled to continuation coverage, may be extended to 29 months provided the qualifying individual, if applicable, notifies the Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of Disability.

If a second qualifying event occurs (for example, the Employee's death or divorce) during the 18- or 29-month coverage period resulting from the Employee's termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is the Employee's spouse or Dependent child whose qualifying event was the termination or reduction in hours of the Employee's employment, and the Employee became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is 36 months from the date of the Employee's Medicare entitlement.

7.5 Cost of Continuation Coverage

The cost of continuation coverage is determined by the Employer and paid by the qualifying individual. If the qualifying individual is not Disabled, the applicable contribution cannot exceed 102 percent of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a Disability cannot exceed 150 percent of the Plan's cost of coverage.

Contribution payments for continuation coverage for the Employee's or the Employee's Eligible Dependent(s)' initial contribution month(s) are due by the 45th day after electing continuation coverage. The initial contribution month(s) are any months that end on or before the 45th day after the Employee or the qualifying individual elects continuation coverage. All other contributions are due on the first of the month for which coverage is sought, subject to a 30-day grace period. Contribution rates are established by the Employer and may change when necessary due to Plan modifications. The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

7.6 When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

A. The date the maximum continuation coverage period expires;
B. The date the Employer no longer offers a group health plan to any of its Employees;
C. The first day for which timely payment is not made to the Plan;
D. The date the qualifying individual becomes covered by another group health plan;
E. The date the qualifying individual becomes entitled to coverage under Medicare; and
F. The first day of the month that begins more than 31 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer Disabled.

7.7 Notice of Termination Before Maximum Period of COBRA Coverage Expires

If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Contract Administrator will provide notice to the individual of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the Contract Administrator's determination regarding termination of the continuation coverage.

7.8 Compliance with Applicable Laws

The Plan intends to comply with all applicable laws regarding COBRA continuation coverage. If the information presented in the Plan differs from actual COBRA requirements, the Plan reserves the right to administer COBRA in accordance with such actual COBRA requirements.

7.9 Uniformed Services Employment and Reemployment Rights Act (USERRA)

If the Employee was covered under the Plan immediately prior to taking a leave for service in the uniformed services, the Employee may elect to continue coverage under USERRA for up to 24 months from the date of

leave for uniformed service began, if the Employee pays any required contributions toward the cost of the coverage during the leave.

7.9.1 Early Termination

This USERRA continuation coverage will end earlier if one of the following events takes place:

A. The Employee fails to make a premium payment within the required time;
B. The Employee fails to report to work or to apply for reemployment within the time period required by USERRA following the completion of service; or
C. The Employee loses rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, the Employee's contribution amount will be the same as for active Employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with any continuation coverage.

7.9.2 Reinstatement

If the Employee's coverage under the Plan terminated because of service in the uniformed services, the coverage will be reinstated on the first day the Employee returns to employment if the Employee is released under honorable conditions and returns to employment within the time period(s) required by USERRA.

When coverage under the Plan is reinstated, all of the Plan's provisions will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. This waiver does not provide coverage for any Illness or injury caused or aggravated by the Employee's military service, as determined by the Veterans' Administration. (For complete information regarding rights under USERRA, contact the Employer.)

7.9.3 Compliance with Applicable Laws

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the Plan in accordance with such actual regulations.

7.9.4 Uniformed Services

Members of the uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

In this section, service means the performance of a duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

A. Active duty;
B. Active duty for training;
C. Initial active duty training;
D. Inactive duty training;
E. Full-time National Guard duty;
F. A period for which the Employee is absent from the Employee's job for purpose of an examination to determine fitness to perform any such duties;
G. A period for which the Employee is absent from the Employee's job for the purpose of performing certain funeral honors duty; and
H. Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

Section 8 – Medical - Providers/Networks

8.1 Providers and Facilities

The Contract Administrator contracts with certain Providers and Facilities (known as participating Providers and participating Facilities) to provide Covered Services within the service area. Not all available Providers and Facilities and not all categories of Providers and Facilities are invited to contract with the participating Provider networks. Providers and Facilities must follow federal and state regulations in reference to certification, registration, and licensing.

8.1.1 Participating (In-network) Providers and Facilities

The Participant receives a higher level of benefits when the Participant obtains Covered Services from an In-network Provider or Facility. Refer to the Schedule of Benefits for details.

8.1.2 Nonparticipating (Out-of-network) Providers and Facilities

In most cases, the Participant receives a lower level of benefits when the Participant obtains Covered Services from an Out-of-network nonparticipating Provider or Facility. Refer to the Schedule of Benefits for details.

8.2 Providers and Facilities not Agents/Employees

Providers contract independently with the Contract Administrator or an affiliated network and are not agents or employees of the Contract Administrator or the Plan. They are entitled and required to exercise independent professional medical judgment in providing Covered Services. The Contract Administrator and its affiliated network(s) make a reasonable effort to credential Participating Providers and Facilities, but it does not guarantee the quality of services rendered by Providers and Facilities or the outcomes of medical care or health-related services. Providers and Facilities, not the Contract Administrator or the Plan, are solely responsible for their actions, or failures to act, in providing services to you.

Providers and Facilities are not authorized to speak on behalf of the Contract Administrator or the Plan or to cause the Contract Administrator or the Plan to be legally bound by what they say. A recommendation, order, or referral from a Provider or Facility, including In-network Providers and Facilities, does not guarantee coverage by the Plan.

Providers and Facilities do not have authority, either intentionally or unintentionally, to modify the terms and conditions of the Plan. Benefits are determined by the provisions of the Plan.

8.3 Payment

The Plan may pay Providers in one or more ways, such as discounted fee-for-service, capitation (fixed payment per member per month), and payment of a year-end withhold.

8.3.1 Incentives

Some payment methods may encourage Providers to reduce unnecessary healthcare costs and efficiently utilize healthcare resources. No payment method is ever intended to encourage a Provider to limit Medically Necessary care.

8.3.2 Payments to Participants

The Plan reserves the right to make payments directly to the Participant instead of to nonparticipating Providers and/or Facilities.

8.4 Provider/Participant Relationship

Providers and Facilities are responsible for establishing and maintaining appropriate Provider/Participant relationships with the Participant, and neither the Contract Administrator nor the Plan interferes with those relationships. The Contract Administrator is only involved in decisions about what Services will be covered and paid for by the Plan. Decisions about the services the Participant receives should be made between the Participant or the Participant's Provider without reference to coverage under the Plan.

8.5 Additional Fees

When the Participant obtains health care services through a program offered by the Contract Administrator outside the geographic area, the amount the Participant pays for Covered Services is usually calculated on the lower of:

- The actual billed charges for Covered Services, or
- The negotiated price that the local Provider passes onto the Plan.

Often, this "negotiated price" will consist of a simple discount. But sometimes it is an estimated final price that factors in expected settlements, or other non-claims transactions, with the Participant's health care Provider or with a specified group of Providers. The negotiated price may also be a discount from billed charges that reflects average expected savings. The estimated or average price may be adjusted in the future to correct for over or underestimation of past prices.

In addition, laws in a small number of states require Plans to use a basis for calculating the Participants payment for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. When the Participant receives covered health care services in those states, the required payment for these services will be calculated using their statutory methods.

Contracting Providers can be verified by contacting the Contract Administrator.

Section 9 – Medical

9.1 This medical benefits section describes the benefits a Participant is entitled to receive, subject to all of the other provisions of the Plan Document. Participants see the best discounts by going to an In-network Provider. Contact the Contract Administrator - Medical to get a list of In-network Providers and with any questions.

Medical Benefits & Coverages		Participating In-network Providers	Non-Participating Out-of-network Providers
Calendar Year Deductible - Individual/Family		$100/$300	$200/$600
Medical Out-of-pocket Maximum - Coinsurance and Deductibles apply Individual (medical only) Family (medical only)*		 $1,100 $3,300*	 $2,200 No maximum
COVERED SERVICES ***By choosing an Out-of-network Provider, the Participant may be responsible for the difference between the Allowed Amount and what the Out-of-network Provider charges. Some services may require Pre-authorization.***	**In-network Deductible and/or Coinsurance payment required before insurance pays?**	**In-network**	**Out-of-network**
Ambulance Transportation Services (Ambulance non-transportation services not covered)	Yes	20% Coinsurance	20% Coinsurance
Ambulatory Surgical Center	Yes	10% Coinsurance	30% Coinsurance
Breastfeeding Support and Supply	No	0%	30% Coinsurance
Chiropractic Care (Limited to 20 spinal manipulations per Participant, per Calendar Year)	Yes	20% Coinsurance	30% Coinsurance
Diabetes Self-Management Education Services	Yes	20% Coinsurance	30% Coinsurance
Diagnostic Services such as Laboratory/X-rays/ Pathology, etc.	Yes	20% Coinsurance	30% Coinsurance
Dialysis (provider to contact Dialysis Cost Containment Program Administrator)	Yes	Plan pays 100% of negotiated rate	If no negotiated rate is applicable, Plan pays 100% of the UCR for reasonable claims
Durable Medical Equipment (DME)	Yes	20% Coinsurance	30% Coinsurance
Emergency Room	Yes	20% Coinsurance	20% Coinsurance
Genetic Testing	Yes	20% Coinsurance	30% Coinsurance
Home Health (Limited to 60 visits per Participant, per Calendar Year)	Yes	20% Coinsurance	30% Coinsurance
Hospice Services	Yes	20% Coinsurance	30% Coinsurance
Hospital Physician Services (Inpatient and Outpatient services such as Surgery, anesthesia, office visits, etc.)	Yes	20% Coinsurance	30% Coinsurance
Immunizations Childhood **Immunizations Adult**	No No	0% 0%	0% 30% Coinsurance
Independent Laboratory Facility	Yes	20% Coinsurance	30% Coinsurance
Infusion Therapy	Yes	20% Coinsurance	30% Coinsurance

COVERED SERVICES ***By choosing an Out-of-network Provider, the Participant may be responsible for the difference between the Allowed Amount and what the Out-of-network Provider charges. Some services may require Pre-authorization.***	**In-network Deductible and/or Coinsurance payment required before insurance pays?**	**In-network**	**Out-of-network**
Maternity Services	Yes	20% Coinsurance	30% Coinsurance
Medical Foods for Inborn Error of Metabolism (Non-infused)	Yes	20% Coinsurance	30% Coinsurance
Mental Health & Substance Abuse Services (Inpatient and Outpatient services; Facility and professional services)	Yes	20% Coinsurance	30% Coinsurance
Mental Health Physician Services – Outpatient (Facility, psychotherapy and other professional services)	Yes	20% Coinsurance	30% Coinsurance
Neurodevelopmental Therapy – Inpatient	Yes	20% Coinsurance	30% Coinsurance
Neurodevelopmental Therapy – Outpatient (Limited to 52 visits per Participant per Calendar Year)	Yes	20% Coinsurance	30% Coinsurance
Orthotic Devices	Yes	20% Coinsurance	30% Coinsurance
Outpatient Cardiac Rehabilitation Services	Yes	20% Coinsurance	30% Coinsurance
Physician Office Visit/General Medicine/Urgent Care	Yes	20% Coinsurance	30% Coinsurance
Prosthetics Appliances	Yes	20% Coinsurance	30% Coinsurance
Preventive Care Benefits – Covered Services	No	0%	30% Coinsurance
Rehabilitation – Inpatient (Physical Therapy/Occupational Therapy/Speech Therapy) (Limited to 22 days per Participant, per Calendar Year**)**	Yes	20% Coinsurance	30% Coinsurance
Rehabilitation – Outpatient (Physical Therapy/Occupational Therapy/Speech Therapy) (Limited to 50 visits per Participant per type of therapy, per Calendar Year)	Yes	20% Coinsurance	30% Coinsurance
Skilled Nursing Facility (Limited to 30 days per Participant, per Calendar Year)	Yes	20% Coinsurance	30% Coinsurance
Specialist Office Visit	Yes	20% Coinsurance	30% Coinsurance
Telehealth	Yes	20% Coinsurance	25% Coinsurance
Telehealth – MDLIVE (includes behavioral health)	No	0%	N/A
Therapeutic Injections	Yes	20% Coinsurance	30% Coinsurance
Transplant Services (Human organ/bone marrow)	Yes	20% Coinsurance	30% Coinsurance

* If any Participant reaches the individual out of pocket maximum then the out of pocket maximum is satisfied for that Participant. If any combination of family members reach the family out of pocket maximum, then the out of pocket maximum is satisfied for the entire family.

Inpatient Hospital Services – The Participant will be responsible for payment of the annual Deductible and the Participant's designated percentage of the balance. If the Participant chooses an Out-of-network Provider the Participant will experience higher Out-of-pocket costs, and the Participant may be billed for balances or amounts over the Maximum Allowance.

This summary describes the general features of this program; it is not a contract. All provisions of the Plan Document apply to this program. Additional services are covered that are not listed here. Pre-authorization may apply to services, even if not listed above.

Section 10 – Medical - Summary

10.1 General

The Employee and/or the Employee's Dependent(s) are entitled to receive medical benefits while enrolled in the Plan. This section describes those benefits in greater detail.

10.2 Identification (ID) Cards

The Employee will be given ID cards that will provide certain information about the Plan in which the Employee is enrolled. Providers and Facilities may require the presentation of the ID card plus one other reliable form of identification as a condition to providing Services. The ID card does not guarantee benefits.

If the Employee or the Employee's enrolled Dependent(s) permit the use of the Employee's ID card by any other person, the card will be confiscated and all rights under the Plan will be immediately terminated for the Employee and/or the Employee's Dependent(s).

10.3 Medical Necessity

To qualify for benefits, Covered Services must be Medically Necessary. Services determined by the Plan to be not Medically Necessary are not covered. The fact that a doctor may prescribe, order, recommend, or approve a service, procedure or supply does not, in and of itself, make it a Covered Service or Medically Necessary, even though it is not specifically listed as an exclusion. Only the Participant's medical condition is considered when deciding which setting (i.e., Inpatient or Outpatient) is Medically Necessary. A recommendation, order or referral from a Provider or Facility, including In-network Providers and Facilities, does not guarantee Medical Necessity.

10.4 Benefit Changes

The Participant's benefits may change if the Plan changes.

10.5 Calendar-Year or Plan-Year Basis

The Participant's benefits are calculated on a Calendar Year basis from January 1st through December 31st. Out-of-pocket Maximums, limitations, and Deductibles start over each January 1st.

10.6 Two Benefit Levels

10.6.1 Participating In-network Benefits

The Participant receives a higher level of benefits when the Participant obtains Covered Services from an In-network Provider or Facility. In-network Providers and Facilities have agreed to accept the Allowed Amount and will not bill the Participant for Excess Charges.

10.6.2 Nonparticipating Out-of-network Benefits

In most cases, the Participant receives a lower level of benefits when the Participant obtains Covered Services from an Out-of-network Provider or Facility. Out-of-network Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, the Participant is responsible to pay for any charges that exceed the amount that the Plan pays for Covered Services. These fees are called Excess Charges, and they do not apply to the Out-of-pocket Maximum.

10.7 Emergency Conditions

In-network Benefits apply to emergency room Services regardless of whether they are received at an In-network Facility or Out-of-network Facility. If the Participant is hospitalized for an emergency in a nonparticipating Facility, once the Emergency Condition has been stabilized, the Participant may be asked to transfer to a participating Facility in order to continue receiving participating benefits.

10.8 Preferred Provider Over 50 Miles

If the Participant does not have access to a Preferred Provider who is able to provide Medically Necessary services within 50 miles of the Participant's residence, the Participant may request a network waiver. Requests for a network waiver will only be reviewed retrospectively (after a claim has processed and the Participant has received an Explanation of Benefits) or if the services require Pre-authorization and the request for network coverage is specifically included with the Pre-authorization request for the service.

The Participant may request a network waiver to pay at the In-network benefit level by submitting the following documentation:

- A letter of explanation from the Participant or the Participant's Provider stating why the Participant saw or needs to see the Out-of-network Provider.
- Details of the research conducted by the Participant or the Participant's Provider to locate a Preferred Provider (in effect, names and phone numbers of Preferred Providers that have been researched and may have been contacted).

If the waiver is related to services for which Pre-authorization is being requested, or for which care is ongoing, the following additional information should be included:

- Performing Provider's name, address, phone number, and National Provider Identifier (NPI) or Tax ID number (TIN).
- Diagnosis code(s).
- Procedure code(s).
- Length of treatment requested or required for services.
- Estimated charges.

The Participant's network waiver request should be sent to Appeals for the Contract Administrator – Medical. The fax and mailing information is found on the Plan Information and Contract Administrators page.If a network waiver is approved, the Participant will still be responsible for the In-network Deductible, Coinsurance and any amounts above the Allowed Amount up to the total charges submitted by the Provider. Network waivers are not approved indefinitely and may be reviewed periodically if services are ongoing.

10.9 Itemized Bill/Other Information

In order to determine if claims are payable by the Plan, the Contract Administrator, third-party audit company or Administrator may request an itemized/detailed bill in order to correctly determine the Plan's payment.

10.10 Claims Audit

In addition to the Plan's healthcare management process, the Contract Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Contract Administrator has the sole discretionary authority for selection of claims subject to a bill review or audit.

The analysis will be to identify charges billed in error and/or charges that are not Usual, Customary, and Reasonable (UCR), and/or Medically Necessary, if any, and may include the Participant's medical billing records review and/or audit of the Participant's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Contract Administrator or its agents to identify the charges deemed in excess of the UCR amounts or other applicable provisions, as outlined in the Plan Document. Despite the existence of any agreement to the contrary, the Contract Administrator has the discretionary authority to reduce any charge to an UCR charge, in accord with the terms of the Plan.

10.11 Two Ways to File a Claim

A Participant (or a health care provider on the Participant's behalf) must submit a claim in order to receive benefits for Covered Services. Except for coordination of benefit claims, all claims for Covered Services must be submitted within one (1) year from the date of service or discharge, as applicable, except as otherwise required by law. A claim not filed in a timely manner will be denied unless it can be demonstrated it could not have been filed timely. The denial may be appealed in accordance with the appeal process. Processing begins as claims are received, not based on order of date of service. Claims can be submitted two ways:

10.11.1 Health Care Provider Files Claim

The health care Provider (doctor, specialist, Hospital or other Facility) can file the claim on behalf of the Participant.

10.11.2 Participant Files Claim

If the Provider is out of network or the Participant prefers that the Participant file his/her own claim, the Participant should file the claim with the Contract Administrator using the online claims submission process or submitting the claim through the mail. Contract the Contract Administrator for details.

Section 11 – Medical - Benefits

11.1 General

This section specifies the benefits a Participant is entitled to receive for Covered Services described in this section, subject to all of the other provisions of the Plan Document.

11.2 Benefit Period

The Benefit Period consists of each Calendar Year.

11.3 Deductible

A. Individual - A Participant's individual Deductible consists of the first $100 in eligible benefits for major medical Covered Services per Calendar Year.
B. Family - The aggregate of the first $300 in eligible benefits for major medical Covered Services per Calendar Year for all Participants enrolled under the same family coverage shall be the Deductible. However, no Participant may be required to pay more than the Individual Deductible amount.
C. Preventive Care - The Deductible does not apply to Covered Services for listed routine immunizations or preventive care as defined by the Affordable Care Act.

11.4 Essential Health Benefits

The Plan covers all Essential Health Benefits as outlined by the federal government under the Affordable Care Act.

11.5 Medical Out-of-pocket Maximum

The Medical Out-of-pocket Maximum shall be based upon a Participant's eligible Out-of-pocket expenses incurred during one Calendar Year. Eligible Out-of-pocket expenses shall include only the Participant's Coinsurance and Deductible for eligible Covered Services. Out-of-pocket expenses associated with the following are not eligible for inclusion in the Out-of-pocket Maximum:

A. Amounts that exceed the Maximum Allowance;
B. Prescription Drugs;
C. Any medical services not covered under the Plan; or
D. Non-Covered Services or supplies.

11.5.1 In-network Services

The medical Out-of-pocket Maximum is $1,100 per Participant and the prescription Out-of-pocket Maximum is $7,050 per Participant, per Calendar Year. The medical family Out-of-Pocket maximum is $3,300 per Calendar Year and the prescription family Out-of-Pocket Maximum is $13,000 per Calendar Year. If any Participant reaches the individual Out-of-Pocket Maximum then the Out-of-Pocket Maximum is satisfied for that Participant. If any combination of family members reach the family out of pocket maximum, then the out of pocket maximum is satisfied for the entire family.

When a Participant and/or family has met the medical Out-of-pocket Maximum, the benefits payable on behalf of the Participant for In-network Covered Services shall increase to 100% of the Maximum Allowance during the remainder of the Calendar Year. When a Participant and/or family has met the prescription Out-of-pocket Maximum, the benefits payable on behalf of the Participant for Covered Services shall increase to 100% of the Maximum Allowance during the remainder of the Calendar Year.

11.5.2 Out-of-network Services-

The medical Out-of-pocket Maximum shall be $2,200 per Participant, per Calendar Year. There is no family maximum. When a Participant has met the medical Out-of-pocket Maximum, the benefits payable on behalf of the Participant for Out-of-network Covered Services shall increase to 100% of the Maximum Allowance during the remainder of the Calendar Year. Prescription Drugs will not have an Out-of-pocket maximum.

