PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR
ABILITIES SERVICES, INC.
MEDICAL PLAN
EFFECTIVE OCTOBER 1, 2017

For assistance in a non-English language, please call 1-844-804-8118.

Para obetener asistencia en Español, por favor llame al número arriba.

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Introduction

Welcome to the ABILITIES SERVICES, INC. Medical Plan. This document explains the operation of your health plan. Please call 1-844-804-8118 with any questions regarding this document.

Introduction and Purpose
The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. This is the final version of your benefits. No oral interpretations can change this plan.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a Non-Occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for hospital or medical charges.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator. No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

Not a Contract of Employment
This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Plan Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Applicable Law
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction. This document does not impose any duty or obligation on Employer when it refers to ERISA or certain sections of it, If ERISA or certain sections of it, is not applicable to this plan and/or Employer.

Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan. The Plan Administrator reserves the right to amend any part of the plan or terminate the Plan at any time.

Claims Administrator Is Not a Fiduciary
A Claims Administrator is not a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan's rules as established by the Plan Administrator.

Type of Administration
The Plan is a self-funded group health plan and the administration is provided through a third party Claims Administrator.

Plan Contributions & Funding
Premiums are funded by contributions by the Employer and covered Employees. The Plan Administrator reserves the right to change the level of Employee contributions. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. Employer funds are provided out of the Employer's general assets. The Plan is insured by a reinsurance carrier.

Summary of Eligibility, Benefits, and Exclusions

For full details, please see the sections entitled Eligibility, Effective Date and Termination, Schedule of Benefits and Exclusions.

ELIGIBILITY	
Full Time Requirements	30 hours per week or 130 hours per month
Waiting Period	First of the month following 30 days
Dependent	1. Spouse 2. Employee's Child (under 26, unless disability exception applies)
Employee Termination	Last day of the month when no longer under an eligible class.
Dependent Termination	Last day of the month when no longer under an eligible class.
Rehired Employees	Employee is eligible no later than first of the month following rehire if rehire occurred within 13 weeks of termination.

DEDUCTIBLES	
The individual deductible is embedded in the family deductible, which means each family member only needs to meet the individual deductible before the Plan will cover most services.	
Deductible Year Runs January 1st to December 31st	
In Network: $1,000 Individual/$2,000 Family	**Out of Network:** $3,000 Individual/$6,000 Family

OUT-OF-POCKET MAXIMUM	
In Network: $5,000 Individual/$10,000 Family	**Out of Network:** $10,000 Individual/$20,000 Family

COINSURANCE & COPAYS (% indicates Plan Participant responsibility)	
In Network Coinsurance: 20%	**Out of Network Coinsurance:** 50%
Primary Physician Copay: $30	**Specialist Copay:** $60
Emergency Room: $300, then 20%	**Urgent Care:** $100

NOTABLE SERVICES EXCLUDED FROM COVERAGE	
• Hearing Aids • Long-Term Care • Non-Emergency Care Outside the U.S. • Weight Loss Programs or Bariatric Surgery	• Cosmetic Surgery • Routine Foot Care • Acupuncture • Autism Treatment/Behavior Therapy

Eligibility, Effective Date and Termination

If you have any questions regarding eligibility, please call 1-844-804-8118.

NOTE: Failure to adhere to the Eligibility or Enrollment Requirements explained below may result in delay of coverage or no coverage at all.

ELIGIBILITY

Eligibility Requirements for Employee Coverage.

Each full-time Non-Variable Hour Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following completion of a Waiting Period of 30 days, provided the Employee has begun work for the Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work.

Each Variable Hour Employee who has averaged 30 Hours of Service per week or 130 Hours of Service per month will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period. Measurement and Stability Periods are defined by the Employer.

Each Employee who was covered under the Prior Plan, if any, will be eligible on the effective date of this Plan. Any Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Waiting Period of this Plan.

