Piedmont Mechanical, Inc. of Spartanburg, South Carolina, hereby establishes a plan for payment of certain expenses for the benefit of its eligible participants to be known as the Piedmont Mechanical, Inc. Employee Benefit Plan. This plan is a restatement of the plan established on November 1, 2003 and includes amendments to the plan from that date to the date hereof.

The plan assures its covered participants that during the continuance of the plan all benefits hereinafter described shall be paid to or on behalf of them in the event they become eligible for benefits as determined in the sole and absolute discretion of the employer who is the plan sponsor of this Plan.

The plan is subject to all terms, provisions, and conditions recited on the following pages hereof.

This plan is not in lieu of and does not effect any requirements for coverage by worker's compensation insurance.

Piedmont Mechanical, Inc. has caused this restated Piedmont Mechanical, Inc. Employee Benefit Plan to take effect as of 12:01 a.m. standard time on November 1, 2022 at Spartanburg, South Carolina.

Piedmont Mechanical, Inc.

_____

Authorized Signature

_____

Attest

_____

Date

Notice to Employer: by signing this document you are acknowledging that you will distribute this restatement (via paper, employer intranet, etc.) to all active participants on the current benefit plan. You also are certifying that the plan document has been amended to incorporate the Protected Health Information: Use and Disclosure section, including the plan sponsor obligations stated therein, and you agree to comply with such obligations.

Piedmont Mechanical, Inc.
Employee Benefit Plan

Plan Document

Table of Contents

Plan Specifications

Company	Piedmont Mechanical, Inc.
Plan Administrator, **Plan Fiduciary, and** **Agent for Process of Legal Service**	Piedmont Mechanical, Inc. 116 John Dodd Road Spartanburg, SC 29303 (864) 578-9114
Plan Name	Piedmont Mechanical, Inc. Employee Benefit Plan
Plan Supervisor	Key Benefit Administrators, Inc. 534 Rivercrossing Dr. Ft. Mill, SC 29715 (803) 396-4600
Type of Plan	Self-insured group health plan administered by contract with third-party administrator. The third-party administrator has been hired to process claims under the plan. The third-party administrator does not serve as an insurer, but merely as a claims processor. Claims for benefits are sent to the third-party administrator. It processes the claims, then requests and receives funds from Employer to pay the claims and makes payment on the claims to hospitals and other providers. Employer is ultimately responsible for providing plan benefits, and not the third-party administrator.
Participant	Employees of Piedmont Mechanical, Inc. as defined herein
Original Effective Date	November 1, 2003
Updated Effective Date	November 1, 2022
End of Plan Fiscal Year	October 31st of each year

Group Number	324503
Employer Identification Number	58-1504993
Plan Number	501

The Plan believes it is a "grandfathered" health plan under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provisions of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections under PPACA such as the elimination of lifetime limits on benefits.

How to File a Claim

Instructions for filing a claim for yourself and/or your dependents are as follows if your physician or hospital is unwilling to do so for you:

The initial report of a claim should be done on the Benefit Request claim form that you can get from your employer. You should complete the Patient Information section. If you wish your medical benefits paid directly to your benefit providers, sign in item 13. A separate form should be submitted for each family member.

Have your physician give you a complete itemized bill that you can attach to the Benefit Request claim form. An itemized bill is one that shows a patient's name, relationship to the plan participant, date of service, the type of service rendered, and the nature of the accident or illness being treated. If this information is missing, please write it on the bill yourself and sign your name.

Send the completed Benefit Request claim form and the itemized bill directly to the plan supervisor at the address shown on the plan specifications of this document. Please note that if additional information is needed for payment of a claim, the plan supervisor will need to request this information before your claim can be processed.

Claims will be processed based upon the billing practices of your healthcare provider.

Time Limit for Filing a Claim

Written proof of the nature and extent of service must be furnished to the Plan Supervisor within 90 days after the end of the calendar year in which the service was rendered. Claims filed later than that date may be declined or reduced.

Schedule of Benefits

Major Medical Benefits

Patient Protection and Affordable Care Act ("PPACA") Compliance:

The Plan will at all times be in compliance with PPACA rules and regulations. PPACA requires that benefits that are offered by the Plan that are "Essential Health Benefits" as defined by the United States Department of Health And Human Services may not be restricted to less than a certain annual amount. If a major medical benefit of the Plan has a plan maximum below that amount, the Plan will continue to pay benefits for the Essential Health Benefit components of that benefit even though such payments would exceed the plan maximum for that benefit.

Note regarding Deductibles and Out-of-Pocket Expenses

All services are subject to the deductible and out-of-pocket maximums noted in this schedule of benefits unless otherwise stated.

Effective Date of Coverage

Class 1 – Officers – the first of the month following his/her date of hire.

Class 2 – Administrative – the first of the month following his/her date of hire.

Class 3 – Hourly – upon completing 90 days of full-time consecutive employment.

Child Maximum Age

To then end of the month when the child attains age 26.

Managed Care Program

Except in a maternity admission, a participant or covered dependent is required to call a toll-free number upon learning of a future hospital admission, or to call within 24 hours or the next business day after an emergency admission. This toll-free number is on the back of the plan's medical identification card. If this provision is not followed, then hospital charges and all charges related to the hospital admission will be subject to a $200 per-admission penalty, in addition to any deductible that might apply. Maternity admissions **do not** require certification. However, if the newborn baby stays longer in the hospital than the mother, the newborn's continuing hospital stay must be certified.

The following procedures require pre-certification and will be subject to a $200 penalty if not pre-certified. Chemotherapy and Dialysis require pre-certification per course of treatment. Pre-certification is not needed for each date of service under the course of treatment.

- Cat Scans
- MRI
- Chemotherapy

Preferred Provider Network

Benefits at a participating provider will be paid at 70%, while benefits at a non-participating provider will be paid at 60%, resulting in a 10% penalty. Benefits are paid subject to the coinsurance maximums as indicated below in the schedule of benefits.

If a participant or covered dependent receives ancillary and physician services, (i.e., anesthesiologists, radiologists, emergency room physicians, pathologists, etc.,) at a participating provider, the services provided by the non-participating provider will be paid at the participating provider benefit level.

If a condition requires treatment from a specialist and there is no such specialist available in the network, benefits will be paid at 70% subject to the coinsurance maximum indicated below.

For a free listing of participating providers, visit the network's website or call its toll-free number. You also may contact the plan supervisor. Websites and toll-free numbers are on your Identification Card.

Weekend Admissions

If the participant or covered dependent is admitted to the hospital on Friday, Saturday, or Sunday, no benefits are payable for any expenses incurred during the admission. However, benefits are payable if surgery is to be performed on the day following the day of admission or the admission is due to an emergency situation which, without immediate medical attention, could result in death or cause impairment to bodily functions.

Early Admission Deterrent

If the participant or covered dependent is admitted to the hospital more than 24 hours prior to a scheduled surgery, no benefits will be payable for any expenses incurred until after the first day following the surgery. However, benefits are payable if the surgery is due to a life-threatening situation which, without immediate medical attention, could result in death or cause impairment to bodily functions.

Schedule of Benefits

Deductibles

	Network	Non-Network
Individual	$1,000 per covered person per calendar year.	$1,500 per covered person per calendar year.
Family	$1,500 per family per calendar year.	$3,000 per family per calendar year.

- Network deductibles are separate from non-network deductibles.
- Copays do not apply towards deductible.
- Deductibles do not apply toward out-of-pocket maximums.
- Deductibles do not carryover from the last 3 months of the previous year.

Individual Coinsurance

Network	Non-Network
70%	60%

The plan pays the above percentages of eligible charges, unless otherwise stated, after satisfying the deductible. When the out-of-pocket maximum per person per calendar year has been reached, then the plan pays 100% thereafter for the remainder of the calendar year.

Out-of-pocket Maximums

	Network	Non-Network
Individual Maximum	$4,000 per covered person per calendar year.	$7,000 per covered person per calendar year.
Family Maximum	$6,000 per family per calendar year.	$10,000 per family per calendar year.

- In-network out-of-pocket maximums are separate from non-network out-of-pocket maximums.
- Deductibles do not apply toward out-of-pocket maximums.
- Out-of-pocket amounts do not carryover from the last 3 months of the previous year.
- Precertification penalties do not apply toward out-of-pocket maximums.

Supplemental Accident Benefit

100% of eligible charges up to a maximum benefit payment of $300 per accident for services received within 3 months of the accident, **not subject** to the deductible. After the maximum benefit is met, the standard plan benefits apply.

Pre-Admission Testing

Network	Non-Network	Limitations
70%	60%	Not applicable.

Ambulance Services

	Limitations
70%	Non-network services are subject to the network deductible and out of pocket maximum.

Hospital Services

Services	Network	Non-Network	Limitations
Room and Board	70%	60% after satisfying a $200 per confinement copay	Based on the semi-private room rate.
Miscellaneous Charges	70%	60%	Excludes patient convenience items.
Inpatient Surgery	70%	60%	Not applicable.
Outpatient Surgery	70%	60%	Not applicable.
Outpatient Diagnostic Testing/X-ray and Lab	70%	60%	Including PET/CT Scans, MRI and MRA
Outpatient Services - Other	70%	60%	Not applicable.
Emergency Room	70%	70%	Non-network services are subject to the network deductible and out of pocket maximum.

Voluntary Second Surgical Opinion

Network	Non-Network	Limitations
70%	60%	Not applicable.

Organ Transplants

Network	Non-Network	Limitations
70%	60%	Pre-authorization is required. Limited to a calendar year maximum benefit payment of $250,000 per person. Transportation, lodging and meals are limited to a maximum benefit payment of $10,000 for all transportation, lodging and meals per covered transplant procedure. This benefit includes all related services.

Urgent Care Facility

Network	Non-Network
$30.00 copay required by the covered person per non-surgical office **exam only,** due to accident or illness, including lab and other charges. Copay does not apply to the individual deductible or maximum out-of-pocket expense. The first $200 of eligible charges per visit will be paid at 100%, **not subject to the deductible.** Charges in excess of $200 will be subject to the deductible and 70% coinsurance	60%

Physician Services

Primary Care Physician's Office Visits

Network	Non-Network	Limitations
$30.00 copay required by the covered person per non-surgical office **exam only,** due to accident or illness, including lab and other charges. Copay does not apply to the individual deductible or maximum out-of-pocket expense. The first $200 of eligible charges per visit will be paid at 100%, **not subject to the deductible.** Charges in excess of $200 will be subject to the deductible and 70% coinsurance	60%	A primary care physician includes general/family practice medicine, pediatrician, internist, OB/GYN, and Urgent Care. This benefit includes telehealth and virtual visits.

Primary Care Physician Office Surgery

Network	Non-Network	Limitations
$30.00 copay required by the covered person visit, **not subject to the deductible,** then 70%, not including lab and other charges. Copay does not apply to the individual deductible or maximum out-of-pocket expense.	60%	A primary care physician includes general/family practice medicine, pediatrician, internist, OB/GYN, and Urgent Care

Specialist Office Visits

Network	Non-Network	Limitations
$50.00 copay required by the covered person per non-surgical office **exam only,** due to accident or illness, including lab and other charges. Copay does not apply to the individual deductible or maximum out-of-pocket expense. The first $200 of eligible charges per visit will be paid at 100%, **not subject to the deductible.** Charges in excess of $200 will be subject to the deductible and 70% coinsurance	60%	This benefit includes telehealth and virtual visits.

Specialist Office Surgery

Network	Non-Network	Limitations
$50.00 copay required by the covered person visit, **not subject to the deductible,** then 70%, not including lab and other charges. Copay does not apply to the individual deductible or maximum out-of-pocket expense.	60%	Not applicable.

Surgery in a Facility

	Network	Non-Network	Limitations
Inpatient	70%	60%	Not applicable.
Outpatient	70%	60%	Not applicable.

Assistant Surgeons

Charges are limited to a maximum benefit of 50% of the surgeon's allowable amount.

Office Visit Medical Supplies

Network	Non-Network	Limitations
70%	60%	Not applicable.

Lab and X-ray

	Network	Non-Network	Limitations
In Office	70%	60%	Not applicable.
Outpatient Non-Office Facility	70%	60%	Not applicable.

Office Injections

	Network	Non-Network	Limitations
Medical Injections	70%	60%	Not applicable.
Allergy Injections	100% not subject to the deductible	60%	Not applicable.
Allergy Supplies and Services	70%	60%	Not applicable.

Physician Hospital Visits

	Network	Non-Network	Limitations
Inpatient Visits	70%	60%	Not applicable.
Outpatient Visits	70%	60%	Not applicable.
Emergency Room Visits	70%	70%	Non-network services are subject to the network deductible and out of pocket maximum.

Mobile Clinic

Services
Services rendered from a mobile clinic will be payable the same as primary care physician's office visit. If the mobile clinic is a specialized mobile clinic (i.e. MRI, MRA, X-ray, etc.) services will be payable as any other specialized visit.

Birthing Centers

Network	Non-Network	Limits
70%	60%	Not applicable.

Newborn Care

	Network	Non-Network	Limitations
Physician Hospital Visit	70%	60%	Charges to be paid under the baby.
Facility Charges	70%	60%	Charges to be paid under the baby.

Pregnancy

Network	Non-Network	Limitations
70%	60%	Routine prenatal, delivery and postnatal care. Dependent children are not eligible for pregnancy benefits. Charges related to surrogacy, including but not limited to a covered person being a surrogate mother or a covered person being a father of a surrogate child are not covered by this Plan. Notice that a covered person is a surrogate mother or the father of a surrogate child must be given to Key Benefit Administrators, Inc. at the beginning of the program.