11.6 Covered Providers

Providers mean the health care Facilities and professionals who provide health care to the Participant and their Dependent(s). The Contract Administrator has established a unique system of agreements with many types of Providers for its Preferred Provider Organization (PPO). These Providers are called In-network Providers. In-network Providers agree to recognize the Maximum Allowance as their full fee for Covered Services provided to

the Participants of the Plan. Services provided by non-contracting Providers are Out-of-network Providers.

The final choice of what Providers to see is up to the Participant. However, if the Participant receives services from a Contracting Provider included in the PPO, the Plan's Coinsurance may be increased, which may decrease the amount that the Participant must pay.

11.7 Telemedicine

For non-emergency medical conditions, such as allergies, cold and flu, pink eye, ear infections, and sinus infections, telemedicine offers the option for the Participant to talk to a Physician over the phone or via web conference around the clock via phone 24 hours a day, 7 days a week.

11.8 Emergency Services

For the treatment of Emergency Conditions or Accidental Injuries of sufficient severity to require ambulance transportation service to the nearest appropriate Licensed General Hospital, In-network benefits for Covered Services shall be provided by either a contracting or non-contracting Provider and Facility-based Providers only. If the nearest Licensed General Hospital is non-contracting, and the Participant has been admitted through the ER, the Plan will pay at the In-network Coinsurance level of billed charges for the Inpatient Facility services.

11.9 Major Medical Expenses

11.9.1 Hospital Services

A. Inpatient Hospital Services
    1. Bed, board and general nursing service - Bed, board, special diets, the services of a dietician and general nursing service when a Participant is an Inpatient in a Licensed General Hospital shall be covered as follows:
        a. A room with two or more beds, unless the Hospital has only single bed rooms. If a private room is used, the benefit provided in this section for a room with two or more beds will be applied toward the charge for the private room; any difference is a Non-covered Expense under the Plan and is solely the responsibility of the Participant.
        b. Benefits for a bed in a special care unit shall be in lieu of the benefits for the daily room charge stated in the previous paragraph.
        c. A bed in a nursery unit and well-baby nursery expenses, during the initial Hospital confinement of a newborn. Charges for the newborn will be considered separately from the mother's expenses. Refer to medical services for Physician charges.
        d. Hospital confinement expenses for dental services if Hospitalization is necessary to safeguard the health of the Participant.

B. Ancillary Services

    Licensed General Hospital services and supplies including:
    1. Use of operating, delivery, cast and treatment rooms and equipment;
    2. Prescribed drugs administered while the Participant is Inpatient;
    3. Blood clotting factors is covered for hemophilia Participants who meet medical necessity criteria. Blood clotting factors are not covered for prophylactic (Disease prevention) or health or fitness reasons;
    4. The blood draw, preparation and storage of a Participant's own blood for future surgical use is covered for up to, but no longer than 90 days. Administration (including required equipment) and processing of whole blood and blood products when the whole blood or blood products are actually used in a transfusion of a Participant; whole blood or blood plasma that is not donated on behalf of the Participant or replaced through contributions on behalf of the Participant;
    5. Anesthesia, anesthesia supplies and services rendered by the Licensed General Hospitals a regular Hospital service and billed by the Licensed General Hospital in conjunction with a procedure that is a Covered Service;
    6. All medical and surgical dressings, supplies, casts and splints that have been ordered by Physician and furnished by a Licensed General Hospital; specially constructed braces and supports are not a Covered Service under this section;
    7. Oxygen and administration of oxygen; and
    8. Diagnostic Services and Therapy Services - if Diagnostic Services or Therapy Services furnished through a Licensed General Hospital are provided in part or in full by a Physician under contract with the Licensed

General Hospital to perform such services, and the Physician bills separately, the Physician's services shall be a Covered Service.

C. Outpatient Hospital Services
   1. Emergency Care - Licensed General Hospital services and supplies for the treatment of Accidental Injuries, Diseases or Illnesses that can be classified as a medical emergency.
   2. Surgery - Licensed General Hospital or Licensed Ambulatory Surgical Facility services and supplies including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the Licensed General Hospital or Licensed Ambulatory Surgical Facility who is not the surgeon or surgical assistant, in conjunction with a procedure that is a Covered Service.
   3. Therapy Services (see Definitions for list of services).

D. Special Services
   1. Preadmission testing - tests and studies required in connection with the Participant's admission and rendered or accepted by a Licensed General Hospital on an Outpatient basis prior to a scheduled admission to the Licensed General Hospital as an Inpatient. Preadmission testing does not include tests or studies performed to establish a diagnosis.
   2. Hospital benefits may be provided for dental extractions, or other dental procedures if certified by a Physician that a non-dental medical condition requires Hospitalization to safeguard the health of the Participant. Non-dental conditions that may receive Hospital benefits are:
      a. Brittle diabetes;
      b. History of a life-endangering heart condition;
      c. History of uncontrollable bleeding;
      d. Severe bronchial asthma;
      e. Children under six (6) years of age who require general anesthetic; or
      f. Other non-dental life-endangering conditions that require Hospitalization, subject to approval by the Contract Administrator.

11.9.2 Skilled Nursing Facility

Benefits provided under this section to an Inpatient of a Licensed General Hospital are also provided for services and supplies customarily provided to an Inpatient of a skilled nursing Facility. However, benefits will not be provided under this section when the care received consists primarily of:

A. Room and board, routine nursing care, training, supervisory or Custodial Care;
B. Care for senile deterioration, mental deficiency or mental handicap; or
C. Physiotherapy, hydrotherapy, Speech Therapy or Occupational Therapy, when skilled nursing care is not required.

11.9.3 Ambulance Transportation Service

Ambulance transportation by a licensed service Provider for Medically Necessary transportation of a Participant within the local community. Ambulance air transportation only when ground ambulance is either not available or, in the opinion of responding medical professionals, would cause an unreasonable risk of harm because of increased travel time. Ground ambulance only covered:

A. From a Participant’s home or scene of Accidental Injury or Emergency Condition to a Licensed General Hospital;
B. Between Licensed General Hospitals;
C. Between a Licensed General Hospital and skilled nursing Facility;
D. From a Licensed General Hospital to the Participant’s home; or
E. From a Skilled Nursing Facility to the Participant’s home.

For purposes of 11.9.3 A, B, and C above, if there is no Facility in the local community that can provide Covered Services appropriate to the Participant's condition, then ambulance transportation service means transportation to the closest Facility outside the local community that can provide the necessary service.

The Plan covers ambulance services to the nearest Hospital equipped to provide treatment, when any other form of transportation would endanger Participants health and the purpose of the transportation

is not for personal or convenience purposes. Covered ambulance services include licensed ground and air ambulance Providers. Claimants will not be balanced billed for transportation service ground or air.

No benefits will be provided for ambulance non-transportation services.

For purposes of this section, ambulance means a specially designed and equipped vehicle used only for transporting the sick and injured and only for Emergency Conditions and not when the Participant could safely be transported by other means.

11.9.4 Alcohol and/or Substance Use Treatment Services

A. Inpatient Alcohol and/or Substance Use Care
The benefits provided for Inpatient licensed general Hospital services and Inpatient medical services in this section are provided for Alcoholism and/or substance use.

B. Outpatient Alcohol and/or Substance Use Care
The benefits provide for outpatient services, provided by a licensed behavioral health provider for a covered diagnosis for Alcoholism and/or substance use.

11.9.5 Maternity Services

The benefits provided for Hospital Services, Licensed Birthing Center, and Surgical/Medical Services in this section are also provided for the maternity services listed below when rendered by a Hospital, Licensed Birthing Center, nurse midwife, or Physician to the Employee or the Employee's spouse (if a Participant).

Nursery care of a newborn infant is not a maternity service. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, Plans and issuers may not, under federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

No benefits are provided for any normal pregnancy, complications of pregnancy whether voluntary or involuntary or abortion for any reason, for enrolled eligible Dependent children.

A. Normal Pregnancy
   1. Normal pregnancy includes all conditions arising from pregnancy or delivery, including any condition usually associated with the management of a difficult pregnancy that is not defined below as an involuntary complication of pregnancy.

B. Involuntary Complications Of Pregnancy
Involuntary complications of pregnancy shall include, but not be limited to:
   1. Cesarean section delivery, ectopic pregnancy that is terminated, spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible, missed abortion, puerperal infection and eclampsia; and
   2. Conditions requiring Inpatient confinement (when the pregnancy is not terminated), the diagnosis of which are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed bed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

C. Elective Abortion or Termination of Pregnancy
Abortions are not covered except:

1. When determined by the Contract Administrator to be Medically Necessary to save the life of the mother; or
2. Where the pregnancy was caused by a rape or incest if evidence of the rape or incest is presented either from medical records or through the review of a police report or the filing of charges that a crime has been committed.

   Medical complications resulting from an abortion are covered only for 1 and 2. Treatment of a miscarriage/spontaneous abortion (occurring from natural causes) is covered.

11.9.6 Transplant Services

A. Transplants of kidneys, unless covered by any Governmental program, bone marrow, livers, hearts, lungs, heart/lung and pancreas/kidney combinations.
   1. The applicable benefits provided for Hospital Services and Surgical/Medical Services in this section are provided for a recipient of Medically Necessary transplant services.

      Benefits for a recipient of a bone marrow, liver, heart, heart/lung, or pancreas/kidney combinations transplant are subject to the following conditions:
      a. The transplant must be Pre-authorized by the Contract Administrator, on behalf of the Plan;
      b. The recipient must have the transplant performed at an appropriate Recognized Transplant Center. If the recipient is eligible for Medicare, the recipient must have the transplant performed at a Recognized Transplant Center that is approved by the Medicare program for the requested transplant Covered Services. A Recognized Transplant Center is a Hospital that:
         1. Is approved by the Medicare program for the requested transplant Covered Services;
         2. Is included in the Contract Administrator's national transplant networks or has arrangements with the Contract Administrator for the delivery of the requested transplant Covered Services, based on appropriate approval criteria established by the Plan; or
         3. Is approved by the Contract Administrator based on the recommendation of the Contract Administrator's Medical Director.
      c. Expenses for the donor will be considered if they are not eligible for transplant benefits under any other group/health plan and the recipient is covered under the Plan;
      d. Transportation costs including, but not limited to, ambulance transportation service or air service for the donor or to transport a donated organ or tissue;
      e. If the recipient is eligible to receive benefits for these transplant services, organ procurement charges will be paid for the donor, even if the donor is not a Participant. Benefits will be charged to the recipient's coverage; and
      f. If a Participant is the donor and the recipient is not a Participant, the Plan will not pay the donor's expenses.

B. Travel benefits are available in the event a transplant recipient must travel to another city for the transplant. Up to thirty (30) days for travel and lodging is available. This includes hotel, airfare, meals, and rental car. If the recipient is under eighteen (18) years of age, this benefit is available to one adult traveling companion. Expenses submitted with receipts will be subject to Deductible and paid at Coinsurance amount once Deductible met.

C. Transplant Services Exclusions and Limitations

   In addition to any other exclusions and limitations of the Plan, the following exclusions and limitations apply to transplant services:

   No benefits are available under the Plan for the following services:
   1. Transplants of brain tissue or brain membrane, islet tissue, pancreas, intestine, pituitary and adrenal glands, hair transplants, or any other transplant not specifically named as a Covered Service in this section; or for artificial organs, including but not limited to, an artificial heart or pancreas.

2. Any eligible expenses of a donor related to donating or transplanting an organ or tissue unless the recipient is a Participant who is eligible to receive benefits for transplant services.
3. The cost of a human organ or tissue that is sold rather than donated to the recipient.
4. Living expenses for the recipient, donor or family members.
5. Any complication to the donor arising from a donor's transplant Surgery is not a covered benefit under the Participant transplant recipient's Plan.
6. Costs covered or funded by Governmental, foundation or charitable grants or programs; or Physician fees or other charges if no charge is generally made in the absence of insurance coverage.

11.9.7 Surgical/Medical Services

A. Surgical Services
   1. Surgery performed by a Physician or other Provider.
   2. Benefits for multiple surgical procedures performed during the same operative session by one or more Physicians or other Providers shall be calculated based upon the Plan's Maximum Allowance and payment guidelines.
   3. Surgical Supplies - When a Physician or other Provider performs covered Surgery in the office, benefits are available for a sterile suture or Surgery tray normally required for minor surgical procedures.
   4. Surgical Assistant - Medically Necessary services rendered by a Physician or other appropriately qualified surgical assistant who actively assists the operating surgeon in the performance of covered Surgery where an assistant is required.
   5. Surgical Procedures include reconstructive Surgery necessary to treat an Accidental Injury, infection or other Disease of the involved part; or reconstructive Surgery to correct Congenital Anomalies in a Participant who is a Dependent child, to correct damage caused by a birth defect resulting in the malformation or absence of a body part; oral Surgery, which is not covered by the dental Plan or otherwise excluded; functional rhinoplasty; functional blepharoplasty; circumcision; surgical reproductive sterilization; surgical procedures to correct morbid obesity, and podiatry Surgery.
   6. Anesthesia - Administration of anesthesia ordered by the attending Physician and rendered by a Physician or other Provider, other than the surgeon or surgical assistant, in conjunction with a covered surgical procedure.
   7. Second and Third Surgical Opinion
      a. Services consist of a Physician's consultative opinion to verify the need for elective Surgery as first recommended by another Physician.
      b. Specifications
         1. Elective Surgery is covered Surgery that may be deferred and is not an emergency.
         2. Use of a second consultant is at the Participant's option and cost.
         3. A second opinion must be rendered by a Physician other than the Physician who first recommended elective Surgery.
         4. If the first recommendation for elective Surgery conflicts with the second consultant's opinion, then a third consultant's opinion is a Covered Service.
         5. The third consultant must be a Physician other than the Physician who first recommended elective Surgery or the Physician who was the second consultant.

B. Inpatient Medical Services
   Inpatient medical services, including Acute Care of mental/nervous conditions, rendered by a Physician or other Professional Provider to a Participant who is receiving Covered Services in a Hospital, Licensed Skilled Nursing Facility, Licensed Alcoholism and/or Substance Abuse Treatment Facility, Licensed Day/Night Alcoholism and/or Substance Abuse Treatment Facility or Licensed Psychiatric Hospital.

   Consultation services when given to a Participant as an Inpatient of a Hospital by another Physician at the request of the attending Physician. Consultation services do not include staff consultations

that are required by Licensed General Hospital rules and regulations.

Charges for Inpatient well-baby services provided by a Physician or other Professional Provider during the initial Hospital confinement of a newborn will be considered separately from the mother's expenses.

C. Outpatient Medical Services
The following Outpatient medical services given by a Physician or other Professional Provider to a Participant who is an Outpatient, provided such services are not related to pregnancy or chiropractic care, except as specifically provided elsewhere in this section.
   1. Emergency Care - Medical care for the treatment of an Accidental Injury, Disease, or Illness.
   2. Special Therapy Services - Deep Radiation Therapy or Chemotherapy for a malignancy when such therapy is performed in the Physician's office.
   3. Home, Office And Other Outpatient Visits - Medical Care visits and consultations for the examination, diagnosis or treatment of an Accidental Injury, Disease, condition or Illness.

11.9.8 Diagnostic Services

Services used to establish or confirm a diagnosis provided such services are not related to chiropractic care except as specifically provided elsewhere in this section. Diagnostic Services include mammograms, diagnostic x-rays, diagnostic laboratory services, ultrasound, amniocentesis, magnetic resonance imaging (MRI) and allergy testing.

11.9.9 Therapy Services

A. Radiation Therapy
B. Chemotherapy
C. Dialysis
   1. The Plan has entered into an agreement with a third-party to manage outpatient dialysis costs. The Dialysis Cost Containment Program Administrator must be contacted by the Participant's nephrologist and/or the dialysis treatment clinic before the onset of treatment. If the Participant's nephrologist and/or dialysis treatment clinic has not entered into an agreement with the Dialysis Cost Containment Program Administrator, payment for all dialysis services and supplies will be strictly limited to the UCR reimbursement rate as defined by the Plan, and all other Plan limitations and exclusions shall apply.
D. Physical Therapy
   1. Payment is limited to Physical Therapy Services related to developmental and rehabilitative care, where there is a reasonable expectation that the services will produce significant improvement in the Participant's condition in a reasonable period of time.
   2. No benefits are provided for:
      a. The following Physical Therapy Services when the specialized skills of a registered Physical Therapist are not required:
         1. Repetitive exercises to improve gait and maintain strength and endurance;
         2. Range of motion and passive exercises that are not related to restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities;
         3. Assistance in walking, such as that provided in support for feeble or unstable Participants.
      b. Facility-related charges for Outpatient Physical Therapy Services, health club dues or charges, or Physical Therapy Services provided in a health club, fitness Facility or similar setting; or
      c. General exercise programs even when recommended by a Physician or a chiropractic Physician, and even when provided by a registered Physical Therapist.
E. Occupational Therapy
   1. Payment is limited to Occupational Therapy Services related to developmental and rehabilitative care, where there is a reasonable expectation that the services will produce significant improvement in the Participant's condition in a reasonable period of time.

2. No benefits are provided for:
    a. Facility-related charges for Outpatient Occupational Therapy Services, health club dues or charges, or Occupational Therapy Services provided in a health club, fitness Facility or similar setting; or
    b. General exercise programs, even when recommended by a Physician or a chiropractic Physician, and even when provided by a licensed Occupational Therapist.

F. Respiration Therapy

G. Speech Therapy

H. Enterostomal Therapy

I. Home and/or Outpatient Intravenous Therapy
    1. Benefits for this therapy are only available as Pre-authorized and approved where Medically Necessary.

11.9.10 Skilled Nursing Care Services

Professional nursing services that can only be furnished by a Licensed Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.), when the services are Medically Necessary and do not constitute Custodial Care; provided such Nurse does not ordinarily reside in the Participant's household or is not related to the Participant by blood or marriage. No benefits shall be provided during any period of time in which the Participant is receiving services for Hospice Covered Services.

11.9.11 Hospice Home Care Services

A. The following benefits are provided only for services and supplies furnished by a licensed Hospice Provider:
    1. Hospice nursing care visits.
    2. Medical care rendered by a Hospice Physician.
    3. Hospice Physical Therapy, Occupational Therapy, Speech Therapy and Respiration Therapy.
    4. Medical social services, psychological social assessment and counseling of a Participant as part of a Hospice plan of treatment provided by Licensed Certified Social Worker with private practice endorsement.
    5. Individual and group counseling services, for immediate family members and the primary care giver, related to coping with the Participant's condition.
    6. Initial and follow-up dietary counseling sessions provided by a dietician.
    7. Medical and surgical supplies, Durable Medical Equipment, and oxygen and its administration.
    8. Respite care limited to fourteen (14) days per lifetime.

B. Hospice Conditions

Benefits provided under other benefit sections of the Plan are available except as modified by this section. Benefits are provided only for covered Hospice services included in a Hospice plan of treatment.

A Participant must specifically request benefits and must meet the following conditions to be eligible for Hospice benefits:
    1. The attending or primary Physician must certify that the Participant is terminally ill.
    2. The Participant must be formally accepted by the licensed Hospice.
    3. The Participant must have a designated volunteer primary care giver at all times.
    4. Services and supplies must be prescribed by the attending Physician and included in a Hospice plan of treatment. The Hospice must notify Contract Administrator within one working day of any change in the Participant's condition or plan of treatment that may affect the Participant's eligibility for Hospice benefits.
    5. Palliative care, which controls pain and relieves symptoms but does not provide a cure and must be appropriate to the Participant's Illness.

C. Hospice Exclusions and Limitations

No benefits are provided for:
    1. Covered Hospice services not included in a Hospice plan of treatment and not provided or arranged and billed for through a licensed Hospice;

2. Continuous skilled nursing care except as specifically provided as a part of respite care or continuous crisis care;
3. Hospice benefits in any period of time in which a Participant is receiving Home Health Skilled Nursing Care benefits.

11.9.12 Durable Medical Equipment

A. Only when used in conjunction with an otherwise covered Medically Necessary condition.
   1. When prescribed by an attending Physician or other Provider within the scope of license and required for therapeutic use;
   2. Original fitting adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, and traction apparatus are examples of covered benefits;
   3. Primarily used for medical purposes and not for convenience, personal comfort, or other nontherapeutic purposes;
   4. Required for Activities of Daily Living;
   5. Not for duplication or replacement of lost, damaged, or stolen items**;** for less than five years, whether or not the item being replaced was covered under the Plan, and regardless of the reason for replacement; and
   6. Not attached to a home or vehicle.
B. Batteries only when used to power a wheelchair or an insulin pump for treatment of diabetes.
C. Benefits for an insulin infusion pump will be reviewed for Medical Necessity.

The Plan will not provide payment for covered rental equipment that is subsequently purchased, and cumulative rental costs are deducted from the purchase price. Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment. Benefits include expenses related to necessary repairs and maintenance.

11.9.13 Prosthetic Appliances

The purchase, fitting, necessary adjustment, repair and replacement of prosthetic appliances including post mastectomy prostheses. Prosthetic appliances are devices that replace all or part of an absent body organ or to aid in their function when impaired, including contiguous tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ, such as artificial limbs and eyes. Benefits for prosthetic appliances are subject to the following limitations:

A. In all cases, benefits shall not exceed the cost of the standard, most economical prosthetic appliance that is consistent, according to generally accepted medical treatment practices, with the Participant's condition;
B. Benefits shall not be provided for dental appliances or major artificial organs, including but not limited to, an artificial heart and pancreas.