Eligible Classes of Dependents. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage. A Dependent is any one of the following persons:

(1) An Employee's lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, "marriage or married" means a legal union;

(2) An Employee's Child who is less than 26 years of age; and

(3) An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age stated above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age stated above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age stated above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship. At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. This enrollment remains in force for the full coverage period until the next open enrollment and cannot be dropped without a qualifying event.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee who has Dependent coverage, must be enrolled in this Plan within 31 days. If the child is not enrolled within 31 days of birth, there will be no payment from the Plan. The newborn will not be eligible for coverage until the next annual Open Enrollment Period.

OPEN ENROLLMENT

Annual Open Enrollment. Before the end of the current Plan Year, and for a period of no less than 30 days, covered Employees and their covered Dependents will be able elect coverage, change their coverage, or discontinue coverage.

Failure to Make Election During Open Enrollment. A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage.

TIMELY OR LATE ENROLLMENT

(1) Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

a. **Married Employees**. If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) Late Enrollment - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees will not be eligible for coverage until the next annual Open Enrollment Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage) after the coverage ends.

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

(1) Individuals losing other coverage. An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual;

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment;

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated; and

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

Effective Date. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent Claim), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee if:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period); and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

Effective Date for Dependents. The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) In the case of marriage, as of the date of marriage (proof of marriage may be required); or

(b) In the case of a Dependent's birth, as of the date of birth; or

(c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

In addition, an employee who is already enrolled in a benefit package may enroll in another benefit package under the plan if a dependent of that employee has a Special Enrollment right because the dependent lost eligibility for other coverage.

If a qualified beneficiary moves out of his or her PPO service area, an alternative plan may be elected.

Special Enrollment Rights under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

If an Employee has declined enrollment in the Plan for him or herself or his or her dependents (including a Spouse) because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if an Employee has declined enrollment in the Plan for him or herself or his or her dependents (including a Spouse), and later becomes eligible for state assistance through a Medicaid or Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

If you have any questions regarding the application of this provision to you, contact the Plan Administrator.

EFFECTIVE DATE

Effective Date of Employee Coverage. Coverage under the Plan will take effect for an eligible Active Employee when the Employee satisfies all eligibility and enrollments requirements of the Plan, including satisfying the Waiting Period.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, including but not limited to making a fraudulent Claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, Claims paid will be offset from this amount. The employer reserves the right to collect additional monies if Claims are paid in excess of the Employee's and/or Dependent's paid contributions.

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Plan Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, the Plan Participant will be notified sufficiently in advance of the reduction or termination to allow the Plan Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. See the section entitled Continuation Coverage Rights under COBRA for a complete explanation):

(1) The date the Plan is terminated;

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA);

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;

(4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage;

(5) If applicable, at a time designated by the Employer following the end of the Stability Period for Variable Hour Employees, if the Employee failed to qualify during the previous Measurement Period.

Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active Full-Time Employment ceases due to disability, leave of absence or layoff. This continuance will end at the earlier of:

For disability leave only: The date the Employer ends the continuance or at the exhaustion maximum period available under FMLA and/or COBRA.

For leave of absence or layoff only: The date the Employer ends the continuance or at the exhaustion of maximum period available under FMLA and/or COBRA.

Please note: *extended leave of absence/total disability will be allowed to the extension of coverage equal to COBRA. The COBRA period will not exceed the maximum allowed by Federal or State Law(s), whichever is greater.*

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

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

If Plan coverage terminates during FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

If an Employee takes a leave of absence that qualifies as a family or medical leave under the Family Medical Leave Act (FMLA) of 1993, the Employee should contact the Plan Administrator in order to discuss his or her continued participation in the Plan during the leave. The Employee must continue to pay for his or her health, dental, disability and any health care expense reimbursement benefits via a method mandated by the Employer. Failure by the Employee to make timely payments will result in the discontinuance of coverage for the Employee and any dependents.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a New Employee and be required to satisfy all Eligibility and Enrollment Requirements. However, if an Employee has a break in service of less than

13 weeks the Employee shall be reinstated by the Plan no later than the first of the month following rehire and not treated as a New Employee.