Preventive/Wellness

Network	Non-Network	Limitations
$30 copay, per visit, then 100% not subject to the deductible	60%	This benefit includes, but is not limited to, charges for routine physical examinations, mammograms up to age 40, pap smears, prostate testing, well-baby care, flu shots and immunizations. Also includes labs and x-rays performed and billed at the time of the visit. If labs and x-rays are performed at a hospital outpatient department charges are subject to the deductible and applicable coinsurance rate.

Routine Mammogram Benefit (age 40 and over)

Network	Non-Network	Limitations
100% not subject to the deductible	100% not subject to the deductible	Not applicable.

Colonoscopy and Sigmoidoscopy

Network	Non-Network	Limitations
70%	60%	Not applicable.

Routine Vision Eye Exam

	Limitations
$20.00 copay, then 100% of eligible charges up to a maximum benefit payment of $150.00 per person per calendar year, **not subject to the deductible.** Charges in excess of the $150.00 maximum will be subject to the deductible and 70% coinsurance; limited to one exam per covered person per calendar year.	Not applicable.

Durable Medical Equipment

Network	Non-Network	Limitations
70%	60%	Preauthorization required for durable medical equipment in excess of $200

Prosthetics

Network	Non-Network	Limitations
70%	60%	Not applicable.

Chiropractic Services

Network	Non-Network	Limitations
50%	50%	Limited to a maximum benefit payment of $40.00 per visit, up to a maximum benefit payment of $2,000 per person per calendar year for individuals age 15 and over. Does not apply to the out-of-pocket maximum.

Non-Surgical Temporomandibular Joint Syndrome (TMJ)

Network	Non-Network	Limitations
50%	50%	Limited to a maximum benefit payment of $500 per covered person per calendar year. Does not apply to the out-of-pocket maximum.

Prescription Drugs

Service	Benefits	Limitations
Generic Drugs	$15 copay per prescription or refill. Limited to a 30-day supply.	Does not apply toward the individual deductible or maximum out-of-pocket.
Brand when Generic is not available	$35 copay per prescription or refill. Limited to a 30-day supply.	Does not apply toward the individual deductible or maximum out-of-pocket.
Brand when Generic is available	$55 copay per prescription or refill. Limited to a 30-day supply.	Does not apply toward the individual deductible or maximum out-of-pocket.
Generic Drugs	$75 copay per prescription or refill. Limited to a 90-day supply.	Does not apply toward the individual deductible or maximum out-of-pocket.
Brand when Generic is not available	$135 copay per prescription or refill. Limited to a 90-day supply.	Does not apply toward the individual deductible or maximum out-of-pocket.
Brand when Generic is available	$195 copay per prescription or refill. Limited to a 90-day supply.	Does not apply toward the individual deductible or maximum out-of-pocket.
Mail Order Generic Drugs	$37.50 copay per prescription or refill. Limited to a 90-day supply.	Does not apply toward the individual deductible or maximum out-of-pocket.
Mail Order Brand when Generic is not available	$100 copay per prescription or refill. Limited to a 90-day supply.	Does not apply toward the individual deductible or maximum out-of-pocket.
Mail Order Brand when Generic is available	$187.50 copay per prescription or refill. Limited to a 90-day supply.	Does not apply toward the individual deductible or maximum out-of-pocket.

Biotech/Specialty Prescriptions

Network	Non-Network	Limitations
70%	60%	Biotech/Specialty prescriptions are payable under the Major Medical Plan and require preauthorization.

Therapy Services (Physical, Speech, Occupational, Renal Dialysis, Chemotherapy and Radiation)

Network	Non-Network	Limitations
70%	60%	Not applicable.

Substance Abuse and Mental Health Benefit

Not Covered

Home Health Care

Network	Non-Network	Limitations
70%	70%	Limited to a maximum benefit payment of $10,000 per person per calendar year. Preauthorization required. Refer to Section 2 Comprehensive Major Medical Coverage for more information.

Skilled Nursing Facility

Network	Non-Network	Limitations
70%	60%	Refer to Section 2 Comprehensive Major Medical Coverage for more information.

Hospice Care

Network	Non-Network	Limitations
70%	70%	Limited to a maximum benefit payment of $100,000 per person per calendar year. This benefit includes bereavement counseling.

Private Duty Nursing

Network	Non-Network	Limitations
70%	60%	Not applicable.

Diabetic Education

Network	Non-Network	Limitations
70%	60%	Not applicable.

All Other Services

Network	Non-Network	Limitations
70%	60%	Not applicable.

Section 1

Eligibility

Eligibility

Classes Eligible for Coverage

All classes of participants of the plan are eligible except the following:

- Part-time employees,
- Temporary employees,
- Seasonal employees, or
- Any class of employees which has been specifically excluded from this plan.

For the purpose of this plan, a participant's dependent is any person as defined in the definitions section of this plan. Any person who is covered as a participant cannot also be covered as a dependent under this plan. No person shall be considered to be a dependent of more than one participant.

Date Coverage Is Effective

Coverage under the plan shall become effective with respect to an eligible employee and eligible dependents at the end of any applicable waiting period or, if none, on the enrollment date, provided written application for such coverage is made on or before such date and the employee is actively-at-work as of the effective date. If the employee is not actively-at-work on the effective date, coverage for the employee and dependent(s) shall become effective on the date the employee returns to work.

The participant must be regularly working the plan administrator's normal work week of at least 30 hours at any of the plan administrator's business establishments, or at some other location to which he or she is required to travel for business reasons by the plan administrator, to be considered a full-time employee, unless the participant is not at work due to medical reasons and the absence has been approved pursuant to the employer's employment policies.

Working Spouse Rule:

A spouse of an employee who is eligible for coverage under his/her employer’s plan, but who fails to enroll for that coverage, is not eligible for coverage under this plan. The spouse can be eligible under this plan if his/her employer does not offer a health plan. If a spouse who has enrolled in his/her employer’s plan also elects coverage under this plan, this plan will coordinate benefits as a secondary payer. This provision will become effective January 1, 2004.

Enrollment: Open Enrollment

An open enrollment period shall be held each November with an effective date of January 1st. During this open enrollment period, each participant shall have the opportunity to change his or her current health coverage to any other health plan offered by the company. In addition, any eligible employee of the company who was not previously covered under a health plan offered by the company, may choose to be covered under any one of the health plans offered by the company, including himself and any eligible dependents.

Enrollment: Special Enrollees

The Health Insurance Portability and Accountability Act of 1996 requires that group health programs allow certain individuals to be covered by the plan as ***special enrollees*** as follows:

If an otherwise eligible employee or dependent declined coverage under the plan at the time of initial eligibility, and stated in writing at that time that coverage was declined because of other group health coverage, and that other group health coverage is subsequently lost, and that person makes application for coverage hereunder within 30 days of the loss of the other health coverage, such individual shall be a ***special enrollee*** provided:

- Such person lost the other health coverage as a result of loss of eligibility for the coverage (including as the result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including an increase in cost of the other coverage or reduction in benefits of the other coverage); or,

- Employer contributions toward such other coverage were terminated; or,

- The eligible employee or dependent was covered under a COBRA continuation provision and the COBRA continuation period has been exhausted.

Individuals who lose other health coverage due to non-payment of premium or for cause (e.g., filing fraudulent claims) shall not be a ***special enrollee*** hereunder.

An otherwise eligible employee who is not covered by the plan, an otherwise eligible employee and dependent who are not covered by the plan, or a participant's dependent who is not otherwise covered by the plan may apply for coverage under the plan as a result of the acquisition of a new dependent by the participant through marriage and shall be a ***special enrollee*** provided such person is properly enrolled as a participant or dependent of the participant within 30 days of the acquisition of the new dependent.

A newborn child, a child placed for adoption a newly-adopted child of a covered participant or a child that the participant has been granted legal guardianship will be covered from the moment of birth, placement for adoption, adoption, or legal guardianship including coverage for the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, provided the child is properly enrolled as a dependent of the participant within 30 days of the child's date of birth, adoption, or placement for adoption.

Coverage for a ***special enrollee***, other than for a newborn, a child placed for adoption, or a newly-adopted child, shall begin as of the first day of the calendar month following a timely enrollment request.

HIPAA requires that the Plan allow those individuals who enroll as ***special enrollees*** to be offered the opportunity to enroll in a different plan option, if another option exists.

Special Enrollment Rights under state Medicaid or state sponsored children health insurance programs ("CHIP") where available.

The Plan would allow employees and their dependents who are eligible for coverage but not enrolled for coverage to enroll in two additional circumstances:

1. The employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the plan within 60 days after the termination, or

2. The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

Coverage will become effective as of the date that a complete application for coverage is submitted.

Employee Medical/Personal Leave Continued Coverage

The Plan allows coverage during a company approved leave of absence for up to 30 days as long as the employee continues to pay his contribution on a weekly basis. Please contact the Company for their policy guidelines for approved Employee Medical/Personal Leave.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information. The Plan will not discriminate in individual eligibility, benefits or premiums based on any genetic information. The Plan will not require genetic testing of participants or intentionally gather genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes.

What is "genetic information"?

Genetic information means information about an individual's genetic tests, the genetic tests of family members of the individual, family medical history or any request for and receipt of genetic services by an individual or a family member. The term also includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo.

HIPAA: Compliance with Health Insurance Portability and Accountability Act of 1996

All provisions of the plan are intended to bring the plan into compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any provisions of the plan that differ with the requirements of HIPAA are hereby amended so that the plan shall at all times be in compliance with HIPAA and the plan administrator shall administer the plan accordingly.

Pursuant to HIPAA, the plan will at no time take into consideration any health status-related factors (including both physical and mental illnesses, prior receipt of health care, prior medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence, or disability) which exist in relation to a person who is eligible for coverage under the plan for purposes of determining the initial or continued eligibility of that person for coverage under the plan, for determining the level of contribution of the person to plan funding, or for determining the level of benefits which will be made available to a person.

The plan is a self-funded welfare benefit plan that provides medical benefits to covered persons. No benefits are payable by any insurance company. The company will provide all payments for the benefit plan. Employees may be required to pay a contribution that will partially reimburse the employer for the cost of operating the plan and for benefit payments.

All plan participants will be given written notice of any material reduction in benefits provided by the plan within 60 days of the adoption of such material reduction.

Leave of Absence

The company may provide an approved sick leave or personal leave of absence for the participant for a period of up to 30 days. Coverage may be continued during this time if the required contribution is made by the participant. If the employee does not pay the required contribution, the coverage will be terminated. At the end of the 30-day period, the coverage will be terminated and COBRA continuation will be offered.

Medicaid Eligibility

An individual who is otherwise eligible for coverage under this plan shall remain eligible even though such individual is eligible for coverage under a state plan for medical assistance approved under Title XIX of the Social Security Act (i.e., Medicaid).

The plan will make payment of all benefits under the plan for an individual covered by Medicaid coverage in accordance with the assignment of rights requirements of that individual's Medicaid coverage.

Coverage provided by the plan shall be considered primary coverage and shall pay for covered services before Medicaid.

Newborns' and Mothers' Health Protection Act of 1996

The plan will at all times comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The plan will not 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 normal vaginal delivery, or to less than 96 hours following a cesarean section.

The plan will also not require that a provider obtain authorization from the plan for the hospital stay of the mother or newborn child for the first 48 hours following a normal vaginal delivery or for the first 96 hours following a cesarean section.

Qualified Medical Child Support Orders

A medical child support order is a child support order of a court which requires that an employee benefit plan provide coverage for a dependent child of a participant if the plan normally provides coverage for dependent children. Typically, these types of orders are generated as a part of a divorce proceeding or a paternity action.

When the plan receives a medical child support order, it will notify the participant and each child specified in the order that it has been received and that the plan will review the order to determine if it is a qualified medical child support order (i.e., ***qualified order***).

The plan will notify the participant and each named child that the order is or is not a ***qualified order***.

If the order is determined to be a ***qualified order***, each named child will be covered by the plan in the same manner as any other dependent child is covered by the plan. Each named child will be considered a participant under the plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks, and other material which would otherwise be sent directly to the named child.

If it is determined that the order is not a ***qualified order***, each named child may appeal that decision by submitting a written letter of appeal to the plan administrator. The plan administrator shall review the appeal and reply in writing within 30 days of receipt of the appeal.

To be considered a ***qualified order***, the child support order must contain all the following information:

- The name and last known mailing address of the participant and the name and address of each child to be covered by the plan;
- A reasonable description of the type of coverage to be provided by the plan to each named child, or the manner in which the type of coverage is to be determined;
- The period to which such order applies;
- Each plan to which such order applies; and
- That the order does not require the plan to provide any type or form of benefit or coverage not otherwise provided under the plan except to the extent necessary to meet the requirements of a law relating to medical child support which a state must pass to be in compliance with Section 1908 of the Social Security Act.

Reinstatement of Coverage

If coverage for a participant or dependent terminates under the plan due to layoff, reduction in hours, or termination of employment, such coverage may be reinstated upon the participant's return to full-time employment, provided the participant returns to full-time employment within 60 days after coverage ended. Coverage will be effective immediately on the day the participant returns to full-time active employment. The waiting period will not apply.