11.9.14 Orthotic Devices

Orthotic devices are any rigid or semi rigid supportive device that restricts or eliminates motion of a weak or Diseased body part. Orthotic devices shall include, but not be limited to: Medically Necessary braces, back or special surgical corsets, splints for extremities, trusses, arch supports, orthotics, orthopedic or corrective shoes and other supportive appliances for the feet, when prescribed by a Physician, chiropractic Physician, podiatrist or physical therapist. Garter belts are not considered orthotic devices.

11.9.15 Dental Services Related To Accidental Injury

Dental services unless otherwise excluded by the Plan, which are rendered by a Physician or dentist and required as a result of Accidental Injury to the jaw, sound natural teeth, mouth or face, when such Accidental Injury occurred while the Participant is covered under the Plan. Injury as a result of chewing or biting shall not be considered an Accidental Injury.

A. Dental services required as the result of an Accidental Injury. Services include, but are not limited to, crowns, caps, bridges, and root canals.
B. When the Plan determines the following to be Medically Necessary:
   1. Maxillary and/or mandibular procedures;

2. Upper/lower jaw augmentation or reduction procedures, including developmental corrections or altering of vertical dimension;
3. Orthognathic services; or
4. Services for congenital oligodontia or anodontia.

C. For repairs of physical damage to sound natural teeth, crowns, and the supporting structures surrounding teeth when:
1. Such damage is a direct result of an accident independent of Disease or bodily infirmity or any other cause; and
2. Medical advice, diagnosis, care, or treatment was recommended or received for the injury at the time of the accident.

No benefits are available for orthodontia, whitening, caps, or for beautification.

Benefits for dental services under this medical provision shall be secondary to dental benefits available to a Participant under another benefit section of the Plan or available under a dental policy of insurance, contract or underwriting plan that is separate and distinct from the Plan.

11.9.16 Outpatient Diabetes Education

Outpatient diabetes education is a Covered Service for Participants who are either newly diagnosed with diabetes or have had a recent complication of diabetes. Outpatient diabetes education includes instruction in the basic skills of diabetes management through books/educational material as well as an individual or group consultation with a diabetes educator, nurse or dietician.

Coverage for Outpatient diabetes education is contingent upon:

A. Approved programs are Hospital based and meet the standards of the American Diabetes Association or are supervised by a diabetes educator or by a nurse educator with documented credentials;
B. Referral by a Physician;
C. The program must provide written communication back to the referring Physician; and
D. Benefits for the program are contingent upon completion of the program.

11.9.17 Covered Contraceptive Methods

Covered Services include all prescribed Food and Drug Administration approved contraceptive methods including carrier methods, hormonal methods, implanted devices, emergency contraception, sterilization procedures, and Participant education and counseling. No benefits are provided for:

A. Over-the-counter items including, but not limited to condoms, spermicides, and sponges;
B. Prescribed contraceptives that could otherwise be purchased over-the-counter;
C. Oral contraceptive Prescription Drugs and other prescription hormonal contraceptives. Refer to Section 15 for more information.

11.9.18 Breastfeeding Support

Breastfeeding support, counseling, and equipment are provided for the duration of breastfeeding. Some services may be provided before and after birth. Equipment includes the rental and/or purchase of a manual or electric breast pumps. Hospital grade pumps require a Pre-authorization. The breastfeeding support and supplies must be prescribed by a Covered Provider.

11.9.19 Prescription Drug Benefits

Refer to Section 15.

11.9.20 Surgical and Non-Surgical Treatment for Morbid Obesity

Treatment for morbid obesity will be considered if a Participant meets the definition of morbid obesity as defined by the Contract Administrator’s medical policy. Treatment must be provided by a covered Provider.

Covered treatment includes surgical procedures and non-surgical treatment to correct morbid obesity or for reversals or revisions of Surgery for morbid obesity. Refer to the Section 14 for treatment that is not covered, even for morbid obesity. In any case, the Plan will not cover surgeries designed to improve

appearance or remove excess skin (even if excess skin is caused by weight loss as a result of gastric bypass Surgery). A Pre-authorization is required before receiving services.

11.9.21 Psychiatric Care Services

A. Inpatient Psychiatric Care
The benefits provided for Inpatient Hospital services and Inpatient medical services in this section are provided for mental or nervous conditions.

B. Outpatient Psychiatric Care
The benefits provided for Outpatient Hospital services and Outpatient medical services in this section are provided for mental or nervous conditions.

11.9.22 Post-Mastectomy/Lumpectomy Reconstructive Surgery

Reconstructive Surgery in connection with a mastectomy/lumpectomy, in a manner determined in consultation with the attending Physician and the Participant, including:

A. Reconstruction of the breast on which the mastectomy/lumpectomy was performed;
B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. Prostheses and treatment of physical complications at all stages of the mastectomy/lumpectomy, including lymphedemas.

11.9.23 Preventive/Wellness Care Services

Preventative care, such as well child visits and annual wellness exams, along with immunizations are covered at 100% based on age and frequency guidelines within federal guidelines.

The specifically listed preventive care services and immunizations will be adjusted accordingly to coincide with federal government changes, updates, and revisions. For a list of services covered under this benefit, please contact the Contract Administrator.

11.9.24 Sleep Apnea

Benefits are provided for Covered Services, covered Hospital services and Surgical/medical services included in a sleep apnea plan of treatment. Sleep apnea, for the purpose of the Plan, is the cessation of breathing for significant periods during sleep. During the apneic periods, the O2 saturation decreases, arterial pressures increase, and the heart rate slows.

11.9.25 Nutritional Therapy

In order to be eligible for nutritional therapy benefits a Participant must be unable to take adequate calories by normal feeding. The nutritional therapy must be prescribed by a Physician, Medically Necessary, necessary to sustain life, be used in conjunction with a feeding tube and must be used only when pureed, normal diets cannot be used. Nutritional therapy supplies must be purchased from a Durable Medical Equipment supplier.

11.9.26 Tobacco Cessation

Tobacco cessation will be covered as a preventative service.

11.9.27 Cochlear Implants

For pre lingual deafness in children or post lingual deafness in adults in limited circumstances that satisfy the Plan’s criteria. Must be Pre-authorized. One per ear per lifetime. The repair and/or replacement of external components falls under the Durable Medical Equipment benefit.

11.9.28 Nutritional Counseling

Nutritional counseling is limited to three (3) visits per lifetime.

11.9.29 Breast Reduction

Breast reduction will be covered if Medically Necessary.

Section 12 – Medical – Pre-authorization

12.1 Medical

Pre-authorization refers to the process by which the Contract Administrator- Medical determines that a proposed service or supply is Medically Necessary and provides approval for it before it is rendered.

Pre-authorization is performed to ensure that the services the Participant receives are aligned with evidence based criteria and to determine whether the requested service meets the Contract Administrator's Medical Necessity criteria. Pre-authorization also ensures that services or supplies the Participant receives are safe, effective, and appropriate, with the goal of helping the Participant obtain the most out of the Plan and receiving the right care, at the right time, and in the right place.

Contracted Providers may be required to obtain Pre-authorization from the Claims Administrator in advance for certain services. Out-of-network Providers are not required to obtain Pre-authorization from the Contract Administrator in advance for services. The Participant, however, may be liable for costs if the Participant elects to seek services and those services are not considered Medically Necessary and/or not covered under the Plan. The Participant may request that an Out-of-network Provider pre-authorize services on his/her behalf to determine Medical Necessity prior to the services being rendered.

A comprehensive list of services and supplies that must be Pre-authorized may be obtained from the Contract Administrator. Pre-authorization requests should be faxed by the Provider following the instructions from the Contract Administrator.

12.2 Dialysis

The Plan's dialysis cost containment program, described herein, is a cost containment program designed for Participants requiring outpatient dialysis treatment(s). The Plan has entered into an agreement with a third-party Dialysis Cost Containment Program Administrator for purposes of repricing, prior authorization, utilization review, and case management applicable to all outpatient dialysis treatment and supplies, for which benefits are sought from the Plan. The Plan provides coverage for outpatient dialysis services and/or supplies in accordance with the following process.

The Plan encourages the Participant's nephrologist and/or the dialysis treatment clinic to contact the Dialysis Cost Containment Program Administrator before the onset of treatment. If the Participant's nephrologist and/or dialysis treatment clinic has not entered into an agreement with the Dialysis Cost Containment Program Administrator, payment for all dialysis services and supplies will be strictly limited to the UCR rate as defined by the Plan, and all other Plan Limitations and Exclusions shall apply. Inpatient dialysis will be administered by the Contract Administrator – Medical.

Section 13 – Medical - Other Provisions

13.1 Coordination of Benefits (COB)

When the Participant has healthcare coverage under more than one medical benefit plan, the Plan will apply maintenance of benefits (MOB).

MOB limits what this Plan will pay when coordinating benefits and it is not the primary plan. This Plan's payment will not exceed what this Plan would have paid if it had been the primary plan. MOB could reduce the total benefits available by all plans if this Plan is not the primary plan.

13.1.1 Eligible Dependent Employees

When multiple Employees are legally married and/or have a parent/child(ren) relationship and are Eligible Employees with the Employer, each may elect single coverage through the Plan, or elect to be covered as a Dependent of the other, but may not also elect single coverage. When each are enrolled for coverage as Employees under the Plan, Dependent(s) can be covered under either Employee's coverage, but not both.

If a life event occurs, see Life Events, section 4.2 for information on how to modify coverage. If coverage is separated or combined, such coverage shall be deemed a continuation of prior coverage and any previous benefit limitations, maximums, or waiting periods applied prior to the change in enrollment will be applied under the replacement coverage.

13.1.2 Required Cooperation

The Participant is required to cooperate with the Plan in administering COB. Cooperation may include providing notice of other health benefit coverage, copies of divorce decrees, bills and payment notices from other payers, and/or signing documents required by the Plan to administer COB. Failure to cooperate may result in the denial of claims.

13.1.3 Direct Payments

The Plan may make a direct payment to another health benefit plan when the other plan has made a payment that was the responsibility of the Plan. This amount will be treated as though it was a benefit paid by the Plan, and the Plan will not have to pay that amount again.

13.2 Subrogation and Right of Recovery

The provisions of this section apply to all current or former Participants who incur claims and are or have been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of the Employee's estate, the Employee's decedents, minors, and incompetent or Disabled persons. No adult Participant hereunder, may assign any rights that it may have to recover expenses from any tortfeasor or other person or entity to any minor child or children of said adult Participant without the prior express written consent of the Plan.

The Plan's Right of Subrogation or reimbursement, as set forth below, extends to all insurance coverage available to the Participant due to an injury, Illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

The Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage, excess coverage or similar contract or insurance.

No disbursement of any settlement proceeds, other recovery funds from any insurance coverage, or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

The Plan will not assert its recovery rights to any funds that are intended only to compensate a Participant for property damage claims.

13.2.1 Subrogation

The "Right of Subrogation" means the Plan is entitled to pursue any claims that the Participant may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of the Participant's rights of recovery with respect to any claim or potential claim against any party, due to an injury, Illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in the Participant's name and take appropriate action to assert its subrogation claim, with or without the Participant's consent. The Plan is not required to pay the Participant part of any recovery it may obtain, even if it files suit in the Participant's name.

13.2.2 Reimbursement

If the Participant receives any payment as a result of an injury, Illness or condition, the Participant agrees to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, Illness or condition, up to and including the full amount of the Participant's recovery. Benefit payments made under the Plan are conditioned upon the Participant's agreement to reimburse the Plan in full from any recovery the Participant receives for the Participant's injury, Illness or condition.

13.2.3 Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Participant or made on the Participant's behalf to any Provider) the Participant agrees that if the Participant receives any payment as a result of an injury, Illness or condition, the Participant will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of the Participant's Fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

13.2.4 Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the injury, Illness, or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any injury, Illness, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Participant, the Participant's representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

13.2.5 Assignment

In order to secure the Plan's recovery rights, the Participant agrees to assign to the Plan any benefits or claims or rights of recovery the Participant has under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim the Participant may have, whether or not the Participant chooses to pursue the claim.

13.2.6 First-Priority Claim

By accepting benefits from the Plan, the Participant acknowledges that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before the Participant receives any recovery for the Participant's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make the Participant whole or to compensate the Participant in part or in whole for the damages sustained. The Plan is not required to participate in or pay the Participant's court costs or attorney fees to any attorney the Participant hires to pursue the Participant's damage claim.

13.2.7 Applicability to All Settlements and Judgments

The terms of this entire Subrogation and Right of Recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than expenses provided by the Plan. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and

suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to the Participant's own negligence.

13.2.8 Cooperation

The Participant agrees to cooperate fully with the Plan's efforts to recover benefits paid. It is the Participant's duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Participant's intention to pursue or investigate a claim to recover damages or obtain Compensation due to the Participant's Injury, Illness or condition. The Participant and the Participant's agents agree to provide the Plan or its representatives notice of any recovery the Participant or the Participant's agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, the Participant and the Participant's agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. The Participant and the Participant's agents shall provide all information requested by the Plan, the Contract Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery the Participant receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of the Participant's health benefits or the institution of court proceedings against the Participant.

The Participant shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of the Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

The Participant acknowledges that the Plan has the right to conduct an investigation regarding the Injury, Illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

13.2.9 Workers' Compensation

If the entity providing workers' compensation coverage denies the Participant's claim and the Participant has filed an appeal, benefits may be advanced for Covered Services if the Participant agrees to hold any recovery obtained in a segregated account for the Plan.

13.2.10 Future Medical Expenses

Benefits for otherwise Covered Services may be excluded when the Participant has received a recovery from another source relating to an Illness or Injury for which benefits would normally be provided. However, the amount of any Covered Services excluded under this provision will not exceed the amount of the Participant's recovery.

13.2.11 Interpretation

In the event that any claim is made that any part of this Subrogation and Right of Recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Contract Administrator shall have the sole authority to resolve all disputes regarding the interpretation of this provision.

13.2.12 Jurisdiction

By accepting benefits from the Plan, the Participant agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Participant hereby submits to each such jurisdiction, waiving whatever rights may correspond by reason of the Participant's present or future domicile. By accepting such benefits, the Participant also agrees to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

13.3 Right of Recovery

At the discretion of the Plan, it will have the right to recover any payment made in excess of the obligations of the Plan. This right of recovery will apply to payments made to the Participant, the Participant's Dependent(s), the Participant's Employer, Providers, or Facilities. If an excess payment is made by the Plan to the Participant, the Participant agrees to promptly refund the amount of the excess. The Plan may, at its sole discretion, offset any future Benefits against any overpayment.

13.4 Exclusions and Limitations

See Section 14 for exclusions.

Section 14 – Exclusions and Limitations

14.1 General Exclusions and Limitations

In addition to the exclusions and limitations below, any exclusions and limitations specified in a benefit section also apply to that section. No benefits will be provided for services, supplies, drugs or other charges that are:

A. Not specifically listed as a Covered Service;

B. Not Medically Necessary;

C. In excess of the Maximum Allowance for covered services;

D. For Hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an Accidental Injury or unless an attending Physician certifies in writing that the Participant has a non-dental, life-endangering condition which makes Hospitalization necessary to safeguard the Participant's health and life;

E. Not prescribed by or upon the direction of a Physician or other Provider; or which are furnished by any individuals or facilities other than Licensed General Hospitals, Physicians, and other Providers;

F. Experimental and/or Investigational treatment, equipment, services or supplies. A drug, device, medical treatment or procedure is Experimental or Investigative:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, or the Participant informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating Facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental study or Investigational study of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating Facility or by another Facility studying substantially the same drug, device, medical treatment or procedure;

G. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Participant is entitled to benefits under occupational coverage, obtained or provided by or through the Employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing Compensation for work-related injuries or conditions. This exclusion applies whether or not the Participant claims such benefits or Compensation or recovers losses from a third-party. The Employer reserves the right to make an exception with regards to its self-insured workers compensation program;

H. Provided or paid for by any federal governmental entity or unit except when payment under the Plan is expressly required by federal law, or provided or paid for by any state or local Governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage under the Plan Document; for which payment has been made under Medicare Part A and/or Medicare Part B or would have been made if a Participant had applied for such payment except when payment under the Plan is expressly required by federal law; or services furnished by or for the United States Government or any other Government unless payment is legally required;

I. Any Illness, injury or other condition, Disability or expense sustained as a result of being engaged in violation of any local, state or federal law as determined by the Administrator;

J. Any court ordered treatment for drug and/or alcohol abuse, regardless of legal or illegal use;

K. Intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime; participation in a civil revolution or a riot; duty as a member of the armed forces of any state or country; or a war or act of war which is declared or undeclared;

L. Services furnished by a Provider who is related to the Participant by blood or marriage and/or who ordinarily dwells in the Participant's household;

M. Received from a dental, vision or medical department maintained by or on behalf of an Employer, a mutual benefit association, labor union, trust or similar person or group;

N. For reconstructive, corrective, and cosmetic services and Surgery intended mainly to improve appearance or for complications arising from Surgery intended mainly to improve appearance. Services provided for the following reasons are not covered:
   1. To improve form or appearance;
   2. To correct a deformity, whether congenital or acquired, without restoring physical function;
   3. To cope with psychological factors such as poor self-image or difficult social relations;
   4. As the result of an accident unless the service is reconstructive and rendered within 5 years of the cause or onset of the injury, Illness, or therapeutic intervention, or a planned, staged series of Services (as specifically documented in the Participant's medical record) is initiated within the five-year period;
   5. To revise a scar, whether acquired through injury or Surgery, except when the primary purpose is to improve or correct a functional impairment;
   6. Treatment for venous telangiectasias (spider veins); or
   7. Sexual reassignment surgery also known as transgender surgery;

O. Expenses for or related to the removal of prosthetic implants that were:
   1. Inserted in connection with cosmetic Surgery, regardless of the reason for removal; or
   2. Not inserted in connection with cosmetic Surgery, the removal of which is not currently Medically Necessary;

P. Services rendered prior to the Participant's effective date; or during an Inpatient admission commencing prior to the Participant's effective date or services provided after the date coverage ends under the Plan;

Q. For personal hygiene, comfort, beautification or convenience items even if prescribed by a Physician, including but not limited to: special mattresses, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools. Personal comfort or service items while confined in a Hospital, such as, but not limited to radio, television, telephone and guest meals;

R. For telephone consultations, for failure to appropriately cancel or keep a scheduled visit or appointment, for completion of a claim form, preparation of medical reports, or itemized bills. For personal mileage, telephone calls, transportation, food, or lodging expenses to a local or distant medical Provider. For mileage, transportation, food, or lodging expenses billed by a Physician or other Provider;

S. For Inpatient admissions that are primarily for Diagnostic Services or Therapy Services; or for Inpatient admissions when the Participant is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change or for treatment not requiring continuous bed care;

T. For Inpatient or Outpatient Custodial Care; or for Inpatient or Outpatient services consisting mainly of educational therapy, behavioral modification, vocational or training services and supplies, self-care or self-help training, except as specifically provided as a Covered Service in the Plan Document;

U. For any cosmetic or non-surgical foot care, including but not limited to treatment of corns, calluses, bunions (except for surgical care) and toenails (except for surgical care of ingrown or diseased toenails;

V. Related to dentistry or dental treatment, except as specifically provided as a Covered Service in the Plan Document;

W. Eyeglasses, contact lenses or the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specifically provided as a Covered Service in the Plan Document;

X. Hearing aids or examinations for the prescription or fitting of hearing aids;

Y. Sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence; including, but not limited to, sexual aids, vacuum devices and penile implants or medication in connection with treatment for impotence;

Z. Made by a Licensed General Hospital for the Participant's failure to vacate a room on or before the Licensed General Hospital's established discharge hour;

AA. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury except as specifically provided as a Covered Service in the Plan Document.

AB. Furnished by a Facility that is primarily for Custodial Care, or a place for treatment for the aged, or that is primarily a nursing home, a Convalescent Hospital, sanitarium, or a rest home;

AC. For Acute Care, rehabilitative care, or diagnostic testing, except as specified as a Covered Service in the Plan; for mental or nervous conditions and substance abuse or addiction services not recognized by the American Psychiatric and American Psychological Association;

AD. Treatment for family, gambling, or sex counseling;

AE. Treatment for biofeedback and hypnosis, unless specifically provided as a Covered Service in the Plan Document;

AF. Expenses for education, counseling, job training or care for learning disorders or behavioral problems, whether or not services are rendered in a Facility that also provides medical and/or mental/nervous treatment;

AG. Incurred by an eligible Dependent child for care or treatment of any condition arising from or related to pregnancy, childbirth, delivery, or a voluntary or involuntary complication of pregnancy or abortion;

AH. Elective abortion;

AI. Developmental malformations related to teeth or structures supporting the teeth; for appliances, splints or restorations necessary to increase vertical dimensions or restore the occlusion, except as specifically provided as a Covered Service in the Plan Document; for orthognathic Surgery, including services and supplies to augment or reduce the upper or lower jaw; for implants in the jaw; for pain, surgical or non-surgical treatment or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies; for surgical or non-surgical for the treatment of malocclusion; for alveolectomy or alveoloplasty when related to tooth extraction; for surgical or nonsurgical treatment of craniomandibular disorder; and for other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint;

AJ. Use of operating, cast, examination or treatment rooms or for equipment located in a Provider’s office or Facility, except for emergency room Facility charges in a Licensed General Hospital, unless specifically provided as a Covered Service in the Plan Document;

AK. Reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties;

AL. Care, supplies, services, treatment, or testing after initial diagnosis for infertility and fertilization procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance a Participant's reproductive ability;

AM. Contraceptive devices and injections, except as specifically provided as a Covered Service in the Plan Document;

AN. Transplant services and artificial organs and maintenance of an artificial organ, except as specifically provided as a Covered Service under the Plan Document;

AO. Acupuncture, rolfing, massage therapy or hypnosis;

AP. Surgical procedures that alter the refractive character of the eye, including but not limited to, Lasik, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive-keratoplasty type, the purpose of which is to cure or reduce myopia or astigmatism, even if Medically Necessary. Additionally, reversals or revisions of such surgical procedures and complications of such surgical procedures are excluded;

AQ. Hospice Care, except as specifically provided as a Covered Service in the Plan Document;

AR. Pastoral, spiritual, marital, or bereavement counseling, except as specifically provided as a Covered Service in the Plan Document;

AS. Homemaker and housekeeping services or home-delivered meals;

AT. Treatment or other health care of any Participant in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Participant to Covered Services under the Plan Document, if and to the extent those benefits are payable to or due the Participant under any medical

payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's or other similar policy of insurance, contract or underwriting plan.