For an approved leave of absence, an Employee will remain eligible for coverage under the Plan as long as the Employee is otherwise eligible (and enrolled) under the Plan. Note that for an approved leave of absence, an Employee will be treated as an Ongoing Employee, even if the Employee's absence was longer than 13 weeks.

Employees on Military Leave (USERRA). Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. See the section entitled Continuation Coverage Rights under COBRA for a complete explanation):

(1) The date the Plan or Dependent coverage under the Plan is terminated;

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA);

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA);

(4) On the last day of the calendar month that a Dependent Child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA);

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;

(6) The earliest date the Dependent has a Claim that is denied in whole or in part because it meets or exceeds an annual limit on non-Essential health benefits; or

(7) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

Schedule of Benefits

Call 1-844-804-8118 to verify eligibility for Plan benefits before the charge is Incurred.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Expenses for which no benefits will be paid. Before benefits can be paid in a Deductible Year a Covered Person must meet the Deductible shown in the Schedule of Benefits. Once the deductible has been met, the Plan will begin paying benefits in accordance with the schedule of benefits.

Family Unit/Individual Deductible Accumulation. The section pertains specifically to Employees who have elected family coverage.

The health plan(s) offered by the Employer utilize an embedded Deductible. This means that, for family coverage, each individual will only have to meet the individual Deductible before the Plan begins paying benefits.

OUT-OF-POCKET LIMIT

After the deductible is met, Plan Participants will be required to continue to pay for a share of the Covered Expenses if the out-of-pocket maximum is not yet met. Covered Expenses are payable at the percentages shown each Deductible Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Once the out-of-pocket maximum is reached, the Plan will pay for the entirety of the Covered Expenses, which does not include premiums or Balance Billed Charges (see definition).

COPAY AND COINSURANCE

Copay. A copay is smaller amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments accrue toward the out-of-pocket maximum.

Coinsurance. A coinsurance is an amount of money that the Plan Participant is responsible for, as listed in the Schedule of Benefits. The coinsurance is expressed as a percentage. The remaining percentage that is not paid by the Plan Participant is paid by the Plan. Some services may require a coinsurance payment from the Plan Participant.

MAXIMUM BENEFIT AMOUNTS FOR NON-ESSENTIAL HEALTH BENEFITS

The Maximum Benefit Amounts, if any, are shown in the Schedule of Benefits for various services. They are the total amount of benefits that will be paid under the Plan for certain non-essential health benefit charges Incurred by a Covered Person.

MEDICAL BENEFITS SUBJECT TO PLAN ADMINISTRATOR DETERMINATIONS

All benefits described in this Schedule are subject to the exclusions and limitations described below including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Customary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the section entitled Defined Terms.

Reduction or Denial of Benefits. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, and timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of Claims or lack of coverage.

When Claim is Incurred. An expense for a service or supply is Incurred on the date the service or supply is furnished. The Plan will pay for expenses Incurred while you are a Plan Participant. It does not cover expenses Incurred before coverage began or after coverage terminated.

Termination or Amendment. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Expenses Incurred before termination, amendment or elimination of any particular benefit or aspect of the Plan.

HOSPITALIZATIONS

Precertification is required for certain medical services to ensure Medical Necessity and efficient care. Please see the Cost Management section in this booklet for details regarding precertification procedures.

PROVIDER NETWORK

The Plan is a plan which contains a Preferred Provider Organization (i.e. network).

PPO name: As Listed on ID card

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to Plan Participants, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher in-Network payment will be made for certain non-Network services:

(1) If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area;

(2) If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at an in-Network facility; or

(3) If a Covered Person receives Physician or anesthesia services by a Non-Participating Provider at an In-Network facility.

Additional information about this option, as well as a list of Network Providers will be made available to covered Employees and updated as needed.