Termination of Coverage

Termination of coverage of a participant will occur on the earliest of the following:

- The provisions of the plan for the coverage terminate;
- His or her class is no longer included in the eligible coverage classes;
- If the coverage is contributory, any contribution required of him or her for any coverage under the plan is not made when due;
- The date employment is terminated for any reason;
- The last day of an approved leave of absence; or
- The date of the covered employee's death.

The plan administrator will signify a participant's termination of employment by notifying the plan supervisor.

No contributory coverage may be continued beyond the end of the period for which the participant has made the required contributions to the plan administrator.

Any dependent coverage of a participant covered for dependent coverage will cease, regardless of continuation of other dependent coverage when one or more of the following apply:

- The individual ceases to be a dependent as defined herein,
- The participant is no longer covered under this plan, and/or
- The dependent becomes eligible for participant coverage hereunder.
- The date dependent coverage is terminated under the plan, or
- The date that the employee ceases to have a dependent as defined by the plan, or
- The end of the period for which a premium charge has been paid if the charge for the next period is not paid when due, or
- The date of the dependent's death, or
- The date the plan is terminated.

If a child who is a dependent as defined herein is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the participant for support and maintenance beginning prior to the end of the calendar year in which he or she turns the age specified in the schedule of benefits, coverage will continue for the dependent until the earliest of the following:

- The participant discontinues his or her coverage hereunder,
- The participant is no longer considered an eligible participant,

- The plan is cancelled, or
- The disability no longer exists as determined by the plan.

Satisfactory evidence of such disability and dependency is required by the plan. Such evidence must be received within 120 days after the end of the calendar year in which the maximum age is attained. The plan may require that the evidence of disability or dependency be updated annually.

Termination and Available Coverage After -- COBRA

All eligible participants and dependents covered under the plan on the date before a qualifying event who would otherwise have lost coverage herein as a result of any of the events listed below shall have the right to elect continuation coverage. Newborns and children placed for adoption with a person covered by COBRA continuation coverage may be added to their parent's coverage while the parent has coverage under COBRA if the plan would otherwise allow such a child to be covered by the plan. If a newborn child or child placed for adoption is added to the COBRA continuation coverage of the participant, such child shall be considered a qualified beneficiary under the plan.

The company will notify the plan administrator of the participant's death, termination of employment, layoff or reduction of working hours, or when he or she becomes entitled to benefits under Title XVIII of the Social Security Act within 30 days of the occurrence of any of these events. The participant or covered dependent must notify the plan administrator within 60 days of his or her divorce or legal separation or when a dependent child is no longer eligible for coverage as defined in the plan, in order for continuation coverage to be offered to the dependent.

The plan administrator will notify the participant or covered dependent of his or her right to elect to continue coverage within 14 days from the date the plan administrator is first notified of any of the events described above. The election period shall begin no later than the date on which coverage terminates under the plan due to any of the events listed below, shall be of at least 60 days duration, and shall end 60 days after the later of:

- The date coverage terminates under the plan due to any qualifying event listed below, or

- The date the plan administrator sends notification to the participant or covered dependent of his or her rights under this provision as described above.

Pursuant to the Trade Act of 1974, workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may become entitled to receive Trade Act Assistance (“TAA”) and may elect continuation coverage during a 60 day period that begins on the first day of the month in which he or she is determined to be a TAA eligible person. The person may elect coverage for himself or herself and his or her family. The election must be made not later than 6

months after the date of TAA related loss of coverage. Any continuation coverage elected during the second election period will begin with the first day of the second election period and not on the date which the coverage originally ended.

Benefits will be identical to those available under the plan to all active participants and covered dependents that are similarly situated beneficiaries.

The plan may require the participant and/or covered dependent pay for all or part of the cost for continuing his or her coverage, not to exceed 102% of the premium. If the participant or covered dependent is required by the plan to pay the cost of continuing coverage, payment for the initial premium must be made within 45 days from the date of election. Payments must be made in monthly installments. Payments are due by the first day of the month for which coverage is being provided.

Covered dependent spouses and children are eligible for continuation of coverage for up to 36 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the plan:

- The death of the participant,
- The divorce or legal separation of the participant from the covered dependent spouse,
- The participant becoming entitled to Medicare benefits under Title XVIII of the Social Security Act, or
- With respect to a dependent child, the dependent child is no longer eligible for coverage as a dependent child as defined in the plan.

The participant and covered dependents shall be eligible for continuation of coverage for up to 18 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the plan:

- The participant's employment with the company terminates (except if due to the participant's gross misconduct), or
- The participant is laid off or his or her working hours are reduced so as to render him or her ineligible for coverage as defined in the plan.

If the participant or covered dependent is disabled on or within 60 days of the initial qualifying event for continuation coverage due to termination of employment or reduction in hours, continuation coverage may be extended for all qualified beneficiaries

within that family for up to 29 months from the qualifying event date rather than for only 18 months. The disabled person is subject to all of the following:

- The Social Security Administration must make a determination that the person was disabled under Title II or XVI of the Social Security Act and that the disability began before or within 60 days after the qualifying event date;

- The disability determination must be made by the Social Security Administration before the end of the original 18-month continuation of coverage period;

- The person must notify the plan administrator within the later of 60 days after the disability determination has been made or the date of the qualifying event which results in a loss of coverage, and before the end of the original 18-month continuation of coverage period;

- The person must notify the plan administrator within 30 days after the final determination is made that the person is no longer totally disabled; and

- The cost for coverage for months one through 18 will be at the rate of up to 102% of the cost of the coverage, and the cost for months 19 through 29 will be at the rate of up to 150% of the cost of the coverage.

The continuation period will end when any of the following occur:

- When the participant or dependent fails to make the required contribution (if any) to the plan before the due date or within a grace period of 30 days;

- When the participant or covered dependent first becomes covered by any other group health plan, except as described below, or first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;

- When the company ceases to maintain any group health plan; or

- In the case of a disabled participant and/or dependent who has been on continuation coverage for more than 18 months due to a disability, the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the person is no longer disabled.

A retired participant and his or her spouse who would otherwise lose health coverage under the plan after the employer files a Chapter 11 bankruptcy proceeding may continue coverage under the plan until the death of the participant. Upon the death of the retired

covered participant, his or her covered dependents shall be entitled to continuation coverage for a period of 36 months from the retiree's death.

Any other group health plan will be considered the primary coverage and must always pay benefits before this plan will consider a claim for benefits. The only exception is that the plan will remain primary if the COBRA covered person is covered by Medicare by reason of end stage renal disease, and then only until the end of the first 30 months of Medicare coverage for that disease.

In no event shall coverage as provided in this provision be continued for more than 36 months. For example, if a dependent is receiving continuation of coverage benefits due to an 18-month qualifying event, and during the 18-month period, another qualifying event occurs which would entitle the person to 36 months of continuation coverage, that dependent shall be eligible for continuation of coverage for not more than a total of 36 months.

USERRA: Continuation of Coverage Under the Uniformed Services Employment and Re-employment Rights Act

In any case in which a participant (or the participant's dependents) has coverage under the plan, and such participant is absent from such position of employment by reason of service in the uniformed services, the participant may elect to continue coverage under the plan as provided in this section. The maximum period of coverage of a participant and the participant's dependents under such an election shall be the lesser of the following:

- The 24-month period beginning on the date on which the participant's or dependent’s absence begins; or

- The day after the date on which the participant fails to apply for or return to a position of employment, as determined under USERRA.

Any continuation coverage provided under this section will run concurrently with any other continuation coverage available, including COBRA continuation coverage.

A participant who elects to continue plan coverage under this section must pay 102% of his or her normal premium under the plan. Except that, in the case of a participant who performs service in the uniformed services for less than 31 days, such participant will pay his or her normal contribution for coverage for the 31 days.

A participant who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the plan upon re-employment. Except as provided in the following paragraph, upon re-employment and reinstatement of coverage,

no new waiting period will be imposed in connection with the reinstatement of such coverage if a waiting period would normally have been imposed.

The paragraph directly above shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

As required by WHCRA, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact your plan administrator for more information.

Section 2

Comprehensive Major Medical

Eligible Expenses

The following services are eligible expenses for participants and dependents covered under this plan. Eligible expenses are subject to the deductible and coinsurance percentage as shown in the schedule of benefits. The plan agrees to provide for eligible expenses provided by healthcare providers as defined in the Plan, eligible expenses may be limited by certain provisions listed in the general exclusions section of this plan.

Birthing Centers

The plan provides benefits for expenses incurred at a birthing center, payable at the coinsurance percentage shown in the schedule of benefits. A birthing center is a licensed institution that provides 24-hour nursing service by or under the supervision of registered graduate nurses and certified nurse midwives, and is staffed, equipped, and operated to provide the following services:

- Care for patients during uncomplicated pregnancy, delivery, and the postpartum period;
- Care for infants born in the center who are normal or have abnormalities which do not impair function or threaten life; and
- Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

Coinsurance Percentage

After eligible expenses incurred in a calendar year equal the deductible amount, eligible expenses incurred in the calendar year shall be paid at the coinsurance percentage as specified in the schedule of benefits.

Deductible: Individual

Participants and dependents covered under this plan must meet an amount of eligible expenses each calendar year equal to the deductible amount as shown in the schedule of benefits before major medical benefits can be paid.

If this plan replaces a prior plan during a calendar year, any deductible or coinsurance met during that calendar year shall apply toward the deductible and/or coinsurance described in this plan for the remainder of that calendar year.

Deductible: Family

When covered family members have met an amount of eligible expense equal to the family deductible amount shown in the schedule of benefits, the individual deductible for all other covered members in that family will be considered satisfied for the remainder of the calendar year.

Deductible: Common Accident

When two or more covered family members are injured in the same accident, only one deductible amount applies to all eligible expenses for treatment resulting from that accident.

Dental Anesthesia and Facility Charges

Outpatient administration of general anesthesia and hospital charges for dental care if:

- The covered person is a child under the age of six.
- The covered person is severely disabled.
- The services are due to an injury.
- The covered person has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

Diabetic Services

The plan will provide coverage for participants and their dependents for the medically necessary treatment for diabetes, including medically necessary supplies, equipment, and self-management training, subject to the general provisions of the plan.

The plan will provide coverage when the treatment provided is medically necessary, ordered in writing by a state licensed physician or podiatrist, and provided by a health care professional that is licensed, registered, or certified under state law, specially trained in the management of diabetes.

Coverage for diabetes self-management training shall be limited to one visit after receiving a diagnosis of diabetes, one visit after receiving a diagnosis by a state licensed physician or podiatrist that represents a significant change in the participant or dependent's symptoms or condition, or makes the participant or dependent's self-management medically necessary.

Coverage for diabetes self-management training is subject to the provisions of the plan regarding the use of participating providers.

Emergency Room Benefit

If treatment is received at a hospital outpatient department the participant and his or her dependents will be covered as shown in the schedule of benefits. The deductible will be waived if admitted to the hospital.

Home Health Care Benefit

Charges made by a home health care agency for the following services and supplies furnished to a covered individual in his or her home for care in accordance with a home health care plan are included as covered medical expenses. Refer to the schedule of benefits for any further limitations.

- Part-time or intermittent nursing care by a registered nurse or a licensed practical nurse if the services of a registered nurse are not available.

- Part-time or intermittent home health aide services which consist primarily of caring for the individual.

- Physical, occupational, and speech therapy.

- Medical supplies, drugs, and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital, but only to the extent that they would have been covered under this plan if the individual had remained in the hospital.

Each four hours of home health care service by a representative shall be considered as one home health care visit. Each visit by a representative of a home health care agency shall be considered as one home health care visit.

Hospice Care

Hospice care coverage pays benefits for many of the charges incurred for the treatment of a terminally ill person while in a hospice care program.

This care may be administered through either of the following:

- Confinement in a hospital, or a centrally administered, medically-directed, and nurse-coordinated program which provides a coherent system primarily of home care, is available 24 hours a day, seven days a week, and uses a hospice team.

- The program must meet standards set by the National Hospice Organization and approved by the plan supervisor. If such program is required by a state to be

licensed, certified, or registered, it must also meet those requirements to be considered an eligible hospice program.

Hospice Care Definitions

- **Counseling Services** means supportive services provided after the death of the terminally ill person by members of the hospice team in counseling sessions with the family unit.

- **Family Unit** means the participant and his covered dependents.

- **Hospice** means a freestanding or hospital-affiliated facility that provides short periods of stay for the terminally ill in a home-like setting for either direct care or respite. It must operate as an integral part of the hospice care program.

- **Hospice Care Program** means a formal program directed by a physician as defined herein to help care for the terminally ill person.

- **Hospice Services** means services and supplies furnished to a terminally ill person by the hospice and/or the hospice team.
- **Hospice Team** means a group of professional and volunteer workers who provide care to do the following:

  a. Reduce or abate pain or other symptoms of mental or physical distress, and

  b. Meet the special needs arising out of the stresses of the terminal illness, dying, and bereavement.

  The team includes at least a physician and a registered nurse. It could also include social workers, clergymen, counselors, volunteers, clinical psychologists, physiotherapists, and occupational therapists.

- **Remission** means a halt in the progression of the disease that led to the terminal illness or an actual reduction in the extent to which the disease has already progressed.

- **Terminally ill** means the primary attending physician who is treating the person has certified that the person's life expectancy is six months or less.

Hospice Care Benefits Other Than Bereavement Benefits

Benefits – The plan will pay benefits up to the maximums shown in the schedule of benefits for any one period of care in a hospice care program for charges incurred for the terminally ill person:

- While not an inpatient in a hospice for hospice services furnished under a hospice care program, or
- While an inpatient in a hospice for hospice room and board and services for a hospice care program.