If the Plan, for any reason makes payment for or otherwise provides benefits excluded by this provision, it shall succeed to the rights of payment or reimbursement of the compensated Provider, the Participant, and the Participant's heirs and personal representative against all Insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Participant or his /her estate for such services, supplies, drugs or other charges provided by the Plan, in connection with such Illness, Disease, Accidental Injury or other condition;

AU. Any services or supplies for which a Participant would have no legal obligation to pay in the absence of coverage under the Plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage;

AV. Routine or periodic physical examination that is required through employment; for a marriage license; or for insurance, school or camp application; or a screening examination;

AW. Immunizations, travel vaccines, unless specifically provided as a Covered Service in the Plan;

AX. Genetic testing or counseling except as specifically provided as a Covered Service;

AY. Wigs or artificial hair pieces; except as associated with the initial purchase of a wig after chemotherapy and/or radiation which is limited to $300 per lifetime;

AZ. Complications arising from any non-covered Surgery or treatment;

BA. Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present services of any covered family member in the armed forces of any Government;

BB. Treatment or services rendered outside the United States of America or its territories, which if had been provided in the United States would or would not be Covered Services under the Plan Document, except for an Accidental Injury or a Medical Emergency;

BC. Adoption expenses;

BD. Providing for, use of or acting as a surrogate mother will not be covered under the Plan, no matter the circumstance, for the Participant. No surrogate or new born expenses will be covered;

BE. Mailing and/or shipping and handling charges;

BF. Any over the counter medication, nutritional supplements, legend vitamins and minerals except as listed as a specifically covered benefit;

BG. Treatment for weight loss, such as weight loss programs (such as Jenny Craig, Weight Watchers, etc.), activities, meals, supplements, instructions and treatment, except those specifically listed as covered. Treatment for weight control or treatment of obesity or Surgery to improve the appearance or remove excess skin, even if Medically Necessary, except as specifically provided as a Covered Service in the Plan Document;

BH. Alterations or modifications to the home or vehicle;

BI. Special clothing, including shoes, unless specifically listed as covered under the Plan Document;

BJ. Provided to a person enrolled as an eligible Dependent, but who no longer qualifies as an eligible Dependent due to a change in eligibility status which occurred after enrollment;

BK. Prescription Drugs are not covered under Section 11 of the Plan, including but not limited to oral contraceptives;

BL. Anything related to smoking cessation including, but not limited to prescriptions, patches, gum, gel, hypnotism or acupuncture, except as specifically provided as a Covered Service in the Plan Document;

BM. Dry needling and acupuncture and acupressure services;

BN. Therapy to treat covered Participants that use animals, pet therapy, animal therapy, equestrian therapy and llama therapy;

BO. Bionic devices, microprocessor controlled prosthetics, and any computer assisted prosthetics or implants;

BP. Certain Illegal Activities - services are not covered for an Illness, condition, accident, or injury arising from:
1. Voluntarily participating in the commission of a felony;
2. Voluntarily participating in disorderly conduct, riot, or other breach of the peace;
3. Engaging in any conduct involving the illegal use or misuse of a firearm or other deadly weapon;

4. Any injury, Illness, impairment or Disability sustained while under the influence of intoxicants, illegal drugs, illegal use of Prescription Drugs, or a controlled substance;
5. Driving or otherwise being in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor-driven vehicle where either:
    a. A subsequent test shows that the Participant has either blood or breath alcohol concentration equal to or greater than the state legal limit at the time of the test;
    b. The Participant has any illegal drug or other illegal substance in the body to a degree that it affected the ability to drive or operate the vehicle safely; or
6. Any Illness or injury while the covered Participant is engaged in an illegal occupation. The presence of drugs or alcohol may be determined by tests performed by or for law enforcement, tests performed during diagnosis or treatment, or by other reliable means. It is not necessary that criminal charges be filed, or, if filed, that a conviction resulted for this exclusion to apply. Proof beyond a reasonable doubt is not required by the Plan;

BQ. Milieu Therapy - the treatment of mental disorder or maladjustment by making substantial changes in a Participant's immediate life circumstances and environment in a way that will enhance the effectiveness of other forms of therapy. Also known as "Situational Therapy";

BR. Personal comfort items or other equipment such as, but not limited to, air conditioners, air purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, Prescription Drugs and medicines, first-aid supplies and non-Hospital adjustable beds. Services and supplies purchased mainly for providing personal comfort or aid;

BS. Expenses related in any way to preventable errors on the part of any Provider or Facility. This exclusion includes all named preventable errors which the U.S. Department of Health and Human Services and/or Medicare have, or will, list as excluded from eligibility for Medicare reimbursement and is automatically amended to include any such listed preventable errors. Such preventable errors include, but are not limited to, objects left in place during Surgery, air embolisms, blood incompatibility, catheter-associated urinary tract infections, pressure (decubitis) ulcers, vascular catheter-associated infections, surgical site infection (mediastinitis) after cardiovascular Surgery, staph, MRSA or other similar Hospital contracted infections, ventilator-associated pneumonia, deep vein thrombosis, and Hospital acquired injuries such as fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes such as falls from beds;

BT. Other **<u>Specific Services</u>**:
1. Anodyne infrared device for any indication;
2. Oncofertility;
3. Pediatric/infant scales;
4. Peripheral nerve stimulation for occipital neuralgia and chronic headaches;
5. Pressure Specified Sensory Device (PSSD) for neuropathy testing; or
6. Prolotherapy;

BU. Services for an Illness, injury, or connected Disability are not covered when caused by or arising out of an act of international or domestic terrorism, as defined by United States Code, Title 18, Section 2331, or from an accidental, negligent, or intentional release of nuclear material or nuclear byproduct material as defined by United States Code, Title 18, Section 831;

BV. Cochlear Implants except as specifically provided as a Covered Service in the Plan Document.

Section 15 – Prescription Drugs

15.1 This Prescription Drugs section describes the benefits a Participant is entitled to receive, subject to all of the other provisions of the Plan Document. Participants see the best discounts by using mail order. Contact the Contract Administrator – Prescription or Contract Administrator - Mail Order 90 Day Brand Name Only for a list of covered Prescription Drugs and with any questions.

Prescription Benefits & Coverages	Retail	Mail Order	Mail Order 90 Day Brand Name Only
Generic Drugs (Tier 1) Covers up to a 90 day supply.	15% Coinsurance, $5 minimum	$5 Copay for 30 day supply, $10 Copay for over 30 day supply	N/A
Preferred Brand Drugs (Tier 2) Covers up to a 90 day supply.	20% Coinsurance, $5 minimum	$15 Copay for 30 day supply, $30 Copay for over 30 day supply	$0 Copay Limited formulary
Non-preferred Brand Drugs (Tier 3) May require Prior Authorization; covers up to a 90 day supply.	35% Coinsurance, $5 minimum	$25 Copay for 30 day supply, $50 Copay for over 30 day supply	$0 Copay Limited formulary
Specialty Drugs (Tier 4) May require Prior Authorization; covers up to a 30 day supply mail order.	N/A	$50 Copay or actual cost whatever is less	$0 Copay Limited formulary

15.2 Use Participating Pharmacies

To get the most from the Prescription Drug benefits, the Participant must use a participating Plan pharmacy (contact the Contract Administrator for a list of pharmacies, which includes Walgreens, RiteAid, CVS, Costco, and most independently owned pharmacies) and present the ID card when filling a prescription.

15.3 Tiered Benefits

There are tiers (or levels) of covered prescriptions. The Coinsurance/Copay applies toward individual prescription out of pocket maximum of $7,050 or family out of pocket maximum of $13,000.

This tiered benefit allows the choice of drugs that best meet medical needs while encouraging the Participant and the Participant's Provider to discuss treatment options and choose lower-tier drugs when therapeutically appropriate. Drugs on each tier are selected by an expert panel of Physicians and pharmacists and may change periodically. To determine which tier a drug is assigned to, contact the Contract Administrator.

15.4 Filling Prescriptions

15.4.1 Retail

Prescriptions can be filled at a designated Plan pharmacy for up to a 30 day supply or a 31-90 day supply.

If the Participant's Provider prescribes a dose of a medication that is not available, the Participant will be charged Coinsurance for each strength of the medication.

15.4.2 Mail Order

Prescriptions can be filled through mail order for a 90 day supply. Prescriptions are mailed to the home address on record.

If the Participant's Provider prescribes a dose of a medication that is not available, the Participant will be charged a Copay for each strength of the medication.

15.4.3 Mail Order 90 Day Brand Name Only

Brand name 90 day maintenance Prescriptions can be filled through mail order for a 90 day supply. Prescriptions are mailed to the home address on record.

This is a voluntary program that does not replace the current Prescription Drug program. This program has a $0 Copay and the prescriptions are shipped to the home address with no shipping and handling costs. Contact the Contract Administrator - Mail Order 90 Day Brand Name Only for the formulary.

15.4.4 Quantity and Day Supply

Prescriptions are subject to Plan quantity and day-supply limitations that have been defined based upon FDA guidance or evidence-based literature. The most current information is available by contacting the Contract Administrator.

15.4.5 Refills

Refills are allowed after 80 percent of the last refill has been used for a 30-day or more supply, and 50 percent for a 10-day supply. Some exceptions may apply; contact the Contract Administrator for more information.

15.5 Maintenance Drugs

The Plan offers a maintenance drug benefit, allowing the Participant to obtain a 90-day supply of certain drugs. This benefit is available for maintenance drugs if the Participant:

A. Has been using the drug for at least one month;
B. Expects to continue using the drug for the next year; and
C. Has filled the drug at least once within the past six months.

15.6 Pre-authorization of Prescription Drugs.

There are certain drugs that require Pre-authorization by the Participant's Provider to be covered by the Plan. Pre-authorization is also required if the drug is prescribed in excess of the Plan limits (quantity, duration of use, maximum dose, etc.). The most current information can be found by contacting the Contract Administrator. To obtain Pre-authorization for these drugs, please have the Provider call the Contract Administrator.

If the Participant's Provider prescribes a drug that requires Pre-authorization, the Participant should verify that Pre-authorization has been obtained before purchasing the medication. The Participant may still buy these drugs if they are not Pre-authorized, but they will not be covered, and the Participant will have to pay the full price.

15.7 Step Therapy

Certain drugs require the Participant's Provider to first prescribe an alternative drug preferred by the Plan. The alternative drug is generally a more cost-effective therapy that does not compromise clinical quality. If the Participant's Provider feels that the alternative drug does not meet the Participant's needs, the Plan may cover the drug without step therapy if the Contract Administrator determines it is Medically Necessary. Contact the Contract Administrator for details.

15.8 Coordination of Benefits

If the Participant has other health insurance that is primary coverage, claims must be submitted first to the primary insurance carrier before being submitted to the Contract Administrator. In some circumstances, the secondary policy may pay a portion of the Out-of-pocket expense. When the Participant mails a secondary claim to the Contract Administrator, the Participant must include a prescription reimbursement form and the pharmacy receipt in order for the Contract Administrator to process the claim. In some circumstances, an Explanation of Benefits (EOB) from the primary carrier may also be required.

15.9 Inappropriate Prescription Practices

The Plan reserves the right to not cover certain Prescription Drugs.

A. In the interest of safety, the following drugs may not be covered:
    1. Narcotic analgesics;
    2. Other addictive or potentially addictive medications; and
    3. Drugs prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question.
B. Drugs are not covered when they are prescribed:
    1. Outside the usual standard of care for the practitioner prescribing the drug;
    2. In a manner inconsistent with accepted medical practice; or
    3. For indications that are Experimental and/or Investigational.
C. Additional exclusions may apply for the following:
    1. Non-FDA approved drugs;

2. Non-Essential drugs with clinically appropriate alternatives available;
3. Compounded medications; and
4. Medications used to treat infertility, impotency, and/or obesity.

This exclusion is subject to review by the Contract Administrator and certification by a practicing clinician who is familiar with the drug and its appropriate use. Additional exclusions to this list are made based upon the Contract Administrator's recommendations and can happen at any time.

15.10 Prescription Drug Benefit Abuse

The Plan may limit the availability and filling of any Prescription Drug that is susceptible to abuse. The Plan may require the Participant to:

A. Obtain prescriptions in limited dosages and supplies;
B. Obtain prescriptions only from a specified Provider;
C. Fill the Participant's prescriptions at a specified pharmacy;
D. Participate in specified treatment for any underlying medical problem (such as a pain management program);
E. Complete a drug treatment program; or
F. Adhere to any other specified limitation or program designed to reduce or eliminate drug abuse or dependence.

If the Participant seeks to obtain drugs in amounts in excess of what is Medically Necessary, such as making repeated emergency room/urgent care visits to obtain drugs, the Plan may deny coverage of any medication susceptible of abuse.

The Plan may terminate the Participant from coverage if the Participant makes an intentional misrepresentation of material fact in connection with obtaining or attempting to obtain drugs, such as by intentionally misrepresenting the Participant's condition, other medications, healthcare encounters, or other medically relevant information. At the discretion of the Plan, the Participant may be permitted to retain coverage if the Participant complies with specified conditions.

15.11 Pharmacy Injectable Drugs and Specialty Medications

While Injectable Drugs apply to the Participant's medical benefits, certain Injectable Drugs are covered under Prescription Drugs when filled at a pharmacy, and such Injectable Drugs are required to be run through the Prescription Drugs benefit. On no less than an annual basis or as reasonably requested by its Contract Administrator - Medical, Plan Sponsor will obtain from its Contract Administrator - Prescription a current list of all Injectable Drugs covered by the Prescription Drugs benefit and will provide this list to its Contract Administrator - Medical. Injectable Drugs and Specialty Medications must be provided by a participating Provider unless otherwise approved in writing in advance by the Contract Administrator. For more specific information, please contact the Contract Administrator.

15.12 Drugs Not Covered

Drugs not included on the formulary may be covered at reduced benefits, or not covered at all, by the Plan. Please contact the Contract Administrator for information.

15.13 Exceptions Process

If the Participant's Provider believes that the Participant requires a certain drug that is not on the formulary, normally requires step therapy, or exceeds a quantity limit, the Participant may request an exception through the Prior Authorization process.

15.14 Prescriptions Dispensed in a Provider's Office

Prescriptions dispensed in a Provider's office are not covered unless expressly approved by the Plan.

15.15 Disclaimer

The Contract Administrator refers to many of the drugs in the Plan by their respective trademarks. The Contract Administrator does not own these trademarks. The manufacturer or supplier of each drug owns the drug's trademark. By listing these drugs, the Contract Administrator does not endorse or sponsor any drug, manufacturer, or supplier. Conversely, these manufacturers and suppliers do not endorse or sponsor any the Contract Administrator's service or Plan, nor are they affiliated with the Contract Administrator.

Section 16 – Dental

16.1 This dental benefits section describes the benefits a Participant is entitled to receive, subject to all of the other provisions of the Plan Document. Participants see the best discounts by going to a PPO dentist. Contact the Contract Administrator - Dental to get a list of PPO dentists and with any questions.

Dental Benefits & Coverages	Preferred Providers (PPO)	Premier/Out-of-network Provider Providers
Calendar Year Deductible Per person/per family Excludes diagnostic and preventive services per Benefit Year	$25/$75	$25/$75
Maximum Benefit Per eligible person per Benefit Year	$1,500	$1,000
Preventative & Diagnostic Services Examinations, x-rays, teeth cleaning	100%	80%
Basic Services Fillings, root canals, extractions, minor oral Surgery	80%	70%
Major Restorative Services Crowns, onlays, bridges, dentures	50%	40%
Implants	0%	0%
Orthodontia	0%	0%

16.2 Annual Benefits / Limitations

16.2.1 Preventive and Diagnostic Services

Examinations once every 6 months; cleanings once every 6 months (restricts against periodontal maintenance within the same time period); fluoride once every 6 months; sealants once per tooth every 3 years for Dependent children under 19; full mouth series or panoramic x-rays once every 5 years; bitewing x-rays once every 6 months; space maintainers under age 14 once a lifetime per permanent tooth.

16.2.2 Basic Services

Periodontal maintenance once every 6 months (restricts against basic cleaning within the same time period); full mouth debridement is a benefit if no cleanings within 12 months of the service date (an additional cleaning is allowed within 60 days of the full mouth debridement); scaling and root planing covered once every 24 months per quadrant (no limit as to the number of quadrants per visit); root canals, extractions, periodontics; fillings restricted to same tooth/surface once every 24 months; posterior fillings are paid as composites; composite fillings are not downgraded to amalgam; nitrous oxide is not covered.

16.2.3 Major Restorative Services

Crowns, build-ups, stainless steel crowns, onlays, or bridges on same tooth once every 5 years; for Dependent children under age 16, benefits are limited to plastic or stainless steel crowns on same tooth; prosthetic services pay on the prep date; occlusal guards are covered for bruxism only once in 24 months; missing tooth clause does not apply; TMJ is not a covered benefit; partials, or dentures 1 time per arch every 5 years, eligible for partials at age 16.

16.2.4 Implants

Implant services are not covered.

16.2.5 Orthodontia

Orthodontia services are not covered.

16.3 Exclusions

A. Appliances, restorations, or procedures necessary to increase vertical dimension or restore the occlusion are considered optional and the cost is the responsibility of the Participant;
B. Service for injuries or conditions which are covered under workers' compensation or Employers' liability coverage; or services which are provided to the member of any federal or state government agency; or are provided, without cost, to the subscriber by any municipality, county or other political subdivision;
C. Cosmetic services for purely cosmetic reasons;
D. Dental services including prosthodontic services, crowns or bridges started prior to the date the Participant became eligible for such services under this agreement;
E. Occlusal (complete) equilibration and/or treatment for TMD disturbances;
F. Separate charges for anesthesia other than general anesthesia and IV sedation administered by a licensed dentist in connection with covered oral surgical services performed in a dental office;
G. Prescription Drugs;
H. Tooth transplants;
I. Oral hygiene instruction and dietary instruction;
J. Plaque control programs;
K. Myofunctional therapy;
L. Veneers placed for cosmetic purposes only;
M. Hospitalization;
N. Failure to appropriately cancel or keep a scheduled visit or appointment;
O. Duplicate dentures;
P. Charges for dental services performed by a dental mechanic or another dental technician who is not licensed;
Q. Periodontal splinting, including crowns or bridgework;
R. The Contract Administrator is not obligated to pay claims received more than twelve (12) months after the date of rendition of the service;
S. Experimental procedures not yet approved by the Contract Administrator;
T. All other services not specifically included in the Processing Policies; and
U. Orthodontic services.

Section 17 – Vision

17.1 This vision benefits section describes the benefits a Participant is entitled to receive, subject to all of the other provisions of the Plan Document. Participants see the best discounts by going to an In-network Provider. Contact the Contract Administrator - Vision to get a list of Providers and with any questions.

Vision Benefits & Coverages	In-network Providers	Out-of-network Reimbursement Amounts
Vision Exam - every 12 months	$10 Copay	Up to $45
Prescription Glasses - every 12 months Lenses (single vision, lined bifocal, and lined trifocal lenses) Polycarbonate lenses for Dependent children up to age 18 Scratch coating Photochromics Tints Anti-reflective Coating	$10 Copay $0 Copay $0 Copay $0 Copay $70 Copay $15 Copay $40 Copay	Up to $30 single Up to $50 lined bifocal Up to $65 lined trifocal Up to $50 progressive
Frame – every 12 months 20% savings on the amount over allowance $170 allowance for featured frame brands $80 Costco frame allowance	$150 Allowance	Up to $70
Contacts – every 12 months Contacts and the contact lens exam (fitting and evaluation). If the Participant chooses contact lenses, the Participant will be eligible for a frame 12 months from the date the contact lenses were obtained. 15% off cost of contact lens exam (fitting and evaluation)	$150 Allowance	Up to $105
Diabetic Eyecare Plus Program Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20 Copay	
Glasses and Sunglasses Extra $20 to spend on featured frame brands. Get 20% off from any In-network doctor within 12 months of the last Exam.		
Retinal Screening No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.		
Laser Vision Correction Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.		

17.2 Non-covered Benefits

There is no benefit for Professional Services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under the Plan which are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental nature.
- Costs for services and/or materials above Plan benefit allowances.
- Services/materials not indicated as covered Plan benefits.

Section 18 – Short-Term Disability (STD)

18.1 This short-term disability section describes the benefits an Employee is entitled to receive, subject to all of the other provisions for the Plan Document. Contact the Contract Administrator – Short-Term Disability with questions.

18.2 Description of Eligible Classes

All Employees who have meet the eligibility criteria as described in Section 3 and have enrolled in health insurance coverage. Premiums are paid by Plan Sponsor.

Class 1: Salaried exempt Employees.

Class 2: Hourly-paid/salaried non-exempt Employees with at least 5 years of service, at the time of Disability.

Class 3: Hourly-paid/salaried non-exempt Employees with less than 5 years of service, at the time of Disability.

18.3 Definition of Disability

Disability and Disabled mean that because of an injury or Illness, a significant change in the Employee's mental or physical functional capacity has occurred in which:

- During the elimination period, the Employee is prevented from performing the material duties of the Employee's regular job on a part-time or full-time basis; and
- After the elimination period, the Employee is:
  - Prevented from performing the material duties of the Employee's regular job on a part-time or full-time basis; and
  - Unable to generate current earnings which exceed 99% of the Employee's weekly earnings due to that same injury or Illness.

Disability is determined relative to the Employee's ability or inability to work. It is not determined by the availability of a suitable position with the Employer.

18.4 Elimination/Waiting Period If the Disability is a result of an injury or Illness, the elimination/waiting period is 13 calendar days. Benefits will start on the 14th day of the Employee's injury or Illness.

18.5 Maximum Benefit Period

The maximum number of weeks that benefits are payable for a continuous period of Disability is 12 weeks.

18.6 Weekly Benefit

18.6.1 Class 1: If the Employee is Disabled and unable to generate current earnings greater than 20% of the Employee's weekly earnings, the weekly benefit while Disabled is the lesser of:

- 100% of the weekly earnings, less other income benefits; or
- The maximum weekly benefit is $9,999, less any other income benefits.

18.6.2 Class 2: If the Employee is Disabled and unable to generate current earnings greater than 20% of the Employee's weekly earnings, the weekly benefit while Disabled is the lesser of:

- 80% of the weekly earnings, less other income benefits; or
- The maximum weekly benefit is $9,999, less any other income benefits.

18.6.3 Class 3: If the Employee is Disabled and unable to generate current earnings greater than 20% of the Employee's weekly earnings, the weekly benefit while Disabled is the lesser of:

- 60% of the weekly earnings, less other income benefits; or
- The maximum weekly benefit is $9,999, less any other income benefits.

18.7 Definition of Basic Weekly Earnings

Basic weekly earnings are based on the average number of hours the Employee worked per week during the preceding 52 weeks (or during the period of employment if less than 52 weeks), but not to exceed 40 hours per week. This does not include commissions, bonuses, overtime, incentive pay or any other extra Compensation.

18.8 Definition of Other Sources of Income

Other sources of income include income from retirement/Government plans, other group disability plans, salary continuance/sick leave, settlement on payment received, and no-fault benefits.

18.9 When the Classification or the Amount of Coverage Changes

Any change in the Employee's classification, coverage or amount of the coverage will take effect on the first day of the Plan month which follows day of the change, provided the Employee is actively working on that day. If the Employee is not actively working on the day of the change, the following conditions will apply:

- If the change involves an increase in the amount of coverage, the change will not take effect until the first day of the Plan month which follows day the Employee returns to active work.
- If the change involves a decrease in the amount of coverage, the change will take effect on the day of the change. In no event will any change take effect during a period of Disability.

18.10 When Coverage Ends

See Section 6.

Section 19 - Long-Term Disability (LTD)

19.1 This long-term disability section describes the benefits a Participant is entitled to receive, subject to all of the other provisions for the Plan Document. Contact the Contract Administrator - Long-Term Disability with questions.

19.2 Description of Eligible Classes

All exempt salaried Employees who have meet the eligibility criteria as described in Section 3. Premiums are paid by Plan Sponsor.

19.3 Minimum Work Hours Required

30 hours per week.

19.4 Elimination Period

The Elimination Period is a period of 90 consecutive days of Total Disability for which no benefit is payable and during which the Person does not become eligible for any other group long term disability insurance.

19.5 Monthly Benefit

If the Employee is Disabled and earning less than 20% of basic monthly earnings, the monthly benefit while Disabled is the lesser of:

A. 67% of the Employee's basic monthly earnings, less other income sources; or

B. The maximum monthly benefit, less any other income sources.

- Maximum Monthly Benefit: $15,000
- Minimum Monthly Benefit: $100/10%

Maximum Benefit Period: Social Security Full Retirement Age

Section 20 – Group Term Life and Accidental Death & Dismemberment (AD&D)

20.1 This group term life benefits section describes the benefits a Participant is entitled to receive, subject to all of the other provisions for the Plan Document. Contact the Contract Administrator – Group Term Life & AD&D with questions.

20.2 Eligibility

The Employee must be performing the normal duties of the Employee's regular job for the Employer on a regular and continuous basis 12 or more hours each week to be eligible for insurance.

20.3 When Insurance Begins

An Eligible Employee will become insured on the first day of the month that follows the day the Employee becomes eligible, subject to certain conditions.

20.4 Description of Eligible Classes and Amount of Coverage

Class 1 - All Eligible Executives, District Managers, Directors, and Store Managers	$15,000
Class 2 - All Other Eligible Employees	$12,500

The Employee's amount of AD&D insurance is equal to the amount of life insurance.

20.5 Benefit Reduction(s)

As the Employee grows older, the amount of life and AD&D insurance for will be reduced according to the following schedule:

At the age of:	The original amount of insurance will reduce to:
70	50%
75	30%
80	20%

20.6 Accelerated Life Benefit

The Employee may request payment of up to 80% of the Life Amount if the Employee is diagnosed with a terminal condition, as defined by the Contract Administrator.

Section 21 – Cafeteria Plan - Flexible Benefits Plan Introduction

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

21.1 Eligibility - Refer to Section 2 for Eligibility and Section 4 for Change of Status

21.2 Contributions to the Plan

21.2.1 Salary Redirection

Benefits under the Plan shall be financed by Salary Redirections sufficient to support benefits that a Participant has elected hereunder and to pay the Participant's Premiums. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his/her pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under 21.3.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 21.4.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under 21.4 of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of the Plan and incorporated by reference hereunder.

21.2.2 Application of Contributions

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the benefits elected by the affected Participants. Any contribution made or withheld for the Health Care Flexible Spending Arrangement or Day Care Flexible Spending Arrangement shall be credited to such fund or account. Amounts designated for the Participant's Premium Conversion Benefit shall likewise be credited to such account for the purpose of paying Premiums.

21.2.3 Periodic Contributions

Notwithstanding the requirement provided above and in other sections of the Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Care Flexible Spending Arrangement, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

21.3 Benefits

21.3.1 Benefit Options

Each Participant may elect any one or more of the following optional benefits:

A. Health Care Flexible Spending Arrangement;
B. Day Care Flexible Spending Arrangement

In addition, each Participant shall have a sufficient portion of his/her Salary Redirections applied to the following benefits unless the Participant elects not to receive such benefits:

A. Health insurance benefit;
B. Dental insurance benefit;
C. Vision insurance benefit

21.3.2 Health Care Flexible Spending Arrangement Benefit

Each Participant may elect to participate in the Health Care Flexible Spending Arrangement option, in which case 21.5 shall apply.

21.3.3 Day Care Flexible Spending Arrangement Benefit

Each Participant may elect to participate in the Day Care Flexible Spending Arrangement option, in which case 21.6 shall apply.

21.3.4 Health Insurance Benefit

A. Coverage for Participant and Dependents. Each Participant may elect to be covered under a health Contract for the Participant, his/her spouse, and his/her Dependent(s).
B. Employer selects contracts. The Employer may select suitable health contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this benefit.
C. Contract incorporated by reference. The rights and conditions with respect to the benefits payable from such health contract shall be determined therefrom, and such contract shall be incorporated herein by reference.

21.3.5 Dental Insurance Benefit

A. Coverage for Participant and/or Dependents. Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.
B. Employer selects contracts. The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this benefit.
C. Contract incorporated by reference. The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

21.3.6 Vision Insurance Benefit

A. Coverage for Participant and/or Dependents. Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.
B. Employer selects contracts. The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this benefit.
C. Contract incorporated by reference. The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

21.3.7 Nondiscrimination Requirements

A. Intent to be nondiscriminatory. It is the intent of the Plan to provide benefits to a classification of Employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.
B. 25% concentration test. It is the intent of the Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.
C. Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of Employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. With respect to

any affected Participant who has had benefits reduced pursuant to this section, the Plan Administrator will adjust in as non-discriminatory way possible that will correct said Plan failure as they see fit. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

21.4 Participant Elections

21.4.1 Initial Elections

An Employee who meets the eligibility requirements of Section 21.1 on the first day of, or during, a Plan Year may elect to participate in the Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his/her effective date of participation pursuant to Section 21.1. Notwithstanding the foregoing, an Employee who is eligible to participate in the Plan and who is covered by the Employer's insured or self-funded benefits under the Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

21.4.2 Subsequent Annual Elections

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which spending account Benefit Options he/she wishes to select. Any such election shall be effective for any benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

A. A Participant or Employee who failed to initially elect to participate may elect different or new benefits under the Plan during the Election Period;
B. A Participant may terminate his/her participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year;
C. An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 21.4.4.

21.4.3 Failure to Elect

With regard to benefits available under the Plan for which no Premiums apply, any Participant who fails to complete a new benefit election form pursuant to Section 21.4.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such benefits.

With regard to benefits available under the Plan for which Premiums apply, any Participant who fails to complete a new benefit election form pursuant to Section 21.4.2 by the end of the applicable Election Period shall be deemed to have made the same benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit Options.

21.4.4 Cost Changes

A. Cost increase or decrease. If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage. A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

B. Loss of coverage. If the coverage under a benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

C. Addition of a new benefit. If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

D. Loss of coverage under certain other plans. A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

E. Change of coverage due to change under certain other plans. A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a spouse's, former spouse's or Dependent's employer if (1) the Cafeteria Plan or other benefits plan of the spouse's, former spouse's or Dependent's employer permits its participants to make a change; or (2) the Cafeteria Plan permits participants to make an election for a period of coverage that is different from the period of coverage under the Cafeteria Plan of a spouse's, former spouse's or Dependent's employer.

F. Change in Day Care Provider. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the day care Provider. The availability of day care services from a new childcare Provider is similar to a new benefit package option becoming available. A cost change is allowable in the Day Care Flexible Spending Arrangement only if the cost change is imposed by a day care Provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

G. Health FSA cannot change due to insurance change. A Participant shall not be permitted to change an election to the Health Care Flexible Spending Arrangement as a result of a cost or coverage change under any health insurance benefits.

H. Changes due to reduction in hours or enrollment in an Exchange Plan. A Participant may prospectively revoke coverage under the group health plan (that is not a Health Care Flexible Spending 10 Arrangement) which provides minimum essential coverage (as defined in Code §5000A(f)(1)) provided the following conditions are met: Conditions for revocation due to reduction in hours of service:

   1. The Participant has been reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and
   2. The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

   The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another

plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a qualified health plan:

1. The Participant is eligible for a Special Enrollment Period to enroll in a qualified health plan through a marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a qualified health plan through a marketplace during the marketplace's annual Open Enrollment period; and
2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a qualified health plan through a marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

   The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a qualified health plan through a marketplace that the Participant and related individuals have enrolled or intend to enroll in a qualified health plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

21.5 Health Care Flexible Spending Arrangement

21.5.1 Establishment of Plan

This Health Care Flexible Spending Arrangement is intended to qualify as a medical reimbursement Plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Care Flexible Spending Arrangement may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Care Flexible Spending Arrangement. Periodic payments reimbursing Participants from the Health Care Flexible Spending Arrangement shall in no event occur less frequently than monthly.

21.5.2 Definitions

For the purposes of this article and the Cafeteria Plan, the terms below have the following meaning:

A. "Health Care Flexible Spending Arrangement" means the account established for Participants pursuant to the Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his/her spouse and his/her Dependent(s) may be reimbursed.

B. "Highly Compensated Participant" means, for the purposes of this Article and determining discrimination under Code Section 105(h), a Participant who is:
   1. One of the 5 highest paid officers;
   2. A shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
   3. Among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

C. "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his/her tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his/her and his/her Dependent(s). "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care. A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin. A Participant may not be reimbursed for the cost of other health coverage such as Premiums paid

under plans maintained by the employer of the Participant's spouse or individual policies maintained by the Participant or his/her spouse or Dependent. A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

D. The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Flexible Spending Arrangement.

21.5.3 Forfeitures

The amount in the Health Care Flexible Spending Arrangement as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 21.5.7 hereof, excluding any carryover) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 21.7.2.

21.5.4 Limitation on Allocations

A. Notwithstanding any provision contained in this Health Care Flexible Spending Arrangement to the contrary, the maximum amount that may be allocated to the Health Care Flexible Spending Arrangement by a Participant in or on account of any Plan Year is $2,000.

B. Participation in Other Plans. All Employers that are treated as a single Employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single Employer for purposes of the statutory limit. If a Participant participates in multiple Cafeteria Plans offering Health Care Flexible Spending Arrangements maintained by members of a controlled group or affiliated service group, the Participant's total Health Care Flexible Spending Arrangement contributions under all of the Cafeteria Plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more Employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Care Flexible Spending Arrangement.

C. Carryover. A Participant in the Health Care Flexible Spending Arrangement may roll over up to $500 of unused amounts in the Health Care Flexible Spending Arrangement remaining at the end of one Plan Year to the immediately following Plan Year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of Salary Redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the runout period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess of $500 will be forfeited. The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts.

21.5.5 Nondiscrimination Requirements

A. Intent to be nondiscriminatory. It is the intent of this Health Care Flexible Spending Arrangement not to discriminate in violation of the Code and the Treasury regulations thereunder.

B. Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination under this Health Care Flexible Spending Arrangement, it may, but shall not be required to, reject any elections or reduce contributions or benefits in order to assure compliance with this section. Any act taken by the Administrator under this section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or benefits, it shall be done in the following manner. First, the benefits designated for the Health Care Flexible Spending Arrangement by the Participant of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next Participant of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Care Flexible Spending Arrangement for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this section or the Code are satisfied. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

21.5.6 Coordination with Cafeteria Plan

All Participants under the Cafeteria Plan are eligible to receive benefits under this Health Care Flexible Spending Arrangement. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Care Flexible Spending Arrangement. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

21.5.7 Health Care Flexible Spending Arrangement Claims

A. Expenses must be incurred during Plan Year. All Medical Expenses incurred by a Participant, his/her spouse and his/her Dependent(s) during the Plan Year shall be reimbursed during the Plan Year subject to Section 6, even though the submission of such a claim occurs after his/her participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

B. Reimbursement available throughout Plan Year. The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Flexible Spending Arrangement for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his/her spouse or Dependent(s).

C. Payments. Reimbursement payments under the Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service Provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third-party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care Flexible Spending Arrangement, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

D. Claims for reimbursement. Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

21.5.8 Debit and Credit Cards

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

A. Card only for medical expenses. Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits;

B. Card issuance. Such card shall be issued upon the Participant's effective date of participation and reloaded for each Plan Year the Participant remains a Participant in the Health Care Flexible Spending Arrangement. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Care Flexible Spending Arrangement;

C. Maximum dollar amount available. The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 21.5.4;

D. Only available for use with certain service Providers. The cards shall only be accepted by such merchants and service Providers as have been approved by the Administrator following IRS guidelines;

E. Card use. The cards shall only be used for Medical Expense purchases at these Providers, including, but not limited to, the following:
   1. Copayments for doctor and other medical care;
   2. Purchase of drugs prescribed by a health care Provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;
   3. Purchase of medical items such as eyeglasses, syringes, crutches, etc.

F. Substantiation. Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service Provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation;

G. Correction methods. If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.
   1. Repayment of the improper amount by the Participant;
   2. Withholding the improper payment from the Participant's wages or other Compensation to the extent consistent with applicable federal or state law;
   3. Claims substitution or offset of future claims until the amount is repaid; and
   4. If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

21.6 Day Care Flexible Spending Arrangement

21.6.1 Establishment of Account

This Day Care Flexible Spending Arrangement is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Day Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Day Care Flexible Spending Arrangement.

21.6.2 Definitions For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

A. "Day Care Flexible Spending Arrangement" means the account established for a Participant pursuant to this Article to which part of his/her Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Day Care Expenses of the Participant may be reimbursed for the care of the qualifying Dependent(s) of Participants;

B. "Earned Income" means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for day care assistance to the Participant;

C. "Employment-Related Day Care Expenses" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependent(s) with respect to such Participant. Employment-Related Day Care Expenses are treated as having been incurred when the Participant's Qualifying Dependent(s) are provided with the day care that gives rise to the Employment-Related Day Care Expenses, not when the Participant is formally billed or charged for, or pays for the day care. The determination of whether an amount qualifies as an Employment-Related Day Care Expense shall be made subject to the following rules:
   1. If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Day Care Expenses only if incurred for a Qualifying Dependent as defined in Section 21.6.2(D)(1) (or deemed to be, as described in Section 21.6.2(D)(1)

pursuant to Section 21.6.2(D)(3)), or for a Qualifying Dependent as defined in Section 21.6.2(D)(2) (or deemed to be, as described in Section 21.6.2(D)(2) pursuant to Section 21.6.2(D)(3)) who regularly spends at least 8 hours per day in the Participant's household;

2. If the expense is incurred outside the Participant's home at a Facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the Facility, the Facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and
3. Employment-Related Day Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's spouse.

D. "Qualifying Dependent" means, for Day Care Flexible Spending Arrangement purposes,

1. A Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;
2. A Dependent or the spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or
3. A child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5). The definitions of the Plan Document are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Day Care Flexible Spending Arrangement.

21.6.3 Day Care Flexible Spending Arrangements

The Administrator shall establish a Day Care Flexible Spending Arrangement for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Day Care Flexible Spending Arrangement benefits.

21.6.4 Increases in Day Care Flexible Spending Arrangements

A Participant's Day Care Flexible Spending Arrangement shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his/her Day Care Flexible Spending Arrangement pursuant to elections made under 21.5 hereof.

21.6.5 Decreases in Day Care Flexible Spending Arrangements

A Participant's Day Care Flexible Spending Arrangement shall be reduced by the amount of any Employment-Related Day Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 21.6.12 hereof.

21.6.6 Allowable Day Care Reimbursement

Subject to limitations contained in Section 21.6.9 of this program, and to the extent of the amount contained in the Participant's Day Care Flexible Spending Arrangement, a Participant who incurs Employment-Related Day Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

21.6.7 Annual Statement of Benefits

On or before January 31st of each Calendar Year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 21.6.6 during the prior Calendar Year, a statement of all such benefits paid to or on behalf of such Participant during the prior Calendar Year. This statement is set forth on the Participant's Form W-2.

21.6.8 Forfeitures

The amount in a Participant's Day Care Flexible Spending Arrangement as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 21.6.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

21.6.9 Limitation on Payments

A. **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Day Care Flexible Spending Arrangement in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

21.6.10 Nondiscrimination Requirements

A. Intent to be nondiscriminatory. It is the intent of this Day Care Flexible Spending Arrangement that contributions or benefits not discriminate in favor of the group of Employees in whose favor discrimination may not occur under Code Section 129(d).

B. 25% test for shareholders. It is the intent of this Day Care Flexible Spending Arrangement that not more than 25 percent of the amounts paid by the Employer for Day Care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

C. Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of Employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this section. Any act taken by the Administrator under this section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the benefits designated for the Day Care Flexible Spending Arrangement by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Day Care Flexible Spending Arrangement for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this section are satisfied. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

21.6.11 Coordination with Cafeteria Plan

All Participants under the Cafeteria Plan are eligible to receive benefits under this Day Care Flexible Spending Arrangement. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Day Care Flexible Spending Arrangement. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

21.6.12 Day Care Flexible Spending Arrangement Claims

The Administrator shall direct the payment of all such day care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service Provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third-party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this program for Employment-Related Day Care Expenses submit a statement which may contain some or all of the following information:

A. The Dependent or Dependents for whom the services were performed;

B. The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

C. The relationship, if any, of the person performing the services to the Participant;

D. If the services are being performed by a child of the Participant, the age of the child;

E. A statement as to where the services were performed;

F. If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

G. If the services were being performed in a day care center, a statement:

1. That the day care center complies with all applicable laws and regulations of the state of residence,
2. That the day care center provides care for more than 6 individuals (other than individuals residing at the center), and
3. The amount of fee paid to the Provider.

H. If the Participant is married, a statement containing the following:
1. The spouse's salary or wages if he or she is employed, or if the Participant's spouse is not employed, that
2. He or she is incapacitated, or
3. He or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

I. **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

21.7 Benefits and Rights

21.7.1 Claim for Benefits

A. Insurance claims. Any claim for benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

B. Health and Day Care Flexible Spending Arrangement Claims. The Participant must submit all claims no later than 90 days after the end of the Plan Year. Any claims submitted after that time will not be considered. If a claim under the Plan is denied in whole or in part, the Participant will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. A level one appeal must be submitted within 180 days of receipt of the denial. Any such request should be accompanied by documents or records in support of the appeal. The Participant may review pertinent documents and submit issues and comments in writing. The Contract Administrator will review the claim and provide, within 30 days, a written response to the appeal (extended by reasonable time if necessary). In this response, the Contract Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. If the Participant disagrees with the level one appeal decision, the Participant may submit a request for a level two appeal to be determined by the Employer. The Participant must submit the request for a level two appeal within 60 days of receipt of the level one notice. The Participant will be notified within 30 days after the Employer received the appeal (extended by reasonable time if necessary). The Employer has the exclusive right to interpret the appropriate Plan provisions. Decisions of the Employer are conclusive and binding.