Conditions for Benefits – A terminally ill person must meet the following conditions:

- Be in a hospice care program, and
- Have the primary attending physician furnish certification of the terminally ill status to the plan supervisor.

Further, the hospice services or stay must meet the following conditions:

- Provided while the individual is covered under this plan,
- Ordered by the supervising physician who is directing the hospice care program,
- Charged for by the hospice care program, and
- Provided within six months of the individual's entry, or re-entry after a period of remission, in the hospice care program.

Hospice Care Exclusions

The following are not covered under this benefit:

- Charges for services or supplies received as a result of an accident arising out of or in the course of work or an illness covered under Worker's Compensation or a similar law.
- Charges for services or supplies furnished by or for the U.S. government or for any other government, unless payment of the charge is required by law.

- Charges for services or supplies provided under any government program or law under which the individual is or could be covered. This exclusion does not apply to a state plan under Medicaid or to any law or plan that state that its benefits are in excess of those of any private insurance program or other non-governmental program.

- Charges incurred during a remission period if the individual is discharged from the hospice care program during that period.

- Charges for services provided by a close relative.

Hospital Admissions: Early Admission Deterrent

If the participant or covered dependent is admitted to the hospital more than 24 hours prior to a scheduled surgery, no benefits will be payable for any expenses incurred until after the first day following the surgery. However, benefits are payable if the surgery is due to a life-threatening situation which, without immediate medical attention, could result in death or cause impairment to bodily functions.

Hospital Admissions: Weekend Admissions

If the participant or covered dependent is admitted to the hospital on Friday, Saturday, or Sunday, no benefits are payable for any expenses incurred during the admission. However, benefits are payable if surgery is to be performed on the day following the day of admission or the admission is due to an emergency situation which, without immediate medical attention, could result in death or cause impairment to bodily functions.

Hospital Expenses: Inpatient

- **Hospital Room and Board** – An amount covered per day up to the semi-private room rate. Intensive care unit (ICU) also covered when ordered by the patient's primary physician.

- **Hospital Miscellaneous** – All other hospital charges during an inpatient confinement, exclusive of personal items or services not necessary to the treatment of illness or injury except the cost of one hospital admission kit per confinement, shall be covered herein.

Hospital Expenses: In or Out of the Hospital

Including but not limited to the following:

- Hospital outpatient services
- X-ray and laboratory services
- Surgery charges
- Anesthesia charges

Services of other physicians including:

- Radiation therapy
- Pathological services
- Electrocardiograms
- Physical therapy
- Electroencephalograms
- Hospital visits
- Assistant surgeon charges
- Occupational therapy
- Renal dialysis
- Chemotherapy
- Partial hospitalization is covered if medically necessary, however the facility must meet the definition of a hospital.

Managed Care Program

The managed care program is a health care benefit management program. It is a cost containment benefit built upon the components of pre-certification and case management.

Pre-certification Process

Participants or their dependents with the benefit of a managed care program must have every inpatient hospital stay certified. This is a participant-driven and participant-responsible program. The participant or agent for the participant may call or have the admitting physician or hospital call to certify the stay. Medical, surgical, and psychiatric admissions must be certified prior to admission. Emergency admissions must be certified within two working days of the admission.

Maternity admissions for deliveries **do not** require certification. If the newborn baby stays longer in the hospital than the mother, the newborn's continued hospital stay must be certified.

Except in the case of maternity, at the time a medical, surgical, or psychiatric inpatient hospital admission **is planned** the participant or his or her dependent must let the physician know that the health care coverage includes the requirement of pre-certification. A penalty per admission as shown in the schedule of benefits will be reflected to the participant if pre-certification requirements are not followed.

Pre-certification is accomplished by telephoning a toll-free number on your I.D. card and providing the following information:

- Plan participant name
- Company name
- Patient's name and age
- Admitting physician's name, address, and phone number
- Name of hospital and address

Calls received after hours will be recorded, and the call will receive a response within one working day. In the case of emergency admissions, the call must be made within 48 hours or two working days of the emergency admission.

Concurrent Review

Inpatient care may be needed beyond the days initially certified. Days needed beyond those certified at admission must also be certified.

The pre-certification unit staff will monitor the patient's progress throughout the hospital stay to assure discharge is not delayed by inadequate planning and that each day of confinement is medically necessary and appropriate.

The pre-certification staff will contact the hospital utilization review department or the admitting physician for information if additional days are needed beyond those days initially certified. This concurrent review will continue until the patient is discharged.

Inpatient days certified at admission DO NOT determine the length of inpatient stay. Only the attending physician determines when a patient is to be discharged. The days anticipated at admission may not be needed, or an extension of inpatient days may be required. The physician determines this.

The appeal process is available for a patient's physician when a determination is made that additional days of inpatient care are not medically necessary.

Case Management Process

Case management is the process of assessing major or catastrophic illnesses and injuries and developing and coordinating a cost-effective alternative treatment plan. The process

can be accomplished by utilizing current contract benefits or by proposing an exception to benefits. Additionally, case management monitors the quality of care in an appropriate place of service.

Clinical case managers, who are all registered nurses, are responsible for identifying and carefully examining as early as possible every reasonable option in the care and treatment of patients suffering from a serious illness or injury. The clinical case managers then coordinate and facilitate a smooth transition to the alternate care setting. The case management component is designed to help control the cost of treating victims of serious illnesses and injuries while monitoring for the highest quality of care.

The managed care company has the authority to modify the length of stay and to approve services which are not otherwise covered by the plan if those services are as effective as a covered service but are less costly.

Mental Health and Substance Abuse Benefit

Treatment of mental health conditions and substance abuse are not covered by the plan.

Newborn Care

Hospital charges incurred by the newborn during the initial period of hospital confinement will be covered as charges of the baby, not to exceed five days. If the mother is not covered for the pregnancy, the child will still be eligible for coverage under this provision if the child is a dependent of the participant. In addition, professional services and/or circumcision will be covered during the same period.

Network

The plan hereby includes the preferred provider organization. The network consists of many participating providers. Covered services provided by a participating provider will be payable at the normal percentage levels. Payments for covered services will be made directly to the participating provider and will not be assignable to any other person. A list of participating providers is available from your employer. Participating providers may vary from one year to the next. Covered services provided by a non-participating provider will be subject to penalty and paid at a lower percentage unless one of the following are applicable:

- If a participating provider within a 50-mile radius of the employer is unable to provide the necessary care to the covered person, the penalty will not apply.

- If the covered person resides outside of a 50-mile radius of a participating provider, the penalty will not apply.

- If the covered person requires emergency medical treatment and is taken to the nearest appropriate hospital, the penalty will not apply. It will be considered emergency medical treatment when an accident is involved, when an illness is life-threatening, or the covered person is not within a 50-mile radius of a participating provider when requiring medical treatment.

For a free listing of participating providers, visit the network's website or call its toll-free number. You also may contact the plan supervisor. Website and toll-free numbers are on your identification card.

Other Covered Services:

:

- Nursing services (except those of a relative) performed by a registered nurse or a licensed practical nurse
- Rental or purchase of medically necessary durable equipment, whichever is more economical
- Orthopedic braces, crutches, prosthetic devices, surgical dressings, splints and casts. Charges will be payable if an appliance is certified to be unserviceable by a qualified physician.
- Ambulance service when medically necessary to and from the medical facility rendering appropriate treatment
- Cervical collar, colostomy bag, ileostomy supplies, catheters, insulin and syringes
- Blood and blood syringes
- Oxygen and its administration
- Allergy injections, services and supplies
- Colonoscopy and sigmoidoscopy
- Speech therapy must be ordered by a physician and follow either:
  - Surgery for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy) of a person while covered under this plan;
  - An injury; or
  - A sickness that is other than a learning or mental disorder.
- Chiropractic services as indicated in the schedule of benefits
- Nurse Midwife Service covered services given by a licensed or certified Nurse-Midwife acting within the scope of that license or certification. The services do not have to be recommended and approved by a physician. Benefits are payable on the same basis as covered services provided by a physician.
- Dental services provided by a dentist, oral surgeon, or physician, including all related hospital outpatient charges, only as specifically provided herein:
  - **a.** Treatment for accidental injuries to natural teeth or facial bones within six months of the injury
  - **b.** Extraction of impacted wisdom teeth

- Breast reconstruction in connection with a mastectomy:
  - **a.** Reconstruction of the breast on which the mastectomy has been performed
  - **b.** Surgery and reconstruction of the other breast to produce symmetrical appearance
  - **c.** Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined appropriate in consultation with the attending physician and the patient
- Any excise tax or surcharge imposed by a governmental entity for services, supplies, and/or treatments rendered by a physician, hospital, facility, or any other health care provider
- Voluntary bill audits, the Plan will provide payment for fees associated with bill discount programs.
- 3D mammography will be considered an eligible expense. If the services are routine/preventive, services will be payable under the Preventive/Wellness Benefit. If services are non-routine services will be payable as any other illness.
- Services rendered from a mobile clinic will be payable the same as a physician's primary care office visit. If the mobile clinic is a specialized mobile clinic (i.e. MRI, MRA, X-ray, etc.) services will be payable as any other specialized services.

Out-of-Pocket Maximum

When eligible charges incurred in a calendar year and paid under this plan reach the maximum out-of-pocket shown in the schedule of benefits, then eligible charges shall be paid at 100% for the remainder of that calendar year.

Physician's In Hospital Visits

If a participant or dependent covered under this plan undergoes treatment by a physician as defined herein during a period of hospital confinement because of injury or illness, the plan shall pay for such treatment as shown in the schedule of benefits.

The word "visit" as used in this provision means a personal interview between the participant or dependent and a physician and includes telephone calls or interviews in which the physician does not see the participant or dependent for treatment.

Physician Office Visit

The plan will pay for physician office visits due to an accident, illness, or preventive/wellness care. The covered person pays the co-payment amount indicated in the schedule of benefits, then the plan will pay the balance charged for the office visit; does not include lab expense and other charges. Benefit includes services rendered by General/ Family Practice, Medicine, Pediatricians, Internists, OB-Gyn, and Urgent Care Facility.

Skilled Nursing Facility

This provision shall provide benefits for expenses incurred during a covered skilled nursing facility confinement after a hospital stay of at least three consecutive days while covered under this plan. Refer to the schedule of benefits for further limitations.

The eligible expenses are the nursing home charges, up to the limits shown in the schedule of benefits, for the following services and supplies furnished while the patient is under continuous care of the attending physician and requires 24-hour care:

- Room, board, and other services and supplies furnished by the facility for necessary care (other than personal items and professional services);
- Use of special treatment rooms;
- X-ray and laboratory examinations;
- Physical, occupational, and speech therapy; and/or
- Oxygen and other gas therapy.

Specialist Visit

The plan will pay for specialist visits due to an accident or illness. The covered person pays the co-payment amount indicated in the schedule of benefits, then the plan will pay the balance charged for the office visit; does not include lab expense and other charges.

Pre-admission Testing

The plan will pay for the participant and his or her covered dependents the amount as shown in the schedule of benefits for outpatient pre-admission testing. The testing must be performed prior to the individual's admission to the hospital. The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the participant or covered dependent is being admitted to the hospital.

Pregnancy

Pregnancy is covered the same as any other illness for participant and covered dependents and there is no pre-existing condition exclusion period which applies to maternity claims. **Dependent children are not eligible for pregnancy benefits.**

Prescription Drug Card

The prescription drug benefit covers drugs which are not available over the counter and which require a physician's prescription to be dispensed by a pharmacist. Benefits shall be payable at the coinsurance percentage specified in the schedule of benefits for drugs prescribed by a physician for use outside the hospital after the prescription drug co-payment amount has been satisfied. This benefit is not subject to the pre-existing conditions provision.

A prescription drug such as, but not limited to, Viagra which is prescribed to treat male or female sexual dysfunction will be a covered benefit subject to the provisions of the plan only when the dysfunction is caused by a physiological injury, illness, or diseased condition, such as diabetes, which is being treated by the prescribing physician, with a limit of six doses for each 30-day period. In order for such prescription drugs to be covered, the participant or covered dependent must submit an acceptable statement to the employer or plan supervisor from the individual's physician which outlines the diagnosis of the underlying physiological condition. Coverage for such prescription drugs will begin only after the plan determines that the individual's physiological condition meets these standards.

Benefits will not be paid for the following:

- **A.** Drugs which are available over the counter,
- **B.** Vitamins (except Pre-natal),
- **C.** Dietary supplements or anti-obesity drugs,
- **D.** Contraceptive (except Oral contraceptives),
- **E.** Ostomy supplies,
- **F.** Fertility drugs,
- **G.** Smoking deterrents,
- **H.** Immunodeficient drugs,
- **I.** DESI drugs,
- **J.** Growth hormones,
- **K.** Rogaine and Accutane,
- **L.** Medicine administered while admitted to a medical facility,
- **M.** Diagnostic (example – Chemstrips),
- **N.** Experimental or investigational drugs,
- **O.** Over-the-counter Diabetic supplies,
- **P.** Medicine covered by Worker's Compensation or similar government program,
- **Q.** Anti-hyperkinetics,
- **R.** DME (crutches, walkers, etc.),
- **S.** Injectables, except insulin

All Biotech prescription drugs, injectibles, or otherwise, require pre-authorization from Health Care Management and are covered only under the Major Medical Plan.

The Prescription Drug Card portion of the Plan does not coordinate benefits with a primary or secondary payor.