The following timetable for claims applies:

- Notification of whether claim is accepted or denied: 30 days;
- Extension due to matters beyond the control of the Plan: 15 days;
- Denial or insufficient information on the claim: notification of 15 days;
- Response by Participant: 45 days; and
- Review of claim denial: 30 days.

The Participant must file the appeal by submitting a written request by email, fax, or mail to the Contract Administrator and indicate either level one or two on the email, fax, or letter. The response will provide written or electronic notification of any claim denial. The notice will state:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provisions on which the denial was based;
3. A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review;
5. 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 claim; and
6. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the Participant upon request. When the Participant receives a denial, the Participant will have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the claim. If the Participant requests, the Participant will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

   The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

1. Was relied upon in making the claim determination;
2. Was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
3. Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan Documents and Plan provisions have been applied consistently with respect to all Participants; or
4. Constituted a statement of policy or guidance with respect to the Plan concerning the denied claim;
5. The review will take 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 the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a Fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

C. Forfeitures. Any balance remaining in the Participant's Health Care Flexible Spending Arrangement (excluding any carryover) or Day Care Flexible Spending Arrangement as of the end of the time for claims reimbursement for each Plan Year and Grace Period (if applicable) shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 21.5.3 or Section 21.6.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his/her account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

21.7.2 Application of Benefit Plan Surplus

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other benefit available under the Plan (excepting any carryover); nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

21.7.3 Named Fiduciary

The Administrator shall be the named Fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

21.7.4 General Fiduciary Responsibilities

The Administrator and any other Fiduciary under ERISA shall discharge their duties with respect to the Plan solely in the interest of the Participants and their beneficiaries and:

A. For the exclusive purpose of providing benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;
B. With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and (c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

21.7.5 Nonalientation of Benefits

No benefit, right or interest of any Participant under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy upon, or otherwise dispose of any right to benefits payable hereunder or legal causes of action, shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by the Participant, but only as a convenience to Participants. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants under any circumstances.

21.8 Administration

21.8.1 Plan Administration

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal (in writing or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Eligible Employees entitled to participate in the Plan in accordance with the terms of the Act, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the

Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by the Plan:

A. To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
B. To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
C. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
D. To reject elections or to limit contributions or benefits for certain highly compensated Participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;
E. To provide Eligible Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;
F. To keep and maintain the Plan Documents and all other records pertaining to and necessary for the administration of the Plan;
G. To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;
H. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and
I. To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

21.8.2 Examination of Records

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

21.8.3 Payment of Expenses

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensate Employees.

21.8.4 Insurance Control Clause

In the event of a conflict between the terms of the Plan and the terms of an Insurance Contract of an independent third-party Insurer whose product is then being used in conjunction with the Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

21.8.5 Indemnification of Administrator

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such

committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

21.9 Amendment or Termination of Plan

21.9.1 Amendment

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with federal, state or local laws, statutes or regulations.

21.9.2 Termination

The Employer reserves the right to terminate the Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Contract shall be paid in accordance with the terms of the Contract. No further additions shall be made to the Health Care Flexible Spending Arrangement or Day Care Flexible Spending Arrangement, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

21.10 Miscellaneous

21.10.1 Plan Interpretation

All provisions of the Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. The Plan shall be read in its entirety and not severed except as provided in Section 21.10.11.

21.10.2 Gender and Number

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

21.10.3 Written Document

The Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to Cafeteria Plans.

21.10.4 Exclusive Benefit

The Plan shall be maintained for the exclusive benefit of the Eligible Employees who participate in the Plan.

21.10.5 Participant's Rights

The Plan shall not be deemed to constitute an employment contract between the Employer and any Employee or to be a consideration or an inducement for the employment of any Employee. Nothing contained in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time regardless of the effect which such discharge shall have upon the Employee as a Participant of the Plan.

21.10.6 Action by the Employer

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

21.10.7 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under the Plan shall be legally enforceable.

21.10.8 Indemnification of Employer by Participants

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such Compensation, less any such additional income and Social Security tax actually paid by the Participant.

21.10.9 Funding

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

21.10.10 Governing Law

The Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by the Plan. To the extent not preempted by federal law, the provisions of the Plan shall be construed, enforced and administered according to the laws of the State of Idaho.

21.10.11 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

21.10.12 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

21.11 Other

21.11.1 Annual Contribution Limits

Annual contribution limits for Health Care Flexible Spending Arrangement and Day Care Flexible Spending Arrangement are defined by the IRS and set by the Employer.

21.11.2 Claims Processing and Reimbursement

A. Section 21.6.7 provides details on Health Care Flexible Spending Arrangement claims processing. Reimbursements can be submitted to the Contract Administrator by mail, by fax, or online. A debit card is available which is described in Section 21.6.8.
B. Section 21.7.12 for details on Day Care Flexible Spending Arrangement claims processing. Reimbursements can be submitted to the Contract Administrator by mail, by fax, or online.

Section 22 – Other Benefits

22.1 Employee Assistance Program (EAP)

The EAP provides assistance with personal and job-related issues such as emotional well-being, family and relationship, legal and financial, healthy lifestyles, substance abuse, and more. Contact the Contract Administrator - EAP with questions.

22.1.1 Eligibility

All Employees and eligible Dependent(s). Premiums are paid by Plan Sponsor.

22.1.2 Benefits

- Unlimited telephone access to professionals 24 hour a day, seven days a week.
- Telephone assistance and referral.
- Three (3) face-to-face sessions with a counselor (per person per Calendar Year).

22.1.3 Contact Information

The contact information for the EAP is on the Plan Information and Contract Administrator page.

22.2 Travel Insurance

22.2.1 This travel insurance section describes the benefits an Employee is entitled to receive, subject to all of the other provisions for the Plan Document. Contact the Contract Administrator – Travel Insurance with questions.

22.2.2 Eligibility

All Employees and eligible Dependent(s). Premiums are paid by Plan Sponsor.

22.2.3 Description of Eligible Classes

Class 1: President and Chairman of the Board

Class 2: Other active, full-time Corporate Offices not in Class 1

Class 3: Active, full-time Supervisory Personnel not in Class 1 or 2

Class 4: Other active, full-time employees excluding truck drivers and delivery personnel not in Class 1, 2, or 3.

22.2.4 Benefits

Insurance to protect employees and their spouses while traveling on business for the Employer.

22.3 Voluntary Benefits

In addition to the benefits listed previously, the Employer offers a selection of voluntary benefits. These voluntary benefits are 100% Employee paid and are not considered Employer sponsored benefits. The Employer's responsibility with respect to these voluntary benefits is limited to making communications available and taking and remitting payroll deductions for those Eligible Employees who choose to participate. For more details about the current offering of voluntary benefits, contact the Benefits Department.

Section 23 – Claims and Appeals

23.1 Claims Inquiry

For any initial questions concerning a claim, a Participant should call or write the Contract Administrators' customer services department, whose address and phone numbers are listed on the Explanation of Benefits (EOB) form and on the back of the identification card, if applicable, and listed under Plan Information and Contract Administrators.

23.2 Formal Appeal Process - Medical

If the Participant or the Participant's Representative (any Representative authorized by the Participant) has a concern regarding a claim denial or other action under the Plan and wishes to have it reviewed, the Participant may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels the Participant may pursue. Certain matters requiring quicker consideration qualify for a level of expedited Appeal and are described separately later in this section. Please note that appeals for dialysis services need to be made directly to the Plan if related to benefits, and appeals for dialysis payment needs to be made directly to the Dialysis Cost Containment Program Administrator.

23.2.1 Appeals

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Contract Administrator. Verbal requests can be made by calling the Contract Administrator.

Each level of Appeal, except voluntary external review, must be pursued within 180 days of the Participant's receipt of the Contract Administrator's determination (or, in the case of the first level, within 180 days of the Participant's receipt of the Contract Administrator's original adverse decision that the Participant is Appealing). The Participant, or the Participant's Representative on the Participant's behalf, will be given a reasonable opportunity to provide written materials. If the Participant does not Appeal within this time period, the Participant will not be able to continue to pursue the Appeal process and may jeopardize the Participant's ability to pursue the matter in any forum.

If the Participant's health could be jeopardized by waiting for a decision under the regular Appeal process, an expedited Appeal may be requested. Please see Expedited Appeals later in this section for more information.

A. First-level Appeals

First-level Appeals are reviewed by a Contract Administrator employee(s) who was not involved in the initial decision that the Participant is Appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Contract Administrator's staff of health care professionals. For Post-service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-service Pre-authorization of a procedure, the Contract Administrator will send a written notice of the decision within 15 days of receipt of the Appeal.

B. Second-Level Appeals

Second-level Appeals are reviewed by a Contract Administrator employee(s) who was not involved in, or subordinate to anyone involved in, the initial or the first-level decision. For Post-service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-service Pre-authorization of a procedure, the Contract Administrator will send a written notice of the decision within 15 days of receipt of the Appeal.

23.2.2 Voluntary External Appeal - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available for issues involving medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or the determination that a treatment is Investigational), but only after the Participant has exhausted all of the applicable non-voluntary levels of Appeal, or if the Contract Administrator has failed to adhere to all

claims and internal Appeal requirements. Voluntary External Appeals must be requested within four months of the Participant's receipt of the notice of the prior adverse decision.

The Contract Administrator coordinates voluntary external Appeals, but the decision is made by an IRO at no cost to the Participant. The Contract Administrator will provide the IRO with the Appeal documentation. The IRO will make its decision and provide the Participant with its written determination within 45 days after their receipt of the request. Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section, except to the extent other remedies are available under State or Federal law.

The voluntary external Appeal by an IRO is optional, and the Participant should know that other forums may be utilized as the final level of Appeal to resolve a dispute the Participant has under the Plan. This includes, but is not limited to, civil action under Section 502(a) of ERISA, where applicable.

23.2.3 Expedited Appeals

An expedited Appeal is available if one of the following applies:

- the application of regular Appeal time frames on a Pre-service or concurrent care claim could jeopardize the Participant's life, health or ability to regain maximum function; or
- according to a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the disputed care or treatment.

A. First-Level Expedited Appeal

The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level expedited Appeals are reviewed by the Contract Administrator's staff of healthcare professionals who were not involved in, or subordinate to anyone involved in, the initial denial determination. A verbal notice of the decision will be provided to the Participant and the Participant's Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. A written notification of the decision will be mailed to the Participant within three calendar days of the verbal notification.

B. Voluntary Expedited External Appeal - IRO

If the Participant disagrees with the decision made in the first-level expedited Appeal and the Participant or the Participant's Representative reasonably believes that Pre-authorization remains clinically urgent (Pre-service or concurrent), the Participant may request a voluntary expedited external Appeal to an IRO. The criteria for a voluntary expedited external Appeal to an IRO are the same as described above for voluntary external Appeal.

The Contract Administrator coordinates voluntary expedited external Appeals, but the decision is made by an IRO at no cost to the Participant. The Contract Administrator will provide the IRO with the Appeal documentation. Verbal notice of the IRO's decision will be provided to the Participant and the Participant's Representative by the IRO as soon as possible after the decision, but no later than within 72 hours of its receipt of the Participant's request, followed by written notification within 48 hours of the verbal notification. Choosing the voluntary expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section.

The voluntary expedited Appeal by an IRO is optional, and the Participant should know that other forums may be used as the final level of expedited Appeal to resolve a dispute the Participant has under the Plan, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

23.2.4 Information

If the Participant has any questions about the Appeal Process outlined here, the Participant may contact the Contract Administrator's Customer Service department by phone, mail or fax.

23.2.5 Definitions Specific To The Appeal Process

A. Appeal means a written or verbal request from a Participant or, if authorized by the Participant, the Participant's Representative, to change a previous decision made under the Plan concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a Participant and the Plan; and
- other matters as specifically required by state law or regulation.

B. Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary external Appeals and voluntary expedited Appeals, through an independent contractor relationship with the Contract Administrator and/or through assignment to the Contract Administrator via state regulatory requirements. The IRO is unbiased and is not controlled by the Contract Administrator.

C. Post-service means any claim for benefits under the Plan that is not considered Pre-service.

D. Pre-service means any claim for benefits under the Plan which must be approved in advance, in whole or in part, in order for a benefit to be paid.

E. Representative means someone who represents the Participant for the purpose of the Appeal. The Representative may be an attorney, the Participant's authorized Representative or a treating Provider. It may also be another party, such as a family member, as long as the Participant or the Participant's legal guardian authorize in writing, disclosure of personal information for the purpose of the Appeal. No authorization is required from the parent(s) or legal guardian of a Participant who is an unmarried and Dependent child and is less than 13 years old. For expedited Appeals only, a health care professional with knowledge of the Participant's medical condition is recognized as the Participant's Representative. Even if the Participant has previously designated a person as the Participant's Representative for a previous matter, an authorization designating that person as the Participant's Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to the Participant or the Participant's treating Provider only.

23.3 Formal Appeal Process – Prescription

The Contract Administrator's appeal process applies to both clinical and administrative denials. The process consists of a single level of internal review and a second level external review for clinical (Adverse Benefit Determinations) appeals and a single level of internal reviews for administrative (benefit denials) appeals.

23.3.1 Clinical Appeals Overview

A. The Contract Administrator has two levels of appeals for adverse benefits determinations included in its appeal process. The level one process described below applies to appeal requests received by the Contract Administrator for which the Contract Administrator is delegated. The second level review is provided by an external independent review organization contracted to the Contract Administrator.

B. Clinical Appeals may be required verbally or in writing. Upon receipt of a verbal appeal, the Participant/Participant's representative is encouraged to complete the Contract Administrator's Appeal/Grievance Form ("Form") and an offer is made to fax the Form to the Participant/Participant's representative. If the Participant/Participant's representative declines to complete the Form and/or the appeal is submitted in writing, the Form is completed by the Contract Administrator Appeals Coordinator.

C. A Participant/Participant's representative may request an expedited review of a clinical appeal. These requests may be reviewed by a Clinical Pharmacist Reviewer to determinate if the criteria for processing the appeal in an accelerated timeframe have been met. However, it is the Contract Administrator's general business practice to accept requests to expedite as expedited. If the expedited appeal criteria have not been met, the Appeals Coordinator notifies the Participant/Participant's representative by telephone within 24 hours of receipt on the request that the appeal will be processed as a standard appeal.

D. If additional information is required to make the appeal determination, the Contract Administrator contacts the Participant/Participant's representative, as appropriate, within the appropriate time frames for standard and expedited appeals to request the required information.

E. Upon receipt of all information necessary to make a determination, the appeal request is reviewed by a Clinical Pharmacist Reviewer using the client approved appropriate medical criteria and clinical guidelines. The Clinical Pharmacist Reviewer was not involved in the initial decision and is not the subordinate of the individuals who make the initial decisions. All denial of the clinical appeals are rendered by a Clinical Pharmacist Reviewer unless otherwise performed by clients.

23.3.2 Turnaround Time and Notification Requirements for Level One Standard Clinical Appeals

A. Level one standard clinical appeal determinations are made and the Participant/Participant's representative is notified of the determination as soon as possible, but not later than 15 calendar days from the date of receipt of the Pre-service standard appeal request of 30 calendar days from the date of receipt of the Post-service appeal request.

B. An acknowledgement letter is sent to the Participant/Participant's representative, within five (5) business days of receipt of the appeal request. The acknowledgement letter includes the following information:

1. The date the Contract Administrator received the appeal request;
2. The name of the prescribed drug;
3. The prescribing Professionals or other healthcare Provider;
4. Timeframe in which the Contract Administrator expects the determination to be made; and
5. The appeal contact phone number.

C. If additional information is required to make the appeal determination, the Participant/Participant's representative is contacted by telephone as soon as possible, but not later than five (5) business days after receipt of the request, and informed of the specific information needed. The Participant/Participant's representative may request the notification of additional information to be sent in writing. The Participant/Participant's representative has the opportunity to submit additional documents, records or other information relating to the appeal within four (4) days of receipt of the notice for request of additional information. If the requested information is not received by the Contract Administrator within the designated timeframe, the appeal is reviewed using the information previously submitted and available to the Contract Administrator.

D. Written notification of the appeal determination is sent by U.S. mail to the Participant/Participant's representative within two (2) business days of making the determination but not later than 15 calendar days after receipt of the Pre-service standard appeal request or 30 calendar days after date of receipt of a Post-service appeal. If the appeal determination upholds the initial Adverse Benefit Determination, the notification includes the following:

1. The decision and specific reason for the Adverse Benefit Determination in clear terms;
2. A general description of the reason for the request for appeal, including information sufficient to identify the claim (including the date or dates of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning (if applicable), the treatment code and its corresponding meaning (if applicable), and the reason for the previous denial;
3. The date that appeal was received and the date of the decision;
4. References to the evidence or documentation, including the specific coverage provision and evidence-based standards, considered in reaching its decision;
5. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
6. A statement that describes how to request an external review; and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.
8. Notices will be available on request of the health plan Participant in the non-English threshold language as defined by PPACA and based on information provided by the Contract Administrator's client.

a. The notification is produced in the non-English threshold language as identified by the client and provided to the Contract Administrator.
b. English letters include statements in the identified non-English threshold languages indicating the availability of a translated notification.

E. If there are special circumstances in which additional time is required to conduct a thorough review and investigation of the appeal request, the Contract Administrator may extend the timeframe to make an appeal determination for up to an additional 15 calendar days. In these circumstances, the Contract Administrator provides written notice of the extension to Participant/Participant's representative prior to the end of the expiration of the initial time period within which to render an appeal determination. The notice of extension to the Participant/Participant's representative shall indicate the special circumstances requiring an extension of time and the date by which the Contract Administrator expects to render the appeal determination.

23.3.3 Turnaround Time and Notification Requirements for Level One Expedited Appeals

A. Expedited clinical appeal determinations are made and the Participant/Participant's representative is notified of the determination as soon as possible, but not later than 72 hours from the date/time of receipt of expedited appeal request.

B. For expedited appeals submitted verbally, confirmation of the appeal request is provided at the time the request is made by the Participant/Participant's representative and is considered acknowledgement of the expedited appeal.

   For expedited appeals submitted in writing, the Participant/Participant's representative is contacted via telephone within 24 hours of receipt of the request to review the appeal request with the Participant/Participant's representative and to verify the relevant information. A written acknowledgement is submitted to the Participant/Participant's representative either by fax or mail, upon request.

C. If additional information is required to make the appeal determination, the Participant/Participant's representative is contacted via telephone and informed of the specific information needed as soon as possible, but not later than 24 hours after receipt of the request. The Participant/Participant's representative may request the notification of the additional information to be sent in writing. The Participant/Participant's representative has the opportunity to submit additional documents, records or other information relating to the appeal via fax, telephone, or other expeditious method within 48 hours of receipt of the notice of request of additional information. If the request information is not received by the Contract Administrator within the designated timeframe, the appeal is reviewed using the information previously submitted and available to the Contract Administrator.

D. Once the level one expedited clinical appeal determination has been made, the Clinical Pharmacist Reviewer, or designee immediately communicates the determination by telephone or fax to the Participant/Participant's representative. Written notification of the expedited appeal determination is mailed to the Participant/Participant's representative by first class mail and a copy is faxed to the health care professional, if applicable, within one (1) business day of making the level one appeal determination but not later than 72 hours after receipt of the expedited appeal. If the expedited appeal determination upholds the initial Adverse Benefit Determination, the notification is provided as described for a standard Adverse Benefit Determination.

23.3.4 Overview of Level Two Clinical Appeals

A. Level two clinical appeals may be requested when a level one clinical appeal determination upholds the initial Adverse Benefit Determination. A level two appeal may be requested verbally or in writing by the Participant/Participant's representative. Level two standard appeals must be requested within 90 days from the date the Contract Administrator issued the level one determination.

B. Requests for expedited review of clinical appeals are reviewed by a Clinical Pharmacist Reviewer to determine if the criteria for processing the appeal in an accelerated timeframe have been met. However, it is the Contract Administrator's general business practice to accept request to expedite

as expedites. If the expedited appeal criteria have not been met, the Participant/Participant's representative is notified of this by telephone and informed that the appeal will be processed a level two standard appeal.

C. The Contract Administrator may contact the Participant/Participant's representative to request additional information required to make the determination, within the appropriate timeframes for standard and expedited appeals, as appropriate.
D. All level two clinical appeals are reviewed by a designated reviewer at the Contract Administrator's contracted independent review organization (IRO). The IRO Clinical Reviewer must not have been involved in the initial decision or level one appeal determination, and is not the subordinate of the individual who made the initial decision or level one appeal determination. Upon receipt of all information necessary to make a determination, the Contract Administrator submits the appeal request and the appropriate Client approved medical criteria and clinical guidelines to the IRO for review.
E. An IRO will be selected on a rotational basis for assignment from a panel of at least three contracted IRO's. The IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

23.3.5 Turnaround Time and Notification Requirements for Level Two Standard Clinical Appeals

The assigned IRO will timely notify the Participant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Participant will submit in writing to the assigned IRO within 10 business days following the date or receipt of the notice additional information that the IRO is not required to, but may, accept and consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

Within five (5) business days after the date of assignment of the IRO, the Contract Administrator shall provide the assigned IRO the documents and any other information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination.

Upon receipt of any information submitted by the Participant, the assigned IRO must within one business day forward the information to the Contract Administrator. The Contract Administrator may reconsider its Adverse Benefit Determination or final internal benefit determination that is the subject of the external review. If the adverse determination is reversed by the Contract Administrator, the IRO must be notified within one business day and must provide written notice to the Participant and the assigned IRO. The IRO must terminate the external review upon receipt of this notice.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to information provided the IRO considers the following in reaching a decision:

- The Participant's medical records;
- The attending health care professional's recommendations;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Participant, or the Participant's treating Provider;
- The terms of the Participant's Plan to ensure that the IRO's decision is not contrary to terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable laws; and

- The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider the appropriate.

The IRO must provide written notice of the final external reviewed decision within 45 days after the IRO received the request for external reviews. The IRO must deliver the notice of final external review decision to the Participant and to the Contract Administrator.

The IRO's decision notice will contain the following:

A. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;
B. The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
C. References to the evidence or documentation, including the specific coverage provision and evidence-based standard, considered in reaching its decision;
D. A discussion of the principal reason or reasons for its decision, including the rational for its decision and any evidence-based standards that were relied on in making its decision;
E. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the Participant;
F. A statement that judicial review may be available to the Participant; and
G. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793;
    1. The notification is produced in the non-English threshold language as identified by the client and provided to the Contract Administrator.
    2. English letters include statements in the identified non-English threshold languages indicating the availability of a translated notification.

23.3.6 Turnaround Time and Notification requirements for Level Two Expedited Appeals

Upon determination that a request is eligible for external review following preliminary review, the Contract Administrator will assign an IRO as set forth in the requirements for a standard review and provide all necessary information and documents considered in making the Adverse Benefit Determination or final Adverse Benefit Determination to the assigned IRO.

The IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO will provide notice of the final external review decision as expeditiously as the Participant's condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. The notice of decision will be provided as described in the requirements for a standard review.

23.3.7 Independent Review of Clinical Appeals

A. All level two clinical appeals are reviewed by the Contract Administrator's designated IRO. Additionally, the Contract Administrator may submit a clinical appeal for independent review by the designated IRO at any point in the appeal process in order to provide additional/supporting medical review expertise or insight.
B. Independent reviews may be obtained with the approval of the Contract Administrator's Medical Director or the Director, Utilization Management and Prior Authorization Programs.
C. The services of the IRO or other independent reviewers are evaluated by the Contract Administrator's Medical Director prior to utilizing those services for independent review.
D. If an IRO is utilized during the appeal review process, the IRO is required to assign the review to a clinical peer. The clinical peer must be a Physician or other appropriate Provider who:

1. Is knowledgeable about the recommended treatment(s) through recent or current actual clinical experience treating Participants with the same or similar medical condition of the Participant; and
2. Holds an unrestricted license in a state of the United States and, for Physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the independent review.
3. Hold same state licensure for those appeals requiring the appeal determination to be rendered by a licensed professional in the same state as the Participant seeking the appeal.

23.3.8 Administrative Appeal Process Overview

A. The Contract Administrator provides one level of review for administrative appeals. Administrative appeals may be requested verbally or in writing by the Participant/Participant's representative. Upon receipt of a verbal appeal, the Participant/Participant's representative is encouraged to complete the Contract Administrator's Appeal/Grievance Form ("Form"). If the Participant/Participant's representative declines to complete the Form and/or the appeal is submitted in writing, the Appeal/Grievance Form is completed by the Contract Administrator Appeals Coordinator.

B. Requests for an expedited review of an administrative appeal are reviewed by a Clinical Pharmacist Reviewer to determine if the criteria for processing the appeal in an accelerated timeframe have been met. However, it is the Contract Administrator's business practice to accept all requests to expedite as expedited. If the expedited appeal criteria have not been met, the Participant/Participant's representative is notified by telephone and informed that the appeal will be processed as a standard appeal.

C. The Contract Administrator may contact the Participant/Participant's representative to request additional information required to make the determination, within the appropriate timeframes for standard and expedite appeals, as appropriate.

D. When an administrative appeal is received, the Appeals Coordinator notifies the Chair and/or Co-Chair of the Administrative Review Committee (ARC) and provides all relevant documentation related to the case. The Chair and/or Co-Chair convene the ARC, which reviews the administrative appeal and renders a decision. All administrative appeals are conducted by an individual(s) not involved in the initial decision and not the subordinate(s) of the individual who made the initial decision.

23.3.9 Turnaround Time and Notification Requirements for Standard Administrative Appeals

A. Standard administrative appeal determinations are made and the Participant/Participant's representative is notified of the determination as soon as possible, but not later than 15 calendar days from the date of receipt of a Pre-service appeal request, and not later than 30 calendar days from date of receipt for a Post-service appeal request.

B. An acknowledgement letter is sent to the Participant/Participant's representative, if applicable, within five (5) business days of receipt of the verbal or written standard appeal requests. The acknowledgement letter includes the following information:
   1. The date the Contract Administrator received the appeal request;
   2. The name of the prescribed drug;
   3. The prescribing Professional or other healthcare Provider;
   4. Timeframe in which the Contract Administrator expects the determination to be made; and
   5. The appeals contact phone number.

C. If additional information is required to make the appeal determination the Participant/Participant's representative is contacted by telephone as soon as possible, but not later than five (5) business days after receipt of the request, and informed of the specific information needed. The Participant/Participant's representative may request the notification of additional information to be sent in writing. The Participant/Participant's representative has the opportunity to submit additional documents, records or other information relating to the appeal via fax, telephone, or other expeditious method within 45 days of receipt of the notice for request of additional information. If the requested information is not received by the Contract Administrator within the

designated timeframe, the appeal is reviewed using the information previously submitted and available to the Contract Administrator.

D. Written notification of the appeal determination is sent by U.S. Mail to the Participant/Participant's representative within two (2) business days of making the determination, but not later than 15 calendar days from the date of receipt of a Pre-service standard appeal request and not later than 30 calendar days from the date of receipt for a Post-service appeal request. If the appeal determination upholds the initial benefit denial, the notification includes the following:
    1. The decision and specific reason for the Adverse Benefit Determination in clear terms;
    2. A general description of the reason for the request for appeal, including information sufficient to identify the claim (including the date or dates of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning (if applicable,), the treatment code and its corresponding meaning (if applicable), and the reason for the previous denial;
    3. The date that appeal was received and the date of the decision;
    4. References to the evidence or documentation, including the specific coverage provision and evidence-based standards, considered in reaching its decision;
    5. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    6. A statement that describes how to request an external review; and
    7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.
    8. Notices will be available on request of the Plan Participant in the non-English threshold language as defined by PPACA and based on information provided by the Contract Administrator's client.
        a. The notification is produced in the non-English threshold language as identified by the client and provided to the Contract Administrator.
        b. English letters include statements in the identified non-English threshold languages indicating the availability of a translated notification.

E. If there are special circumstances in which additional time is required to conduct a thorough review and investigation of the appeal request, the Contract Administrator may extend the timeframe to make an Appeal determination for up to an additional 15 calendar days. In these circumstances, the Contract Administrator provides written notice of the extension to Participant/Participant's representative prior to the end of the expiration of the initial time period within which to render an appeal determination. The notice of extension to the Participant/Participant's Representative shall indicate the special circumstances requiring an extension of time and the date by which the Contract Administrator expects to render the appeal determination.

23.3.10 Turnaround Time and Notification Requirements for Expedited Administrative Appeals

A. Expedited administrative appeal determinations are made and the Participant/Participant's representative is notified of the determination as soon as possible, but not later than 72 hours from the date/time of receipt of expedited appeal request.

B. For Expedited Appeals submitted verbally, confirmation of the appeal request is provided at the time the request is made by the Participant/Participant's representative and is considered acknowledgement of the expedited appeal.

C. For expedited appeals submitted in writing, the Participant/Participant's representative is contacted via telephone within 24 hours of receipt of the request to review the appeal request with the Participant/Participant's representative and to verify the relevant information. A written acknowledgement is submitted to the Participant/Participant's representative either by fax or mail, upon request.

D. If additional information is required to make the appeal determination, the Participant/Participant's representative is contacted via telephone and informed of the specific information needed as soon as possible, but not later than 24 hours after receipt of the request. The Participant/Participant's representative may request the notification of the additional information to be sent in writing. The Participant/Participant's representative has the opportunity to submit additional documents,

records or other information relating to the appeal via fax, telephone, or other expeditious method within 48 hours of receipt of the notice of request of additional information. If the request information is not received by the Contract Administrator within the designated timeframe, the appeal is reviewed using the information previously submitted and available to the Contract Administrator.

E. Once the expedited administrative appeal determination has been made, the Appeals Coordinator immediately communicates the determination by telephone or fax to the Participant/Participant's Representative. Notification of the expedited appeal determination is mailed to the Participant/Participant's Representative by first class mail and a copy is faxed to the Health Care Professional, if applicable, within one (1) business day of making the appeal determination. If the appeal determination upholds the initial benefit denial, the notification includes the elements described for standard appeal determination.

23.3.11 Exhaustion of the Appeal Review Process

The Contract Administrator's appeal review processes are deemed to be exhausted if:

A. The level one clinical appeal process or the administrative appeal process, as applicable, has been completed and an Appeal determination has been communicated by the Contract Administrator.

B. The Contract Administrator has failed to establish or follow established appeal procedures consistent with the requirements of 29 C.F.R § 2560.503-1 of ERISA. Participants shall be entitled to pursue any available remedies under § 502(a) or ERISA, as applicable.

C. The Contract Administrator has not issued a written appeal determination within the designated time frames set forth in the Contract Administrator's appeals policy after receipt of all information necessary to complete the appeal; or

D. The Contract Administrator and the Participant/Participant's representative have mutually agreed to waive any level of the Contract Administrator's appeal process.

23.4 Formal Appeal Process – Dental

In the event that the Contract Administrator denies a claim in whole or in part, the Participant has a right to a full and fair review. The Participant's request to review a claim must be in writing and submitted within 180 days from the Participant's receipt of the claim denial to the Contract Administrator.

The Participant may submit written comments, documents, or other information in support of the Participant's appeal. The Participant will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight. The review will be conducted by a Dental Consultant different from the original decision makers and not by a subordinate of the original decision makers and without deference to any prior decision. That Dental Consultant may either reverse the original determination and allow the appeal or find that the appeal review cannot be fully reversed.

Within 60 days after the date the Participant's request for review is received, the Participant will receive written notice of the decision. If the Contract Administrator affirms the denial of the Participant's claim, in whole or in part, the Participant will receive a notice specifying the reasons, the Plan provisions on which it is based, notice that upon request the Participant are entitled to receive free of charge reasonable access to and copies of the relevant documents, records, and information used in the claims process, and the Participant's right to file a civil action under Section 502(a) of ERISA. If an internal rule, guideline, protocol or similar criterion was relied on in deciding the Participant's claim or re-quest for review, the Participant has the right to request such information free of charge, and the denial notice will contain a statement informing the Participant of this right.

23.4.1 Authorized Representative

The Participant may authorize another person to represent the Participant and with whom the Participant wants us to communicate regarding specific claims or an appeal. The authorization must be in writing. The Participant can revoke the authorized representative at any time, and the Participant can authorize only one person as the Participant's representative at a time.

23.4.2 Deadline to Commence a Lawsuit

If the Participant files the claim within the required time, complete the entire claims procedure, and the appeal is denied, the Participant may sue over the claim (unless the Participant has executed a release of the claim). The Participant must, however, commence that suit within 30 months after the Participant knew or reasonably should have known of the facts behind the Participant's claim, or if earlier, within six (6) months after the claims procedure is complete.

23.4.3 Controlling Law

Except as they may be subject to federal law, including ERISA, any questions, claims, disputes or litigation concerning or arising from the Dental Plan will be governed by the laws of the State of Idaho.

23.5 Formal Appeal Process – Vision

If a claim is denied in whole or in part, a request may be submitted to the Contract Administrator by the Participant or the Participant's authorized representative for a full review of the denial. The Participant may designate any person, including his/her Provider, as his/her authorized representative. Reference in this section to the "Participant" includes the Participant's authorized representative where applicable.

A. Initial appeal: The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the Participant for who the claim was denied, including the Participant's name, the Participant's member identification number, the Participant's name and date of birth, the Provider of services, and the claim number. The Participant may review, during normal working hours, any documents held by the Contract Administrator pertinent to the denial. The Participant may also submit written comments or supporting documentation concerning the claim to assist in the Contract Administrator's review. The Contract Administrator's response to the initial appeal, including specific reason for the decision, shall be provided and communicated to the Participant as follows:
    1. Denied claims for service rendered: Within 30 calendar days after receipt of a request for an appeal from the Participant.

B. Second level appeal: If the Participant disagrees with the response to the initial appeal of the claim, the Participant has a right to a second level appeal. Within 60 calendar days after receipt of the Contract Administrator's response to the initial appeal, the Participant may submit a second appeal to the Contract Administrator along with any pertinent documentation. The Contract Administrator shall communicate its final determination to the Participant in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

C. Other remedies: When the Participant has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation, or group should advise the Participant to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA, (Section 502(s)(1)(B))[29 U.S.C. 1132(a)(I)(B)], the Participant has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and the Participant disagrees with the outcome.

23.6 Formal Appeal Process – Short-Term Disability (STD)

23.6.1 Appeals of Adverse Benefit Determinations

The Participant may appeal within 180 days following the receipt of notification of an Adverse Benefit Determination. The request for an appeal should include:

A. the Participant's name;
B. The name of the person filing the appeal if different from the Participant;
C. The Plan number; and
D. The nature of the appeal.

The Participant should send the request for the appeal to the Plan Administrator identified in the Plan Information and Contractor Administrators Section. Do not send the appeal to the Contract Administrator; the Contract Administrator does not handle the appeal of the claim. The Participant will have the opportunity to submit written comments, documents, records, and other information relating

to the claim. The Participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claim.

The Plan Administrator's review will take 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 the initial claim decision. The Plan Administrator's review will not give deference to the initial Adverse Benefit Determination.

The Plan Administrator will identify any medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional:

A. Who has appropriate training and experience in the field of medicine involved in the medical judgment; and
B. 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.

23.6.2 Appeal Decision

A. Notice of Appeal Decision. The Plan Administrator will notify the Participant of the Plan Administrator's appeal decision within 45 days after receipt of the Participant's timely appeal request, unless the Plan Administrator determines that special circumstances require an extension of time for processing the appeal. The Plan Administrator will provide the Participant with written or electronic notice of its appeal decision.

   Notice of an Adverse Benefit Determination will include:
   1. The specific reason(s) for the Adverse Benefit Determination;
   2. Reference to the specific provision(s) on which the Adverse Benefit Determination is based;
   3. 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;
   4. If an internal rule, guideline, protocol, or other similar criterion was used in making the adverse benefit determination, a statement that it was used in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request;
   5. If the Adverse Benefit Determination was based on a medical necessity or Experimental treatment or similar exclusion, a statement that it was relied upon in making the Adverse Benefit Determination and that an explanation of the scientific or clinical judgment for the determination will be provided free of charge to the Participant upon request; and
   6. A statement of the Participant's right to bring a civil action under ERISA.
B. Notice of Extension. If the Plan Administrator determines that an extension is required, the Participant will be notified in writing of the extension prior to the termination of the initial 45 day period. In no event will the extension exceed 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring the extension and the date by which the Plan Administrator expects to render the appeal decision.
C. Time Periods. The period of time within which an appeal decision is required to be made will begin at the time an appeal is timely filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Employer's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent to the Participant until the earlier of (1) the date on which the Plan Administrator

receives the Participant's response; or (2) the date established by the Administrator in the notice of extension for the furnishing of the requested information.

23.7 Formal Appeal Process – Long-Term Disability and Group Term Life and AD&D

23.7.1 Opportunity to Request an Appeal

The Participant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision. The Participant will have no more than 90 days from the Participant's receipt of notification of the Contract Administrator's claim review decision to submit a request for an appeal.

For questions about the appeal process, contact the Contract Administrator.

23.9 Formal Appeal Process - Flexible Spending Arrangement (FSA)

See Section 21.7.

23.10 Legal Action

If a Participant obtains an external review and does not agree with the decision of the independent review organization, he/she has the right to file suit under Section 502(a) of ERISA. If a Participant does not choose to obtain an external review, or the claim is not eligible for an external review, the Participant has the right to file suit under Section 502(a) of ERISA after he/she has exhausted all required claims and internal appeals processes. No claim may be filed unless the Participant has exhausted all required claims and appeals processes. Any suit must be filed in a court of competent jurisdiction within one year after the date of the final adverse decision on internal appeal or one year after the date of the decision on external review, if later.

23.11 Venue

All lawsuits must be file in federal court in Ada County, Idaho.

23.12 Governing Laws

Except as subject to federal law, including ERISA, any questions, claims, disputes or litigation concerning or arising from any of the offered benefits will be governed by the laws of the State of Idaho.

Section 24 – HIPAA Provisions

24.1 The Plan has "protected health information" (including "electronic protected health information") as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations thereunder, such information being referred to as "PHI;" and Employees of Plan Sponsor have access to the PHI of Plan Participants for administration functions of the Plan. The Plan provides Plan Sponsor access to PHI from the Plan only as follows:

24.2 Permitted Disclosure of Enrollment Information

The Plan may disclose to Plan Sponsor information on whether an individual is participating in, is enrolled in, or has disenrolled from the Plan, any program offered under the Plan.

24.3 Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information (as defined below) to Plan Sponsor if Plan Sponsor requests the information for the purpose of

A. Obtaining premium bids for providing health insurance coverage under the Plan, or
B. Modifying, amending or terminating the Plan.

"Summary Health Information" means information that

A. Summarizes the claims history, claims expenses, or types of claims experienced by individuals, and
B. From which certain identifying information has been removed as required by the HIPAA regulations.

24.4 Permitted and Required Uses and Disclosures for Plan Administration

Unless otherwise permitted by law, and subject to the conditions of disclosure specified in Section 4 and the written certification required by Section 6, the Plan may disclose PHI (including electronic PHI) to Plan Sponsor, provided Plan Sponsor uses or discloses the PHI only for administration functions performed by Plan Sponsor on behalf of the Plan, including without limitation quality assurance, claims processing or adjudication, auditing, and monitoring. Plan administration functions do not include

A. Functions performed by Plan Sponsor in connection with any other benefit or benefit plan (including non-health programs offered under the Plan); or
B. Any employment-related actions or decisions.

Enrollment and disenrollment functions performed by Plan Sponsor are performed on behalf of Plan Participants and beneficiaries and are not Plan administration functions. Enrollment and disenrollment information held by Plan Sponsor is held in its capacity as Employer and is not PHI. Notwithstanding any provision of the Plan to the contrary, Plan Sponsor shall not be permitted to use or disclose PHI in a manner inconsistent with 45 CFR §164.504(f).

24.5 Conditions of Disclosure for Plan Administration

Plan Sponsor agrees that with respect to any PHI disclosed to it by the Plan (other than enrollment/disenrollment information provided under Section 24.2, Summary Health Information provided under Section 24.3 or information provided pursuant to an authorization, none of which is subject to the restrictions of this Section 24.5), Plan Sponsor shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
- Ensure that any agent, including a subcontractor, to whom Plan Sponsor provides PHI received from the Plan agrees to the same restrictions and conditions that apply to Plan Sponsor with respect to the PHI.
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or benefit plan.
- Report to the Plan any use or disclosure of PHI inconsistent with the uses and disclosures permitted under this Amendment of which Plan Sponsor becomes aware.
- Make PHI available to comply with HIPAA's right to access in accordance with 45 CFR §164.524.
- Make PHI available for amendment and incorporate any agreed-upon amendments to PHI in accordance with 45 CFR §164.526.
- Make the information required to provide an accounting of disclosures available in accordance with 45 CFR §164.528.

- Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with HIPAA's privacy requirements.
- Return or destroy all PHI received from the Plan that Plan Sponsor maintains in any form and retain no copies of PHI when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible.
- Ensure that adequate separation between the Plan and Plan Sponsor is satisfied as required in accordance with 45 CFR §164.504(f)(2)(iii).

Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information provided under Section 24.1, Summary Health Information provided under Section 24.3 or information provided pursuant to an authorization, none of which is subject to the restrictions of this Section 24.5), Plan Sponsor shall:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and Plan Sponsor required by 45 CFR §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonably and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware, as follows: report as soon as feasible any successful unauthorized access, use, disclosure, modification or destruction of electronic PHI or interference with systems operations in an information system containing electronic PHI; and report with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify or destroy electronic PHI or to interfere with systems operations in an information system containing electronic PHI.