Private Duty Nursing

This plan will provide benefits for non-custodial nursing care provided by a registered nurse or a licensed practical nurse, when prescribed by a physician when the participant or covered dependent is confined to home. Eligible charges are payable up to the limits shown in the schedule of benefits.

Second Surgical Opinion: Voluntary

The plan will pay for a second surgical opinion when obtained by a covered person. The plan will also pay for a third and final surgical opinion in the case of a conflict between the first two opinions. Eligible charges will include all diagnostic procedures needed for evaluation. A second or third opinion must be an opinion of a second or third surgeon acting on a consulting basis only and one that agrees not to perform surgery, if deemed necessary, nor to otherwise treat the patient. A surgeon in association or practice with a prior surgical consultant will not be accepted.

Sterilization: Elective

The plan pays for certain elective sterilization procedures such as tubal ligations and vasectomies. These procedures shall be considered the same as any other illness only for covered participants and spouses.

Eligible expenses under this plan shall not include reversals or attempted reversals of these procedures.

Supplemental Accident Benefit

A payment up to the maximum shown in the schedule of benefits will be made toward expenses which are incurred within 3 months as a direct result of the accident, or as otherwise specified in the schedule of benefits. Additional benefits are payable under normal coverage of this plan when this benefit is exhausted.

Surgical Expense

Upon receipt of due notice and satisfactory proof that the participant or dependent while covered under this plan has undergone an operation by a physician as defined herein or received other services included in this provision whether or not hospital confinement was required, the plan supervisor will consider as eligible expenses the reasonable and customary amount charged up to the limits shown in the schedule of benefits.

If multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed during the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s).

When an incidental procedure is performed through the same operative incision, the total value shall be the value for the major procedure only.

Inpatient Surgery

This plan provides inpatient surgery benefits for the participant and covered dependents. Benefits will be payable as shown in the schedule of benefits, including all related expenses.

Outpatient Surgery

Outpatient surgical procedures will be payable as shown in the schedule of benefits provided surgery is performed in the outpatient department of a hospital, in an ambulatory surgical center, or in a physician's office.

Temporomandibular Joint Syndrome (TMJ)

The plan provides benefits for expenses incurred for medical treatment of the temporomandibular joint (TMJ) and other jaw disorders and services directly attributable to the TMJ dysfunction. Eligible charges are payable up to the limits shown in the schedule of benefits.

Transplants: Donor/Organ

The plan provides benefits for expenses incurred by the participant or covered dependents for services and supplies provided in connection with any non-experimental human organ and tissue transplant services from a human donor to a human transplant recipient.

Donor expenses include but are not limited to, procurement of a donor organ, evaluation, surgical removal, transportation, and storage of the donor organ. Such expenses will be considered eligible under the plan whether or not the donor is covered under the plan.

If a scheduled transplant is cancelled because of the patient’s medical condition or death, and the organ cannot be used for someone else, donor benefits will still be paid.

If the donor is covered under any plan, that plan will be primary and obligated to pay donor expenses. If a donor is not covered under another plan, this plan will pay expenses incurred by the donor under and as part of the recipient’s expenses.

Eligible employees and their dependents requiring human organ and tissue transplant services will be eligible for transplant-related benefits under and on the terms of this plan document for human organ and tissue transplant service charges that are not covered by the additional transplant policy described below. Examples of some of the charges not covered by the additional transplant policy include:

- Transplant-related charges for the period after the additional transplant policy's benefit period elapses, which will typically be up to 365 days after transplant; and
- Transplant-related charges incurred by eligible employees and their dependents who are initially excluded from the additional transplant policy due to a pre-existing condition for the period before the employee or dependent is eligible for benefits under the additional transplant policy.

Additional Transplant Policy

Transplant benefits
Additional transplant benefits are provided through the Group Specified Disease Policy Organ & Tissue Transplant ("Transplant Policy") underwritten and administered by QBE Insurance Corporation. The following are key benefits of the Transplant Policy:

- Covered persons include eligible employees and their dependents
- Coverage under the Transplant Policy is dependent on eligibility under the plan and all terms and conditions of the Transplant Policy on the date(s) of service
- Benefit period starts at evaluation and ends up to 365 days after transplant
- After transplant drugs are provided through QBE
- Any charges covered by the Transplant Policy are not considered a covered benefit under this plan document
- Any charges not covered by the Transplant Policy are subject to the medical benefits of this plan document
- Transplant related expenses after the benefit period under the Transplant Policy ends are subject to the medical benefits of this plan document

Transplant benefits under the Transplant Policy are fully explained in the Additional Transplant Policy.

Transplant network

For 100% in-network benefits with no copay or deductible, QBE's approved transplant network providers must be used. Charges not covered by the Transplant Policy are subject to the transplant network provider rates and the medical plan benefits.
Call QBE at 978.619.1560 extension 621560 for:

- Transplant benefits
- Pre-authorization of transplant-related services including evaluation

- Transplant network provider information
- Claims questions

Note: The Transplant Policy has in-network and out-of-network benefits

Pre-existing conditions
The Transplant Policy includes a 12-month pre-existing condition provision beginning on the covered person's effective date of coverage under the Major Medical Plan. If a participant or covered dependent receives a transplant during the pre-existing condition waiting period, that transplant and all related charges are excluded from coverage under the Transplant Policy, but the participant or covered dependent are eligible for the transplant benefit under and on the terms of this plan document. For additional information, please contact the plan supervisor or plan administrator.

Wellness Benefit

Benefits are payable herein for routine preventive expenses including but not limited to physical examinations, immunizations, mammograms, pap smears, prostate testing, flu shots and well-baby care up to the maximum benefit shown in the schedule of benefits per covered person per calendar year. Labs and x-rays performed and billed at the time of the visit will be payable.

X-ray and Laboratory Expenses: Outpatient Diagnostic

Diagnostic x-ray and laboratory expense benefits provide payment for x-ray and laboratory tests and their interpretation. Benefits under this provision of the plan are payable as shown in the schedule of benefits.

Benefits hereunder are not payable for pre-marital laboratory tests, x-ray therapy, dentistry, eye refraction, expenses incurred while confined in a hospital or x-ray or laboratory charges which would be considered under any other benefits of this plan.

Section 3

General Exclusions

General Exclusions to the Plan

Covered expenses do not include and no benefits are payable for the following:

1. Charges that are not for the care or treatment of an accident or illness except as specifically provided for in this plan.

2. Cosmetic treatment, surgery or related hospital admissions, unless made necessary:

   - by an accidental injury,
   - for correction of congenital deformity within six years of birth,
   - for re-constructive surgery as necessary for the prompt treatment of a diseased condition.

3. Charges for or in connection with treatment of teeth or periodontium or treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, except as provided herein.

4. Charges or disabilities for or in connection with an injury arising out of or in the course of any employment for wage or profit.

5. Services or disabilities covered by or for which the participant is entitled to benefits under any Worker's Compensation or similar law.

6. Services and supplies in a hospital owned or operated by the United States government or any government outside the United States in which the participant or dependent is entitled to receive benefits, except for the reasonable cost of services and supplies which are billed, pursuant to federal law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are covered herein and which are not incurred during or from service in the Armed Forces of the United States.

7. Charges that the participant is not legally required to pay for or charges which would not have been made if this coverage had not existed.

8. Charges that are in excess of the reasonable and customary rates.

9. Charges and services that are not medically necessary for the treatment of the diagnosed illness or injury as determined by the plan.

10. Charges for a covered person that are reimbursed, that could be reimbursed, or that could have been reimbursed by any public program, such as Medicare or Medicaid, even if the person could have, but does not, elect to be covered by that public program.

11. Treatment made necessary as the result of illegal use of narcotics or use of hallucinogens in any form unless prescribed by a physician or as provided herein.

12. Treatment made necessary by or a disability arising from war, declared or undeclared, or any act of war. An act of terrorism will not be considered an act of war, declared or undeclared.

13. Eyeglasses, contacts, eye refractions, hearing aids, or examinations for prescriptions or fitting of eyeglasses, contacts, hearing aids or charges for radial keratotomy, except for the first pair of glasses or contact lenses following cataract surgery. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

14. Routine services such as, but not limited to, routine physical exams and premarital exams unless specifically stated in the plan.

15. Routine pediatric care of well newborns, unless specifically provided for herein.

16. Elective, voluntary abortions.

17. Travel, whether or not recommended by a physician, except as provided herein.

18. Sanatoria or rest cures.

19. Custodial care whose primary purpose is to meet personal rather than medical needs and which is provided by persons with no special medical skills or training. Such care includes, but is not limited to, helping a patient walk, getting in or out of bed, or taking normally self-administered medicine. The plan administrator shall determine, based on reasonable medical evidence, whether care is custodial.

20. Treatment or services provided by anyone other than a healthcare provider as defined herein unless specifically stated in the plan.

21. Investigatory and experimental treatment, services, and supplies.

22. Birth control medications or devices, unless provided for under the prescription drug card benefit.

23. Hospital services performed in a facility other than as defined herein.

24. Services or supplies that are primarily educational in nature including education, training, and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home.

25. Organ transplant surgeries which are considered experimental in nature.

26. Charges resulting from attempted suicide or intentionally self-inflicted injury while sane or insane, unless charge results from a medical condition such as depression.

27. Charges for private hospital rooms in excess of the semi-private room rate, as defined herein, except as follows:

- If a private room is prescribed by a physician for medically necessary reasons or because the hospital does not have a semi-private room that would meet the medical needs of the patient, or

- If the hospital has no semi-private rooms, the lowest cost private room for the condition being treated shall be an allowable expense.

28. Charges for injuries, illness, or disability resulting from, or which occur as a part of, the covered employee's or dependent's commission of, or attempt to commit, an assault, felony, or act of aggression.

29. Any procedure or treatment to change physical characteristics to those of the opposite sex and other treatment or studies related to sex change.

30. Services of a physician, registered nurse, a licensed practical nurse, or a licensed physical therapist who usually resides in the same household or who is related by blood, marriage, or legal adoption to the covered person or the covered person’s spouse.

31. Services or supplies provided for weight control and/or surgical treatment for obesity, except for morbid obesity. Gastric surgery will be covered if medically necessary.

32. Charges for fertility or infertility treatment, including drugs and testing and related charges for artificial insemination, and for in vitro fertilization.

33. Charges for or disability resulting from reversal of sterilization.

34. Charges for the completion of claim forms, or charges for failure to keep scheduled appointments, unless provider for herein.

35. Recreational or diversional therapy.

36. Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if prescribed by a physician.

37. Services or supplies for the removal of corns, calluses, or for the trimming of toenails.

38. Charges in connection with an illness or injury which was sustained while involved in a dangerous activity, including but not limited to, sky-diving, auto or motorcycle racing, bungee jumping, rock climbing, rappelling, or hang-gliding.

39. The Plan will not deny otherwise payable claims if the claims are the result of Domestic Violence except if the claims are for the aggressor..

40. Expenses incurred outside of the United States if the covered person traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.

41. Charges for the care of weak, unstable or imbalanced foot, metatarsalgia, bunion, corns, calluses, toenails, fallen arches, or chronic foot strain are excluded except for care of corns, bunions, calluses, or toenails when medically necessary because of diabetes or circulatory problems and for surgical intervention when medically necessary for treatment of foot disorders.

42. Charges in connection with injuries sustained while intoxicated, unless the injuries resulted from alcoholism, which is a medical condition.

43. Care and treatment for smoking cessation programs, including smoking deterrent patches, unless medically necessary due to a severe active lung illness such as emphysema or asthma.

44. A prescription drug such as, but not limited to, Viagra which is prescribed to treat male and female sexual dysfunction will not be a covered benefit under the plan unless specifically stated in the plan.

45. Services rendered for the treatment of mental and nervous diseases and disorders.

46. Services rendered for the treatment of substance abuse.

47. Care, treatment, or supplies for which a charge was incurred before a person was covered under this plan.

48. Spare braces of the leg, arm, back or neck; artificial arms, legs or eyes; or lenses for the eyes.

49. Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a physician. This exclusion does not include wigs for cancer or other illnesses involving radiation or chemotherapy.

50. Exercise programs for treatment of any condition.

51. Care and treatment of pregnancy and complications of pregnancy for a dependent child.

52. Care, services or treatment required as a result of complications from a treatment not covered under the plan.

53. Charges for outpatient drugs. (Outpatient drugs will only be considered for payment under the Prescription Drug Card Benefit.)

54. Spinal manipulation/chiropractic charges for individuals under the age of fifteen (15).

55. Additional fees or charges for robotic assistance (beyond fees or charges for surgery performed without robotic assistance) except to the extent required by the contract with the preferred/provider network.

Section 4

Definitions

Actively-at-Work

Actively-at-work means that on the day that coverage under the plan would begin, an employee is not absent from work, or if he or she is absent from work, the absence is not related to the health of the employee.

Ambulatory Surgical Center

For surgery benefits covered under this plan, the term hospital shall include freestanding ***ambulatory surgical centers*** licensed by the state in which treatment is received as defined below.

An ***ambulatory surgical center*** is a freestanding surgical facility that meets licensing standards, is set up, equipped, and run to provide general surgery and make charges. A staff of physicians, one of who must be on the premises when surgery is performed and during the recovery period, directs it. It must have at least one certified anesthesiologist at the site when surgery, which requires general or spinal anesthesia, is performed and during the recovery period. It must extend surgical staff privileges to physicians who practice surgery in an area hospital and dentists who perform oral surgery.

It must have at least two operating rooms and one recovery room. It must provide or arrange with a medical facility in the area for diagnostic x-ray and lab services needed in connection with the surgery. It must not have a place for patients to stay overnight. It must provide, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse.

It must be equipped and have trained staff to handle medical emergencies and have a physician trained in cardiopulmonary resuscitation, a defibrillator, a tracheotomy set, and a blood volume expander. It must have a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff aware of them. It must provide an ongoing quality assurance program with reviews by physicians who do not own or direct the facility. It must maintain a medical record on each patient.

Ancillary Provider

Ancillary providers are state licensed healthcare professionals such as, but not limited to a physician's assistant, nurse practitioner, nurse assistant, licensed clinical social worker, health service provider in psychology, registered physical therapists, registered speech therapists, certified registered nurses of anesthesia or state licensed healthcare providers who are licensed and acting within the scope of their license.

Chiropractic or Chiropractic Services

Chiropractic or chiropractic services means the diagnosis and analysis of any interference with normal nerve transmission and expression, the procedure preparatory to and complementary to the correction thereof by an adjustment of the articulations of the vertebral column, its immediate articulation, and includes other incidental means of adjustments of the spinal column and the practice of drugless therapeutics. However, chiropractic does not include any of the following:

- The prescription or administration of legend drugs or other controlled substances;
- Performing of incisive surgery or internal or external cauterization;
- Penetration of the skin with a needle or other instrument for any purpose except for the purpose of blood analysis;
- Use of colonic irrigations, plasmatics, ionizing radionics;
- Conducting invasive diagnostic tests or analysis of body fluids except for urinalysis;
- The taking of x-rays of any organ other than the vertebral column and extremities;
- The treatment or attempt to treat infectious diseases, endocrine disorders, or atypical or abnormal histology.

Complications of Pregnancy

The term ***complications of pregnancy*** means conditions requiring hospital confinement (when pregnancy is not terminated), whose diagnosis is distinct from pregnancy or is caused by pregnancy, such as:

- acute nephritis,
- nephrosis,
- cardiac decompensation,
- missed abortion,
- similar medical and surgical conditions of comparable severity.

Complications of pregnancy also include the following:

- non-elective cesarean section,
- ectopic pregnancy, which is terminated,
- spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy do not include the following:

- false labor,

- occasional spotting,
- physician prescribed bed rest during the period of pregnancy,
- morning sickness,
- hyperemesis gravidarum,
- similar conditions associated with the management of a difficult pregnancy not constituting a medically distinct complication of pregnancy.

Dependent

The term ***dependent*** means the spouse of a participant, and the following children:

- Natural children,
- Stepchildren, and/or
- Legally adopted children under the age of 18 who have been placed for adoption or who have been adopted by the participant.

  a. Such a child shall be eligible for coverage as of the date of placement for adoption, or as of the date of actual adoption, whichever occurs first.

  b. Coverage under the plan for such a child shall be the same coverage which is available to all other dependent children under the plan.

- Children for whom the person or the person's spouse is legal guardian.

A dependent child shall remain a dependent hereunder until attaining the age specified in the schedule of benefits.

A child who has lost eligibility hereunder may resume coverage if the child's reason for loss of eligibility no longer exists and the child otherwise meets the eligibility criteria of the plan.

Donor

A ***donor*** is the person who provides the organ for the recipient in connection with organ transplant surgery. A donor may or may not be a participant or covered dependent covered under the provisions of this plan. Charges for donor expenses may or may not be covered by the plan depending on the benefits set out in the plan.

Effective Date

The ***effective date*** shall mean the first day this plan was in effect as shown in the plan specifications. As to the individual, it is the first day that benefits under this plan would be in effect after satisfaction of the waiting period and any other provisions or limitations contained herein.

Eligible Charges

Eligible charges means charges for services covered under this plan to the extent that such charges are not excessive, based upon professional medical opinion, or upon the reasonable and customary charge for similar providers who perform like covered services.

Emergency

Emergency means an unexpected acute illness or injury which, in the judgment of the attending physician and/or a prudent layperson who possesses an average knowledge of health and medicine, could risk permanent damage to the patient's health unless immediate medical or surgical treatment is provided.

Enrollment Date

The term ***enrollment date*** is defined as the first day of coverage or, if there is a waiting period for coverage to begin under the plan, the first day of any applicable waiting period.

For a person who is a late enrollee or who enrolls as a special enrollee, the enrollment date will be the first date of actual coverage.

Experimental

The term ***experimental*** is if one or more of the following is true of a treatment, procedure, device, drug, or medicine:

- It cannot be lawfully marketed without U.S. Food and Drug Administration approval and approval for marketing for the condition treated has not been given at the time the device, drug, or medicine is furnished.

- Reliable evidence shows that to determine its maximum tolerated dose, toxicity, safety, efficacy (or efficacy as compared with the standard means of treatment or diagnosis):

a. It is undergoing phase I, II, or III clinical trials or is under study; or

b. Further clinical trials or studies are needed, according to the experts' consensus of opinion.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature or the written protocol or written informed consent used by the treating facility (or by another facility studying substantially the same treatment, procedure, device, drug, or medicine).

Experimental or ***investigational*** shall also mean:

- Any treatments, services, supplies or related expenses that are educational or provided primarily for research; or

- Treatments, procedures, devices, drugs or medicines, or other expenses relating to the transplant of non-human organs.

Gender

Whenever a personal pronoun in the masculine ***gender*** is used, it shall include the feminine also, unless the context clearly indicates the contrary.

Hospital

A ***hospital*** is a legally licensed or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) approved institution which, for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and ill persons by or under the supervision of a staff of physicians who are duly licensed to practice medicine, and which continuously provides 24 hour a day nursing services by registered graduate nurses. It is not, other than incidentally, a place for rest or for the aged. For the services covered under this plan and for no other purpose, inpatient services for treatment of mental illness or substance abuse that are provided by a community mental health center or by any psychiatric hospital licensed by the State Board of Health or the Department of Mental Health will be considered services rendered in a hospital as defined herein.

Illness

The term ***illness*** means a physical or mental condition causing loss while this plan is in force for the covered person whose illness is the basis of the claim. Illness shall also be deemed to include disability caused or contributed by pregnancy, miscarriage, childbirth,

and recovery therefrom. It shall only mean illness or disease which requires treatment by a physician.

Incurred Charges

Incurred charges are the charges for a service or supply and are considered to be incurred on the date furnished. In the absence of due proof to the contrary when a single charge is made for a series of services, the date of service shall be considered the last date of service shown on the claim.

Injury

The term ***injury*** shall mean only bodily injury caused by an accident while the plan is in force for the covered person whose injury is the basis of the claim. Injury shall mean only those injuries that require treatment by a physician. A hernia shall be considered an illness, not an injury.

Late Enrollee

The term ***late enrollee*** means an employee or dependent that request enrollment for coverage under the plan other than during the period of initial eligibility or during a period of special enrollment.

Medically Necessary

The term ***medically necessary*** refers to medical services and/or supplies which are absolutely necessary and essential, as determined by the plan, to treat an illness or injury of a covered participant or dependent while covered by this plan. Such items are as follows:

- Consistent with the patient's diagnosis or symptoms; and
- Appropriate treatment according to generally accepted standards of medical practice; and
- Not provided only as a convenience to the patient or provider; and
- Not experimental or unproven; and
- Not educational, vocational, or provided primarily for medical or other research; and
- Not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment to the covered person.

Any service or supply provided at a provider facility will not be considered medically necessary if the covered person's symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

Medicare

Medicare refers to the programs established by Title XVIII of the U.S. Social Security Act as amended and as may be amended, entitled Health Insurance for the Aged Act, and which includes Part A – Hospital Insurance Benefits for the Aged and Part B – Supplementary Medical Insurance Benefits for the Aged.

Morbid Obesity

The term ***morbid obesity*** is defined as follows:

- A weight of at least two times the ideal weight for body frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables; or

- A body mass index of at least thirty-five kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or

- A body mass index of at least forty kilograms per meter squared without comorbidity

Non-participating Provider

A ***non-participating provider*** is a provider that is not a member of the preferred provider organization.

Open Enrollment Period

An ***open enrollment period*** is a period during which an individual may apply for or adjust coverage under the benefit plan(s) of the company. A person who enrolls in the plan during an open enrollment period shall be considered a late enrollee under the plan.

Participant

A ***participant*** is a person directly involved in the regular business of and compensated for services by the company, who is regularly scheduled to work at least 30 hours per week on an active, full-time basis.

Participating Provider

A ***participating provider*** is a provider that is a member of the preferred provider organization. The member list is subject to change.

Physician

The term ***physician*** means a Doctor of Medicine or Doctor of Osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery, or obstetrics at the time and place service is rendered. For services covered by this plan and for no other purpose, Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Podiatry or Surgical Chiropody, Optometrists, and Chiropractors will be considered a physician.

Plan Administrator

The ***plan administrator*** is the person, group, or organization responsible for the day-to-day functions and management of the plan. The plan administrator may employ persons or firms to process claims and perform other plan-connected services. The plan administrator is the company that is the named fiduciary.

Plan Document

The term ***plan document*** whenever used herein shall mean the document held by the company, which describes the terms and conditions of the benefits of the plan and will prevail over the ***summary plan description***.

Plan Supervisor

The ***plan supervisor*** is the person or group providing administrative services to the company 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.

Plan Year

The term ***plan year*** means an annual period beginning on the effective date of this plan and ending 12 calendar months thereafter or upon termination of the plan, whichever occurs earliest.

PPACA

Patient Protection and Affordable Care Act

Pregnancy

The term ***pregnancy*** means the condition of being pregnant and all conditions and/or complications resulting therefrom.

Primary Care Physician

Primary Care Physician includes family practitioner, internist, pediatrician or OB/GYN or urgent care facility.

Reasonable and Customary

A ***reasonable and customary*** charge shall be the usual charge made by a physician or supplier of services, medicines, or supplies and shall not exceed the general level of charges made by others rendering or furnishing such services, medicines, or supplies within the area in which the charge is incurred for illness or injuries comparable in severity and nature to the illness or injury being treated. The term area as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of level charges.

Recipient

The ***recipient*** is the person who receives the organ for transplant from the organ donor. The recipient shall be a participant or dependent covered under the provisions of this plan. Only those organ transplants **not** considered experimental in nature are eligible for coverage under this plan.

Room and Board Charges

Room and board charges are the institution's charges for room and board and its charges for other necessary institutional services and supplies, made regularly at a daily or weekly rate in consideration for the type of accommodations occupied.

Semi-private Rate

The ***semi-private rate*** is the daily room and board charge that an institution applies to its semi-private rooms, containing two or more beds, for the condition being treated, or it is the lowest single room rate when a single room is deemed medically necessary as determined by the attending physician or if the institution has no semi-private rooms.

Skilled Nursing Facility

A ***skilled nursing facility*** is an institution or a distinct part of an institution meeting all of the following tests:

- It is licensed to provide and is engaged in providing, on an inpatient basis, for persons convalescing from injury or disease, professional nursing services, rendered by a registered graduate nurse or by a licensed practical nurse under the direction of a registered graduate nurse, and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.

- Its services are provided for compensation from its patients, which are under the full-time supervision of a physician or registered graduate nurse.

- It provides 24 hour per day nursing services by licensed nurses under the direction of a full-time registered graduate nurse.

- It maintains a complete medical record on each patient.

- It has an effective utilization review plan.

- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, the mentally handicapped, custodial or educational care, or care of mental disorders.

Special Enrollee

The term ***special enrollee*** means an employee or dependent who is entitled to, is qualified for, and who requests special enrollment under the plan within 30 days of losing other health coverage or who is added to the plan as a result of marriage, birth, placement for adoption, or is a newly adopted child under the age of 18.

Spouse

The term ***spouse*** means a person that is considered to be a lawful spouse under the law of the state of the Employer.

Definitions

Summary Plan Description

Each participant covered under the plan will be issued a ***summary plan description***, which is a document which tell participants what the plan provides and how its operates, including information on various provisions of the plan affecting the participant.

The document is designed to be a summary of the participant's benefits and, in the event of any question, the master plan document shall be the prevailing document.

Surgical Procedure

A ***surgical procedure*** includes but is not limited to cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, paracentesis, applying plaster casts, administering pneumothorax, endoscopy, injecting sclerosing solution, arthroscopic procedures, lithotripsy, or urethral dilation.

Total Disability

Total disability is the condition wherein a covered employee is prevented solely because of a non-occupational injury or non-occupational disease from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit.

Treatment

The term ***treatment*** refers to any service or supply used to evaluate, diagnose, or remedy a condition of a participant or his covered dependents.

Waiting Period

The term ***waiting period*** means the term that must pass under this plan (or for purposes of determining creditable coverage, under any other health plan) before an employee or dependent is eligible to be actually covered by the plan. Notwithstanding the foregoing, the time between the date a late enrollee or special enrollee first becomes eligible for enrollment under the plan and the first day of coverage shall not be treated as a waiting period.

Section 5

General Claim Information

Medical Claim Payment and Appeals

Pre-Service Urgent Care Claims

When a request to review an "urgent" pre-service claim is submitted, the participant will be notified of the plan's decision as soon as possible, but no more than 72 hours after the plan receives the claim (unless the participant fails to provide sufficient information to determine whether or what benefits are covered or payable under the Plan). If the treating physician classifies a claim as "urgent," the plan will do so as well.