24.6 Adequate Separation

Plan Sponsor shall allow only the following classes of Employees access to PHI:

- Privacy Officer
- Security Officer
- CEO, COO, CFO, VP Labor & HR
- Corporate Counsel
- Benefits Personnel
- IT Personnel
- HR Personnel at Distribution Centers
- Asst. Controller, Treasury/Risk and assistants
- Accounts Payable and Retail Accounting Personnel
- Mailroom and Front Desk Personnel

These Employees and classes of Employees shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that Plan Sponsor performs for the Plan. If any of these Employees do not comply with the provisions of this Section 5, he or she shall be subject to disciplinary action by Plan Sponsor for noncompliance, up to and including termination. Plan Sponsor shall ensure that the provisions of this Amendment are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit electronic PHI on behalf of the Plan.

24.7 Plan Sponsor's Certification

The Plan shall disclose PHI to Plan Sponsor only upon the receipt of a certification by Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii) and that Plan Sponsor agrees to the conditions of disclosure set forth in Section 4.

Section 25 – Rights Under the Employee Retirement Income Security Act (ERISA)

25.1 As a Participant in the Plan, the Participant is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

25.2 Receive Information about the Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including Insurance Contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Insurance Contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

25.3 Continue Group Health Plan Coverage

Continue health care coverage for the Participant(s) if there is a loss of coverage under the Plan as a result of a qualifying event. The Participant(s) may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

25.4 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 the Plan, called Fiduciaries of the Plan, have a duty to do so prudently and in the interest of the Employee and other Plan Participants and Beneficiaries. No one, including the Employer, the union, or any other person, may fire the Employee or otherwise discriminate against the Employee in any way to prevent the Employee from obtaining a benefit or exercising rights under ERISA.

25.5 Enforce Employee Rights

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

Under ERISA, there are steps the Employee can take to enforce the above rights. For instance, if the Employee requests a copy of Plan Documents or the latest annual report from the Plan and does not receive them within 30 days, the Employee may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Employee up to $110 a day until the Employee receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Employee has a claim for benefits which is denied or ignored, in whole or in part, the Employee may file suit in a state or federal court. In addition, if the Employee disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the Employee may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Employee is discriminated against for asserting the Employee's rights, the Employee may seek assistance from the U.S. Department of Labor, or the Employee may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Employee is successful, the court may order the person sued to pay these costs and fees. If the Employee loses, the court may order the Employee to pay these costs and fees, for example, if it finds the Employee's claim if frivolous.

25.6 Assistance with Questions

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

Section 26 – Definitions

The Plan Document contains certain defined terms that are capitalized in the text and described in this section. Words that are not defined have their usual meaning in everyday language unless noted.

Accidental Injury - Any injury caused by external forces under unexpected circumstances and which does not arise out of or in the course of the employment of a Participant. Sprains and strains will not be considered Accidental Injury for purposes of benefit determination.

Activities of Daily Living - Eating, personal hygiene, dressing, and similar activities that prepare an individual to participate in work or school. Activities of Daily Living do not include recreational, professional, or school-related sporting activities.

Acute Care - Medically Necessary Inpatient treatment in a Licensed General Hospital or other Facility for medical and/or surgical conditions that require sustained medical intervention by a Physician and skilled nursing care to safeguard a Participant's life and health. The immediate medical goal of Acute Care is to stabilize the Participant's condition, rather than upgrade or restore a Participant's abilities.

Administrator/Sponsor - The Employer unless another person or entity has been designated by the Employer pursuant to Section 21.8 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

Adverse Benefit Determination - Any denial, reduction or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under the Plan.

Affordable Care Act (ACA) - The Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act of 2010 and associated regulations.

Alcoholism - A behavioral or physical disorder manifested by repeated excessive consumption of alcohol to the extent that it interferes with a Participant's health, mental, social or economic functioning.

Allowed Amount - The dollar amount allowed by the Plan for a specific Covered Service.

Ambulatory Surgical Facility - Any public or private establishment with an organized medical staff of Physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous Physician services and registered professional nursing services whenever a Participant is in the Facility; and which does not provide services or other accommodations for Participants to stay overnight.

Benefit Period - The 12-month period beginning January 1 and ending December 31. All annual Deductibles and Calendar Year limits accumulate during the Benefit Period and start over at the beginning of each new Benefit Period. If a Participant is Inpatient at the end of a Benefit Period and the Hospitalization continues uninterrupted into the succeeding Benefit Period, all eligible expenses incurred for Inpatient Hospital Services are considered part of the Benefit Period in which the date of admission occurred.

Benefit Options - Any of the optional benefit choices available to a Participant as outlined in Section 21.3.

Cafeteria Plan - A plan that meets the specific requirements of and regulations of Section 125 of the Internal Revenue Code. Participants have an opportunity to receive certain benefits on a pretax basis.

Cafeteria Plan Benefit Dollars - The amount available to Participants to purchase Benefit Options as provided under Section 21. Each dollar contributed to the Plan shall be converted into one Cafeteria Plan Benefit Dollar.

Calendar Year - The period beginning on January 1st and ending the following December 31st, at midnight or if a person first becomes covered during the Calendar Year, the period beginning on the effective date of coverage and ending December 31.

Cardiac Rehabilitation - Outpatient program including medical evaluation, prescribed exercise, education and counseling. Must be prescribed by a Physician and Medically Necessary and prior authorized.

Code - The Internal Revenue Code of 1986, as amended or replaced from time to time.

Coinsurance - The percentage of a Covered Expense which the Participant is responsible to pay per service or visit to the Provider after the Deductible has been met, if applicable.

Compensation - The amounts received by the Participant from the Employer during a Plan Year.

Congenital Anomaly - A condition existing at or from birth, which is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or Disease. In the Plan, the term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

Contract Administrator - The organization providing claim processing and other administrative services to the Plan in connection with the operation of the Plan and performing such other functions, including processing and payment of claims as may be delegated to it.

Convalescent Hospital - An institution which is duly licensed as a Convalescent Hospital, Extended Care Facility, skilled nursing Facility, or intermediate care Facility and is operated in accordance with governing laws and regulations; is primarily engaged in providing accommodations and skilled nursing care 24 hours a day for convalescing persons, is under the full-time supervision of a Physician or a registered graduate nurse; admits Participants only upon the recommendation of a Physician (other than the Participant's own Physician), maintains complete medical records, and has available at all times the services of a Physician; has established methods and procedures for the dispensing and administering of drugs; has an effective utilization review plan; has a written transfer agreement in effect with one or more Hospitals; and is not, other than incidentally, a place of rest, for Custodial Care, for the aged, for drug addicts, for alcoholics, for the care of the mentally ill or persons with nervous disorders, for the care of senile persons, a nursing home, a hotel, a school or a similar institution.

Copay or Copayment - An amount a Participant must pay per service or visit to the Provider after the Deductible has been met, if applicable.

Covered Expense - Any expense listed in Section 11, to the extent such expense is not excluded or otherwise limited by the Plan.

Covered Service – A necessary service, drug, or supply which is covered under the plan that a Participant is entitled to receive under the Plan Document.

Custodial Care - Services (including room and board) or supplies provided to a Participant which consist primarily of Activities of Daily Living given to maintain life and/or comfort with no reasonable expectation of cure or improvement of the Illness and which can generally be provided by an individual without special training. Services that are provided principally for personal hygiene or for assistance in daily activities.

Deductible - An amount which each Participant must contribute toward payment before insurance starts to pay. The Deductible is paid to the service Provider. For example, Employee only coverage has a $100 Deductible, so that means the Participant pays the first $100. After the Deductible is met, the Participant pays a Copayment or Coinsurance for Covered Services as set forth in the Schedule of Benefits.

Dependent - Any individual who qualifies as a Dependent under the self-funded Plan for purposes of that Plan or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under the Plan. Dependent shall include any child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Care Flexible Spending Arrangement or as allowed by reason of the Affordable Care Act. For purposes of the Health Care Flexible Spending Arrangement, a Participant's "child" includes his/her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the Calendar Year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Diagnostic Services - A test or procedure performed on the order of a Physician or other Provider because of specific symptoms, in order to identify a particular condition, Disease, Illness, or Accidental Injury. Diagnostic Services include, but are not limited to:
1. Radiology services
2. Laboratory and pathology services
3. Cardiographic encephalographic, and radioisotope tests

Disability or Totally Disabled - With reference to an Employee, a Disability is solely as a result of an Illness or injury which prevents an Employee from engaging in any employment or occupation for which he/she is or becomes qualified by reason of education, training, or experience and only when such Employee is, in fact, not engaged in any employment or occupation for wage or profit. For a Dependent, it is Disability which prevents a Dependent from substantially engaging in all the normal activities of a person in good health of like age and sex or results from the lack of mental capacity, cerebral palsy or other neurological disorder and is diagnosed by a Physician as a permanent or long term continuing condition. A Participant must also be under the regular care of a Physician in order to be Totally Disabled for benefit purposes.

Disease - Any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital functions, thereby causing or threatening pain, weakness or dysfunction. A Disease is also a particular abnormal condition, a disorder of a structure or function that affects part or all of an organism. It is often construed as a medical condition associated with specific symptoms and signs. A Disease can exist with or without a Participant's awareness of it and can be of known or unknown cause.

Durable Medical Equipment - Equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of Illness or injury, (d) is appropriate for use in the home, and (e) has been prescribed by a Physician.

Election Period - The period immediately preceding the beginning of each Plan Year stablished by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 21.4.

Eligible Employee - Any Employee who has satisfied the provisions of Section 3. An individual shall not be an Eligible Employee if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not Eligible Employees and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors. However, "2% shareholders" as defined under Code Section 1372(b) shall not be eligible to participate in the Plan.

Emergency Condition(s) - A condition of recent onset and sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect that failure to obtain immediate medical care could result in:
1. Placing a Participant's health in serious jeopardy;
2. Placing the health of a pregnant woman or her unborn child in serious jeopardy;
3. Serious impairment to bodily functions; or
4. Serious dysfunction of any bodily organ or part.

Employee - Any person who is employed by the Employer. The term Employee shall not include leased Employees within the meaning of Code Section 414(n)(2).

Employer – WinCo and any successor which shall maintain the Plan as Plan Sponsor; and any predecessor which has maintained the Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

Essential Health Benefits - Ambulatory patient services, emergency services, Hospitalization, pregnancy, maternity and newborn care, mental health and substance abuse use disorder services, including behavioral health treatment, Prescription Drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic Disease management, pediatric services, including oral and vision care, as outlined by the federal government. This may change throughout the year as changed by the federal government under the Affordable Care Act.

Excess Charges - Any charges that exceed the amount that the Plan pays for Covered Services. These charges do not apply to the Out-of-pocket Maximum.

Experimental and/or Investigational - Medical services and supplies (equipment, drug, devices, treatments, or procedures are considered investigational if one or more of the following apply:
1. It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;
2. It is the subject of a current investigational new drug or new device application on file with the FDA;
3. It is being provided pursuant to an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial as set forth by FDA regulation;
4. It is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or
5. If the predominant opinion among qualified objective experts is that further basic science, laboratory-based clinical studies, clinical studies, clinical outcomes research, or clinical trials are necessary in order to define safety, effectiveness, comparative effectiveness, and anticipated outcomes as compared with standard means of treatment of diagnosis of the condition in question or there is no clear medical consensus about the role and value of the Service.

ERISA - The Employee Retirement Income Security Act of 1974, as amended from time to time.

Facility - An institution that provides certain healthcare services within a specific licensure requirement.

Fiduciary - The person or organization that has the authority to control and manage the operation and administration of the Plan. The Fiduciary has discretionary authority to determine eligibility for benefits and to construe the terms of the Plan. The named Fiduciary for the Plan is the Employer.

Home Health Care Agency/Home Health Skilled Nursing Services - A Licensed General Hospital, Home Health Care service organization or agency possessing a valid operating certificate issued in accordance with public health law authorizing such organization or agency to provide Home Health Care services.

Home or Outpatient Intravenous Therapy - Treatment of a medical condition by intravenous injections, administered in an Outpatient setting or at the Participant's home at or under the direction of a Home Health Agency or other Provider approved by the Contract Administrator.

Hospice - A facility or services to provide comfort and support for a Participant in the last stages of a terminal Illness.

Hospital/Licensed General Hospital - A Facility that is licensed by the state in which Services are provided that is legally operated for the medical care and treatment of sick or injured participants and a Facility that is licensed and operating within the scope of such license, which:

1. Operates primarily for the admission, acute care, and treatment of injured or sick persons as inpatients;
2. Has a 24-hour-a-day nursing service by or under the supervision of a graduate registered Nurse (R.N.) or a licensed practical Nurse (L.P.N.);
3. Has a staff of one or more licensed Physicians available at all times; and
4. Provides organized facilities for diagnosis and surgery either on its premises or in facilities available to the Hospital on a contractual prearranged basis.
5. Is an institution which is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals or other accrediting agencies, such as the department of health, as recognized by Medicare; complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located.

Illness - An Illness shall be deemed to mean a bodily disorder, Disease, mental infirmity or bodily injury. However, bodily injuries sustained in any one accident shall be considered one Illness, and all bodily disorders existing simultaneously which are due to the same or related causes shall be considered one Illness. Pregnancy is considered an Illness for the purposes of coverage under the Plan.

Injectable Drugs and Specialty Medications - A class of drugs that may be administered orally, as a single injection, intravenous infusion or in an inhaled/nebulized solution. Injectable Drugs and Specialty Medications include all or some of the following:

1. Are often products of a living organism or produced by a living organism through genetic manipulation of the organism's natural function.
2. Are generally used to treat an ongoing chronic Illness.
3. Require special training to administer.
4. Have special storage and handling requirements.
5. Are typically limited in their supply and distribution to Participants or Providers.
6. Often have additional monitoring requirements.

In-network - The higher level of benefits available to the Participant when the Participant obtains Covered Services from a Provider or Facility who is under contract with the Contract Administrator to accept Allowed Amounts as payment in full for Covered Services.

Inpatient - A person physically occupying a Hospital room to which the person has been assigned on a 24 hour a day basis without being issued passes to leave the Hospital premises.

Insurance Contract - Any contract issued by an Insurer underwriting a benefit.

Insurer - Any insurance company that underwrites a Benefit under the Plan or, with respect to any self-funded benefits, the Employer.

Key Employee - An Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

Licensed Alcoholism and/or Substance Use Treatment Facility - A facility Provider that is primarily engaged in providing detoxification and rehabilitative care for Alcoholism and/or substance abuse or addiction.

Licensed Birthing Center - Any licensed health facility, place, or institution which is not a Hospital, or in a Hospital, where births are planned to occur away from the mother's usual residence, following a normal uncomplicated pregnancy.

Life Event - A qualifying event that allows the Employee to make changes to health insurance coverage. Examples include the birth of a baby, getting married, or losing other health coverage. An Employee has 31 days from the date of the Life Event to make changes.

Maximum Allowance - For Covered Services, other than dialysis, under the terms of the Plan, Maximum Allowance is the lesser of the billed charge or the amount established by the Contract Administrator as the highest level of Compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by a Contracting or Non-contracting Provider with a Contract Administrator affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as Compensation.

The Maximum Allowance is determined using many factors, including pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); ambulatory payment classifications (APCs); the Provider's charge(s); the charge(s) of Providers with similar training and experience within a particular geographic area; Medicare reimbursement amounts; and/or the cost of rendering the Covered Service. Moreover, Maximum Allowance may differ depending on whether the Provider is contracting or non-contracting.

For dialysis, the Maximum Allowance is 100% of the negotiated rate with the Participant's nephrologist and/or dialysis treatment clinic and the Dialysis Cost Containment Program Administrator or 100% of UCR if the Plan has not entered into an agreement with the Dialysis Cost Containment Program Administrator.

Medically Necessary (or Medical Necessity) - The Covered Service or supply recommended by the treating Covered Provider to identify or treat a Participant's condition, Disease, Illness or Accidental Injury and which is determined to be:

1. The most appropriate supply or level of service, considering potential benefit and harm to the Participant.
2. Proven to be effective in improving health outcomes
3. For new treatment, effectiveness is determined by peer reviewed scientific evidence.
4. For existing treatment, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.
5. Not primarily for the convenience of the Participant or covered Provider.
6. Cost Effective for this condition.

The fact that a covered Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under the Plan. The term Medically Necessary as defined and used in this Policy is strictly limited to the application and interpretation of the Plan, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Services.

Non-Covered Service - A service, drug, or supply not covered under the Plan.

Open Enrollment - The one time each year Employees can enroll, change, or remove benefits and/or Dependent(s) without a Life Event.

Out-of-network - The lower level of Benefits available to the Participant when the Participant obtains Covered Services from Provider or Facility who is not under contract with the Contract Administrator to accept Allowed Amounts as payment in full for Covered Services.

Out-of-pocket Maximum - Means the maximum amount of Coinsurance a covered Insured must pay for Covered Expenses during a Calendar Year and does not include Prescription Drugs, dental and vision, Non-Covered Services and charges over the Allowed Amount.

Outpatient - Hospital services rendered on other than an Inpatient basis or services rendered at a covered non-Hospital facility.

Participant - An Eligible Employee and/or the Employee's eligible Dependent(s) who are enrolled in coverage and have satisfied the requirements of Sections 3 and 4 and has not for any reason become ineligible to participate further in the Plan.

Physician - A person, other than the Participant or a relative of the Participant, licensed to practice medicine or Surgery as a Doctor of Medicine, (MD) or as a Doctor of Osteopathy, (D.O.).

Plan - This document, including all amendments thereto.

Plan Document - The document that describes the Plan's terms and conditions related to the operation and administration of the Plan.

Plan Year - The 12-month fiscal period for the WinCo Holdings, Inc. Employee Benefit Plan beginning January 1 and ending December 31, which is used for the purpose of IRS tax filing.

Premiums - The Participant's cost for the self-funded Benefits described in Section 21.3.

Premium Conversion Benefit - The account established for a Participant pursuant to the Plan to which part of his/her Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

Post-service Claim - Any claim for benefit under the Plan that does not require Prior Authorization before services are rendered.

Preferred Provider Organization (PPO) - Hospitals, Physicians and Providers who have contracted with the Plan or Contract Administrator on behalf of the Plan Sponsor. A directory of Preferred Providers is available from the applicable benefit Provider or Contract Administrator. Inquiries concerning a particular Provider can also be directed to the Contract Administrator.

Prescription Drugs - Drugs and medications, including insulin, that by law must be dispensed by a licensed pharmacist and that require a Provider's written prescription.

Pre-authorization/Prior Authorization - The Provider's or the Participant's request to the applicable benefits Provider, delegate entity, or Contract Administrator, for a medical necessity determination of a Participant's proposed treatment. Contract Administrator may review medical records, test results and other sources of information to make the determination. Preauthorization is not a determination of benefit coverage.

Provider - The health care facilities and professionals who provide health care to the Participant and their Dependent(s) is required to follow federal and state regulations in reference to certification, registration, and licensing.

Recognized Transplant Center - A Licensed General Hospital that meets any of the following criteria:
1. Is approved by the Medicare program for the requested Transplant Covered Services.
2. Is included in the Contract Administrator's national transplant network.
3. Has an arrangement(s) with the Contract Administrator for the delivery of the requested Transplant Covered Services, based on appropriate approval criteria established by that Plan.
4. Is approved by the Contract Administrator based on the recommendation of the Contract Administrator's Medical Director or by the Plan.

Salary Redirection - Contributions made by the Employer on behalf of Participants pursuant to Section 21.2.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Section 21.4.

Salary Redirection Agreement - An agreement between the Participant and the Employer under which the Participant agrees to reduce his/her Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking the Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

Schedule of Benefits - The benefits a Participant is entitled to receive under the Plan along with a listing of the applicable Coinsurance or Copays.

Special Enrollment Rights - The right an Employee has to enroll, change, or cancel health insurance coverage when a specific Life Event occurs.

Surgery - Any operative or diagnostic procedure performed in the treatment of an injury or Illness by instrument or cutting procedures through any natural body opening or incision. The performance is limited to be within the scope of a Provider's license, of:
1. Generally accepted operative and cutting procedures.
2. Endoscopic examinations and other invasive procedures utilizing specialized instruments.
3. The correction of fractures and dislocations.
4. Customary pre-operative and post-operative care.

Therapy Services - Therapy Services include only the following:
1. Radiation Therapy - The treatment of Disease by x-ray, radium or radioactive isotopes.
2. Chemotherapy - The treatment of malignant Disease by chemical or biological antineoplastic agents.
3. Renal Dialysis - The treatment of an acute or chronic kidney condition, which may include the supportive use of an artificial kidney machine.
4. Physical Therapy - The treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, or devices to relieve pain, restore maximum function or prevent Disability following a condition, Disease, Illness, Accidental Injury or loss of a body part.
5. Respiration Therapy - Introduction of dry or moist gases into the lungs for treatment purposes.
6. Occupational Therapy - The treatment of a physically Disabled Participant by means of constructive activities designed and adapted to promote the restoration of the Participant's ability to satisfactorily accomplish the ordinary task of daily living and those tasks required by the Participant's particular occupational role.
7. Speech Therapy - The corrective treatment of a speech impairment resulting from a condition, Illness, Disease, Surgery or Accidental Injury; or from Congenital Anomalies or previous therapeutic processes.

8. Enterostomal Therapy - Counseling and assistance provided by a specifically trained Enterostomal Therapist to Participants who have undergone a surgical procedure to create an artificial opening into a hollow organ (e.g., colostomy).
9. Growth Hormone Therapy - Treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction.

Usual, Customary, and Reasonable (UCR) – The amount paid for a service in a geographic area based on what Providers in the area charge for the same or similar medical service. The UCR amount is sometimes used to determine the Maximum Allowance amount.