If information to review of an "urgent" claim is incomplete, the following will occur:

- The plan will notify the participant of the deficiency and specify what information is missing. This will be done within 24 hours after receipt of the claim.
- The participant has 72 hours to provide the missing information.
- The plan will make its decision within 48 hours after the earlier of (1) when it receives all necessary information or (2) the end of the period provided for the participant to submit the information (usually 72 hours).

If a participant appeals the denial of a pre-service "urgent" claim, the plan must render a review decision as soon as possible, but no more than 24 hours after receiving the appeal.

Concurrent Care Claims

Reduction or Termination of Coverage by the Plan:

If a plan has approved an on-going course of treatment and then determines that such treatment should be reduced or terminated, the plan must notify the participant of this decision far enough in advance of the reduction or termination date to allow for an appeal and review of the decision.

However, this does not apply if the plan has been amended to reduce or end coverage for the treatment, or when the plan itself terminates.

Extensions of Treatment:

When a participant requests an extension of an on-going course of treatment beyond that which the plan has approved, the plan must do the following:

- Make a decision about the extension as soon as possible; and

- Notify the participant of the decision within 24 hours after receipt of the request, if the request was made at least 24 hours before the end of the treatment that had already been approved.

Pre-Service Benefit Claim Review for Coverage

If the plan requires that benefits for a service be predetermined prior to the service being provided, the participant or the health care provider must submit a request for that pre-service benefit claim review to the plan supervisor. A decision for a pre-service benefit determination will be made within 15 days after receipt of the request.

Extensions:

- The 15 day period may be extended for another 15 days if it is necessary because of matters beyond the plan's control, and if the plan notifies the participant of those circumstances and the expected date of the decision before the end of the first 15 day period.

- If the extension is necessary because insufficient information was submitted, the extension notice will describe the missing information and give the participant 45 days to submit such information.

Normal Post-Service Health Claims

A participant or health care provider must file a claim with the plan supervisor within the time frames set out in the plan. A claim will be considered to have been filed upon receipt by the plan supervisor. The participant will be notified within 30 days of receipt of a claim by the plan as to the benefits to be paid for that claim.

Extensions:

- The 30 day period may be extended for 15 days if it is necessary due to matters beyond the control of the plan, but the plan will notify the participant before the end of the 30 day period of those circumstances and the expected date of the decision.

- If more information is necessary to properly process the claim, a notice will be given within the 30 day period that the plan can not meet the 30 day time frame. The notice will describe the missing information and give the participant at least 45 days to provide the missing information. Upon receipt of the missing information, the claim will be processed within the later of 45 days after the

original receipt of the claim or within 15 days of receipt of the missing information.

If more information is necessary to properly process the claim and it is not received within the 45 day time frame, the claim will be denied. The claim may thereafter be re-submitted with the missing information as long as the re-filing is completed within the claim filing time limits set out in the plan.

General Conditions

The period of time within which a benefit determination is required to be made shall begin at the time the claim is filed with the plan, without regard to whether all the information necessary to make the benefit determination accompanies the filing. In the case of any extension of time to make a benefit determination which is based on a lack of submitted information necessary to determine a claim, the period for making the benefit determination shall stop running until the claimant responds to the request for additional information.

Any adverse determination shall set forth the following:

- The specific reason or reasons for the adverse determination;
- A reference to any specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the participant to make the claim payable and an explanation of why such material or information is necessary;
- A description of the plan's review procedures and the time limits which are applicable to such procedures, including a statement of the participant's right to bring a civil action under Section 502(a) of ERISA;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the plan will provide that criterion free of charge upon request; and
- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the plan will provide an explanation of how it made that determination free of charge upon request.

Appealing an Adverse Decision

In order to appeal an adverse decision, the plan will do the following:

- Allow a participant 180 days following receipt of a notification of an adverse benefit determination within which to file a written appeal to the plan administrator at the address found in the summary plan description;

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

- Provide a participant upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information which is relevant to the participant's claim for benefits;

- Provide a participant any new or additional evidence or rationale that is relied upon, considered or generated by or at the direction of the plan. The new evidence or rationale shall be provided free of charge as soon as possible, and sufficiently in advance of the time within which a final determination or appeal is required to allow the participant to respond.

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

- Provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the plan who is neither the individual who made the original adverse benefit determination, nor the subordinate of such individual;

- In deciding an appeal from an adverse benefit determination that is based in whole or in part on a medical judgment, provide that the appropriate plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

- Provide that the health care professional engaged for purposes of a consultation as a part of the appeal of the benefit determination shall be an individual 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; and

- Notify the participant of the plan's benefit determination on review within a reasonable time, but not later than 60 days after receipt of the participant's appeal, unless the plan administrator determines that special circumstances require an extension of time for processing the appeal.

Standard External Review

The Plan shall allow an external review of a benefit denial when a request for a standard external review is submitted within four months after the date of receipt of a notice of an adverse benefit determination.

The Plan will complete a preliminary review of the request within five business days following receipt of the external review request to: 1) determine if the claimant was covered by the plan at the time the claim was incurred, 2) determine if the claimant has exhausted the Plan's internal review process, if required, and 3) determine that the claimant has provided all information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will notify the covered person in writing if the request is complete. If the request is incomplete the Plan will allow the covered person to provide complete information within the later of the end of the four month period after the date of receipt of the notice of adverse benefit determination or within a 48-hour period after receipt of notification to complete the request. If the plan determines that the claim is ineligible for external review the claimant will be notified and will be given the telephone number of the Employee Benefits Security Administration (866-444-3272).

If accepted for external review the file will be assigned to an accredited independent review organization (IRO).

Upon receipt of a final external review decision the claimant will be notified of the decision. If the decision reverses in whole or in part the adverse benefit determination, the Plan will provide coverage or payment for the claim to the extent that the claim is found payable.

Expedited External Review

The Plan shall allow an "expedited external review" when he/she receives:

(a) An adverse benefits determination, if (i) the adverse benefit determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal appeal under the final

regulations would seriously jeopardize the covered person's (I) life or health, or (II) ability to regain maximum function, and (ii) the covered person has filed a request for an expedited internal appeal; or

(b) A final internal adverse benefit determination, if (i) the covered person has a medical condition where the time frame completion of a standard external review would seriously jeopardize the covered person's (I) life or health, or (II) ability to regain maximum function; or (ii) the final internal adverse benefit determination concerns an admission, availability or care, continued stay, or health care item or service for which the covered person received emergency services, but has not been discharged from a facility.

Upon receipt of the request, the Plan will determine whether the request meets the reviewability requirements for standard external review. The Plan will immediately send a notice of the eligibility determination to the claimant.

Upon receipt of a final external review decision the Plan and the claimant will be notified of the decision. If the decision reverses in whole or in part the adverse benefit determination, the Plan will provide coverage or payment for the claim to the extent that the claim is found payable.

Administration of the Group Medical Plan

The plan is administered through the plan administrator. The services of an independent plan supervisor experienced in claims processing have been retained to process claims for the plan.

The plan is a legal entity. Legal notices may be filed with, and legal process served upon the plan administrator.

The plan administrators, and all persons, who are plan fiduciaries, are given the specific discretionary authority to determine eligibility for benefits or to construe terms of the plan.

Benefits under this plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them.

Amounts paid out under this plan shall be based solely upon the benefits in effect as of the date the services are rendered.

No payment will be made for services incurred before coverage is in effect or after coverage terminates for the patient receiving the services.

Amendment of Plan Document

The company reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the Internal Revenue Code or other applicable law) to modify, amend, or terminate in whole or in part, any or all provisions of the plan, provided, however, that no modification, amendment, or termination shall deny a participant or covered dependent of a right to those benefits to which he or she has become entitled under the plan. Any amendment to the plan may be effected by the plan administrator in writing at the direction of the company.

Application and Identification Card

To obtain coverage, an eligible participant must complete and deliver to the plan administrator an application on a form supplied by the plan supervisor.

Acceptance of this application will be evidenced by the delivery of an identification card, showing the participant's name, by the plan supervisor to the plan administrator.

Assignment of Payment

Except where otherwise provided in this plan, the plan will pay any benefits accruing under this plan to the participant unless the participant shall assign benefits to a hospital, physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment, however, shall be binding on the plan unless the plan supervisor is notified in writing of such assignment prior to payment hereunder.

Cancellation

A participant may cancel his coverage by giving written notice to the plan administrator who will notify the plan supervisor.

In the event of the cancellation of this plan, all participant and dependent coverage shall cease automatically without notice and these participants and dependents shall not be entitled to further coverage or benefits thereafter.

Choice of Physician

Plan participants may select any physician who is a member of the portion of the managed care network selected by the participant for medical benefits to be considered at the maximum benefit percentage shown in the schedule of benefits. If services are not received from such a participating provider, or if one of the exceptions does not apply, the penalty shown in the schedule of benefits will apply. Benefits will then be paid at the lesser benefit percentage.

Conditions Precedent to the Payment of Benefits

The participant or dependent shall present the plan identification card upon admission to a hospital or upon receiving service from a physician.

Forms are available through the plan supervisor and are required along with an itemized statement with a diagnosis, the participant's name, Social Security number, and the name of the plan administrator.

The participant and all dependents agree that in order to receive benefits hereunder, any physician, nurse, hospital, or other providers of service, having rendered service or being in possession of information or records relating thereto, is authorized and directed to furnish the plan supervisor, at any time, upon request, any and all such information and records, or copies thereof.

The plan administrator has the right to have a physician examine a participant or dependent as often as reasonably required during the pendency of a claim or to aid in the determination of whether services are medically necessary. The plan administrator will notify the participant or dependent in advance of the time and place for such examination and shall pay for the cost of the examination.

Contributions and Funding

The plan is a self-funded welfare benefit plan that provides medical benefits to covered persons. No benefits are payable by any insurance company. The company will provide all payments for the benefit plan. Employees may be required to pay a contribution that will partially reimburse the employer for the cost of operating the plan and for benefit payments.

Employer Contributions: The employer shall pay such amounts needed to provide plan benefits.

Participant Contributions: Upon election to participate, each participant must contribute such amounts as may be required by the employer toward the cost of benefits.

Authorization: An employee shall authorize the deduction from earnings for required contributions in writing at the time of application to participate. The employee may revoke the authorization for deduction at any time, which will cause coverage to end.

Funding: Benefits provided under the plan are paid out of the general assets of the employer and authorized earnings deductions withheld from employee from an account maintained by the employer.

All funds are applied to benefit payments, insurance costs, and reasonable expenses for administration or plan maintenance. The order of priority for payment is as follows:

- First from authorized earnings deductions withheld from employees;
- Second from employer contributions.

Coordination of Benefits

Definitions

The term ***allowable expense*** shall mean the amount of expenses, at least a portion of which is paid under at least one of any multiple plans covering the person for whom the claim is made.

The term ***order of benefits determination*** shall mean the method for ascertaining the order in which the plan renders payment hereunder. The principle applies when another plan has a coordination of benefits provision.

Application

Under the order of benefits determination method, the plan that is obligated to pay its benefits first is known as the primary plan. The plan that is obligated to pay additional benefits for allowable expenses not paid by the primary plan is known as the secondary plan. Where another plan contains a coordination of benefits provision, the following order of benefits determination will establish the responsibility for payment hereunder:

- If the patient has individual insurance coverage that covers medical expenses, that plan will be deemed the primary plan. If the patient does not have such individual insurance coverage, the health coverage which covers the patient as an employee shall be deemed the primary plan and is obligated to pay benefits before the health coverage covering the patient as a dependent.
- The plan covering the patient as a dependent of a person whose birthday anniversary occurs earlier in the calendar year will be deemed to be the primary plan and is obligated to pay before the plan covering the patient as a dependent of a person whose birthday anniversary occurs later in the calendar year. If the birthday anniversaries are identical, the plan that has been in force the longer period of time shall be deemed to be primary.

If either plan is lawfully issued in another state and does not have the coordination of benefits procedure regarding dependents based on birthday anniversaries as provided herein, and as a result each plan determines its benefits after the other, the coordination of benefits procedure set forth in the plan which does not have the coordination of benefits procedure based on birthday anniversaries shall be deemed to be primary.

In the event of divorce or legal separation, the following order will establish responsibility for payment. If this order of benefit determination is not recognized by the plan being coordinated with, order will be determined at the option of the plan supervisor on a case-by-case basis.

- If a court decree has determined financial responsibility for a child's health care expenses, the plan of the parent having that responsibility pays first.

- The plan of the parent with custody of the child pays before the plan of the other parent or the plan of any stepparent.

- The plan of the step-parent married to the parent with custody of the child pays before the plan of the parent not having custody.

- Where the order of payment cannot be determined in accordance with the provisions above, the primary plan shall be deemed to be the plan which has covered the patient for the longer period of time.

In the case of an inactive employee, the benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
If a person, whose coverage is provided under a right of continuation pursuant to federal or state law, is also covered under another plan, the benefits of the plan covering the person as an employee (or as the employee's dependent) will be determined first and the benefits under the continuation coverage will be determined second.

As the primary plan, the plan will provide payment in accordance with the provisions of this plan.

As a secondary plan, the plan will provide payment for allowable expenses and services of hospitals and physicians, but only to the extent that payment for such hospital services and services of physicians are not provided by the primary plan or other secondary plans.

In no event will total payment by the plan exceed the amount which would have been paid as primary plan.

The plan shall be considered to be the secondary plan when the other plan does not contain a coordination of benefits provision. The total payment by the plan for hospital services and physician services shall not exceed the amount that would have been paid as a secondary plan.

Dependents: Privileges Regarding

The participant shall have the privilege of adding or withdrawing the name or names of any dependents to or from this coverage, as permitted by the plan, by submitting to the plan administrator an application for reclassification, furnished by the plan supervisor. Each dependent added to the coverage shall be subject to all conditions and limitations contained in this plan.

Facility of Payment

If, in the opinion of the plan supervisor, a valid release cannot be rendered for the payment of any benefit payable under this plan, the plan supervisor may, at its option, make such payment to the individuals as have, in the plan supervisor's opinion, assumed the care and principal support of the covered person and are therefore equitably entitled thereto. In the event of the death of the covered person prior to such time as all benefit payments due him or her have been made, the plan supervisor may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such covered person.

Any payment made by the plan supervisor in accordance with the above provisions shall fully discharge the plan to the extent of such payment.

Fiduciary Operation

Except as may be otherwise specifically provided in the plan or in any benefit contract or policy, the plan administrator or its designee shall have full discretionary authority to enable it to carry out its duties under the plan, including, but not limited to, the authority to determine eligibility under the plan and to construe and interpret the terms of the plan and to determine all questions of fact or law arising hereunder and to authorize coverage in a manner which is cost effective under the plan. All such determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby.

The plan administrator or its designee shall have full discretionary authority to correct any defect, supply any omission or reconcile any inconsistency, and resolve ambiguities in the plan in such manner and to such extent as it may deem expedient, and subject to the above, the plan administrator or its designee shall be the sole and final judge of such expediency. Each fiduciary shall discharge his or her duties with respect to the plan solely in the interest of the participants and beneficiaries:

- For the exclusive purposes of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the plan;

- With care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

- In accordance with the documents and instruments governing the plan to the extent that they are consistent with the provisions of the Employee Retirement Income Security Act of 1974.

Inadvertent Error

Inadvertent error by the plan administrator or plan supervisor in the keeping of records or the transmission of participants' applications shall not deprive any participant or dependent of benefits otherwise due.

Medicare

To the extent allowable under applicable law, if the participant or his or her dependents are eligible to be covered under Medicare, coverage under the plan will be secondary to coverage provided by Medicare. If the plan is primary to Medicare and if the participant or his or her dependents are eligible to be covered by Medicare and incur a claim, coverage under the plan will be paid as usual for eligible charges, subject to any applicable deductible and any applicable co-pay, exclusion, and any other limitations as set forth in the plan.

The following rules apply:

- When the employer has less than 20 employees, Medicare is the primary coverage. In that situation participants and covered dependents must inform their health care providers that Medicare is the primary coverage.

- When the employer has more than 20 employees, the benefit plan is primary and Medicare is the secondary coverage for active employees and their dependents regardless of age.

- Medicare is the primary coverage for retirees over age 65 and for over age 65 dependents of retirees, unless the spouse is an active employee of another group health plan of more than 20 employees.

- The benefit plan is primary and Medicare is the secondary coverage for the first 30 months of Medicare eligibility due to End Stage Renal Disease. After the first 30 months, Medicare is the primary coverage. This applies if the person is covered due to active employment, being the dependent of an active employee, or covered due to COBRA continuation coverage.

- COBRA always pays secondary to Medicare except in the case of the first 30 months of Medicare eligibility due to End Stage Renal Disease.

- When the employer has less than 100 employees and Medicare coverage for an active employee or dependent is due to disability, Medicare is the primary coverage. When the employer has more than 100 employees, the benefit plan is primary. When the employee is no longer an active employee, Medicare is primary.

If the participant or his or her dependents choose not to be covered by the plan and choose to be covered primarily by Medicare, Medicare will provide coverage and coverage under this plan will terminate. The participant or his or her dependents are considered eligible for Medicare for the purposes of the plan during any period the participant or his or her dependents have coverage under Medicare or, while otherwise qualifying for coverage under Medicare, do not have such coverage solely because the participant or his or her dependents refused, discontinued, or failed to make any necessary application for Medicare coverage.

Misrepresentation

Any fraudulent or material misrepresentation on the part of a participant or dependent in making application for benefits, or any application for reclassification thereof, or for any claim for benefits hereunder may result in rescission of coverage back to the original effective date or termination of ongoing coverage after a 30 day notice is given to the covered individual.

No Surprise Act

The No Surprise Act specifically bans the following:

- Surprise bills for emergency services from an out-of-network provider or facility and without prior authorization.
- Out-of-network cost-sharing, like out-of-network coinsurance or copayments, for all emergency and some non-emergency services
- Out-of-network charges and balance bills for supplemental care, like radiology or anesthesiology, by out-of-network at a network facility.

Protection from Surprise Bills.

A surprise bill is a bill the covered person receives for covered services in the following circumstances:

- For services performed by an out-of-network provider at a network hospital or ambulatory surgical center, when:
- A network provider is unavailable at the time the health care services are performed.
- An out-of-network provider performs services without his/her knowledge; or
- Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a network provider is available, and the covered person elected to receive services from an out-of-network provider. The covered person was referred by a network physician to an out-of-network provider without the covered person's explicit written consent acknowledging that the

referral is to an out-of-network provider, and it may result in costs not covered by the Plan.

For a surprise bill, a referral to an out-of-network provider means:

- Covered services are performed by an out-of-network provider in the network physician's office or practice during the same visit.
- The network physician sends a specimen taken from the covered person in the network physician's office to an out-of-network laboratory or pathologist; or
- For any other covered services performed by an out-of-network provider at the network physician's request when referrals are required under the Plan.

The covered person will be held harmless for any out-of-network provider charges for the surprise bill that exceed the covered person's network copayment, deductible or coinsurance. The out-of-network provider may only bill the covered person for the covered person network copayment, deductible or coinsurance. The covered person can sign a form to let the Plan and the out-of-network provider know the covered person received a surprise bill.

Notice

Any notice given under this plan shall be sufficient, if given to the plan administrator when addressed to it at its office; if given to the plan supervisor, when addressed to it at its home office; or if given to a participant, when addressed to the participant at his address as it appears on the records of the plan supervisor in the care of the plan administrator.

Not Liable for Acts of Hospitals or Physicians

Nothing contained herein shall confer upon a participant or dependent any claim, right, or cause of action, either at law or at equity, against the plan for the acts of any hospital in which he receives care, or for the acts of any physician from whom he receives service under this plan.

Plan Administration

The plan administrator shall be responsible for compliance by the plan with all requirements of Part 1, Subtitle B or Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Is Not a Contract

The plan shall not be deemed to constitute a contract between the plan administrator and any participant or to be a consideration for, or an inducement or condition of, the employment of any participant. Nothing in the plan shall be deemed to give any

participant the right to be retained in the service of the plan administrator or to interfere with the right of the plan administrator to discharge any employee at any time, provided that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the plan administrator with the bargaining representative of any participants.

Protected Health Information: Use and Disclosure

Use and Disclosures of Protected Health Information (PHI)

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability act of 1996 (HIPAA). For a copy of the Plan's Notice of Privacy Practices, contact your employer. Specifically, the plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

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

- Determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, plan maximums, and copays as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities, and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including pre-certification, and pre-authorization;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name

and address, date of birth, Social Security number, payment history, account number, and name and address of the provider and/or health plan); and

- Reimbursement to the plan.

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

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the plan, including, but not limited to the following:

  a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
  b. Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
  c. Resolution of internal grievances; and
  d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

The plan is not allowed to use genetic information that is PHI for underwriting purposes, such as to decide whether to give an individual coverage, or the price of that coverage. This limitation does not apply to long term care plans.

Treatment includes, but is not limited to, activities undertaken by the Plan to help support health care treatments provided by hospitals, physicians and other health care providers.

The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With an authorization, the plan will disclose PHI to the pension plan, disability plan, EAP plan, Section 125 cafeteria plan, Workers' Compensation plan, and other benefit plans established by the plan sponsor for the purposes related to administration of these plans.

For Purposes of this Section Piedmont Mechanical, Inc. Is the Plan Sponsor

The plan will disclose PHI to the plan sponsor only upon receipt of a certification from the plan sponsor that the plan documents have been amended to incorporate the following provisions.

The Plan hereby includes the following provisions, and all of the other provisions of this Protected Health Information: Use and Disclosure section.

With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The plan sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the plan sponsor provides PHI received from the plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the plan sponsor unless authorized by an individual;
- Report to the plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from plan available to the HHS Secretary for the purposes of determining the plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the plan that the plan sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction

is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

- Ensure that adequate separation is established in accordance with HIPPA and this Plan.

Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- The benefits manager; and
- Staff designated by the benefits manager.

Limitations of PHI Access and Disclosure

The persons described in the ***Adequate Separation*** section above may only have access to and use the disclosed PHI for plan administration functions that the plan sponsor performs for the plan.

Non-compliance Issues

If the persons described in the ***Adequate Separation*** section above do not comply with this plan document, the plan sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Electronic Protected Health Information

Electronic Protected Health Information – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Security Incidents – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan sponsor on behalf of the Plan, the Plan sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;

- Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

- Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

- Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

  a. Plan sponsor shall report to the Plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

  b. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis annually, or more frequently upon the Plan's request.

Right of Recovery

Whenever payments have been made by the plan in excess of the maximum amount of payment necessary at that time to satisfy the intent of this plan, the plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the plan supervisor shall determine: any persons to or for, or with respect to whom such payments were made, and/or any insurance companies or other organizations.

Rights of Participants

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to do the following:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents

filed by the plan with the U.S. Department of Labor, such as detailed reports and plan descriptions.

- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request materials from the plan administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay up to $120 fine a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Subrogation

If the Plan receives claims for expenses that were either the result of the alleged negligence of another person, or which arise out of any claim or cause of action which may accrue against any third party responsible for injury or death to the Covered Employee or Dependent of the Covered Employee (hereinafter named the Covered Person) by reason of their eligibility for benefits under the Plan, the Plan has no duty or obligation to pay these claims.

The Plan may choose to advance benefits. If the Plan advances benefits, the Covered Person, by accepting benefits agrees to the following terms and conditions.

The Covered Person agrees that the Plan will be reimbursed out of any recovery by the Covered Person for all benefits paid by the Plan. The Covered Person agrees that the Plan has a secured proprietary interest in any settlement proceeds that the Covered Person receives or may have an entitlement to receive. The Covered Person confesses that the Plan is entitled to a constructive trust interest in the proceeds of any settlement or recovery. The Covered Person consents to the position of said trust, the funding of said constructive trust using any settlement proceeds and the payment of said funds held in said trust directly to the Plan or its authorized representative. The Plan will be reimbursed in full prior to the Covered Person receiving any monies recovered from any party or their insurer as a result of judgment settlement or otherwise. The duty and obligation to reimburse the Plan also applies to any money received from any underinsured or uninsured motorist policy of insurance. The obligation to repay the Plan remains in force even if the Covered Person is not fully compensated or made-whole from any settlement or verdict or judgment.

The Plan has the right to the Covered Person's full cooperation in any matter involving the alleged negligence of a third party. In such cases, the Covered Person is obligated to provide the Plan with whatever information, assistance, and records the Plan may require to enforce the rights in this provision. The Covered Person further agrees that in the event that the Plan has reason to believe that the Plan may have a subrogation lien, the Plan may require the Covered Person to complete a subrogation questionnaire, sign an acknowledgement of the Plan's Subrogation rights and an agreement to provide ongoing information, before the Plan considers paying, or continuing to pay, any claims. Upon receipt of the requested materials from the Covered Person, the Plan may commence or may continue advancing claims payments according to its terms and conditions provided that said payment of claims in no way prejudices the Plan's rights to recovery.

The Covered Person agrees to include the Plan's name as a co-payee on any settlement check.

The Plan may, but is not obligated to, take any legal action it sees fit against the third party or the Covered Person, to recover the benefits the Plan has paid. The Plan's exercise of this right will not affect the Covered Person's right to pursue other forms of recovery, unless the Covered Person and his legal representative consent otherwise.

The Plan retains the right to employ the services of any attorney to recover money due to the Plan. The Covered Person agrees to cooperate with the attorney who is pursuing the subrogation recovery. The compensation that the Plan's attorney receives will be paid directly from the dollars recovered for the Plan.

The Plan specifically states that it has no duty or obligation to pay a fee to the Covered Person's attorney for the attorney's services in making any recovery on behalf of the Covered Person. The Covered Person consents to this provision and by accepting any advance of benefits agrees to instruct their attorney to not assess any fees against the Plan in the event of settlement or recovery.

The Covered Person is obligated to inform their attorney of the subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan. The Covered Person agrees that they will instruct their attorney to reimburse the Plan out of any sums the attorney holds or may hold in his trust account.

The Covered Person agrees that he will not release any party or their insured without prior written approval from the Plan, and will take no action which prejudices the Plan's subrogation right.

The Covered Person agrees to refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan's lien or right to reimbursement.

The Plan Administrator retains discretionary authority to interpret this and all other plan provisions and the discretionary authority to determine the amount of the lien.

The Plan pays secondary as to any and all PIP, Med-Pay or No-Fault coverage. The Plan has no duty or obligation to pay any claims until PIP, Med-Pay or No-Fault coverage is exhausted. In the event that the Plan pays claims that should have been paid by PIP, Med-Pay or No-Fault coverage under this provision, then the Plan has a right of recovery from the PIP, Med-Pay or No-Fault carrier.

In the event that the Covered Person receives any form or type of settlement and either fails or refuses to abide by the terms of this agreement, in addition to any other remedies the Plan may have, the Plan retains a right of equitable offset against future claims.