INFORMATION AND RECORDS

At times the Plan may need additional information from the participants in order to furnish the Plan with all information and proof that the Plan may reasonably require regarding any matters pertaining to the Policy. If the Participants do not provide this information within 30 days of when requested, it may delay or deny payment of Benefits. This may include, but is not limited to, requests for other insurance information, accident reports and verification of dependent status.

By accepting Benefits under this plan, participants authorize and direct any person or institution that has provided services to them to furnish the Plan with all information or copies of records relating to the services provided. The Plan has the right to request this information at any reasonable time. This applies to all Covered Participants, including Enrolled Dependents whether or not they have signed the enrollment form. The Plan agrees that such information and records will be considered confidential.

CLAIMS AUDIT

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

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

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

CLAIMS NEGOTIATION

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accordance with the terms of this Plan Document.

The Plan reserves the right to reduce the cost of any out of network Claim to the Medicare reimbursement rate

Schedule of Benefits
COPAYPLAN

Embedded Deductible	In Network	Out of Network
DEDUCTIBLE		
Individual Coverage	$1,000	$3,000
Family Coverage	$2,000	$6,000
Deductible accumulates towards out of pocket maximum.		
OUT-OF-POCKET MAXIMUM		
Individual Coverage	$5,000	$10,000
Family Coverage	$10,000	$20,000
Both Medical and Pharmacy copayments will accrue toward the out-of-pocket maximum		

Annual Maximum	Grandfathered status	Coinsurance/Copay
Unlimited	Not grandfathered	Indicates Plan Participant responsibility.
PREVENTIVE CARE SERVICES		
Well Child Care (up to age 18) Routine physical examination, laboratory blood tests, x-rays, hearing and vision screens, and immunizations/flu shots. Behavior assessments for children of all ages, autism screening 18-24 months, blood pressure screening, development screening for children under age 3 and dyslipidemia.		No Charge / Not Covered
Adult Preventive Care Routine preventive office visit, prostate screening, routine physical exam, x-rays, laboratory blood tests, blood pressure and cholesterol screening, type 2 diabetes screening, hearing & vision screenings, HIV screening, immunizations/flu shots, colonoscopies, bone density scans, stress tests, and Sigmoidoscopy. Counseling for: tobacco cessation, weight loss, eating healthfully, reducing alcohol use, sexually transmitted infections.		No Charge / Not Covered
Female Specific Preventive Care Well-woman visit, Pap smear, mammogram, gynecological exam, HPV DNA testing for women over 30, counseling for domestic violence, screening for cervical dysplasia, contraceptive counseling, non-oral female contraceptives, screening for abdominal aortic aneurysm, screening for mutations in BRCA 1 and 2 genes, osteoporosis screening for women over 60 based on risk factor. Counseling for breast feeding associated with childbirth.		No Charge / Not Covered
Routine Physical		No Charge / Not Covered

Routine Prenatal care All routine care including screening for anemia, bacterial vaginosis, gestational diabetes mellitus, Hepatitis B, home uterine activity monitoring, neural tube defects, preeclampsia, RH incompatibility, rubella, syphilis, ultrasonography in Pregnancy. Expanded tobacco cessation counseling.	No Charge	Not Covered
Breast Feeding Equipment Limit to one manual pump per Pregnancy at no cost. A Plan Participant may choose to upgrade to an electric pump with a $250 limit for reimbursement.	No Charge ($250 limit)	No Charge ($250 limit)
Routine Eye Exam One per year Vision acuity screening covered under Well Child Care for children age 5 and under.	No Charge	Not Covered
CLINIC CHARGES		
Physician Office Visit Includes office visits and associated labs & x-rays	$30/Visit	50% Coinsurance after deductible
Specialist Office Visit	$60/Visit	50% Coinsurance after deductible
Urgent Care Clinic	$100/Visit	50% Coinsurance after deductible
Allergy Shots and testing Allergy injections not subject to copay if no Physicians charge is assessed	PCP: $30/Visit Specialist: $60/Visit	50% Coinsurance after deductible
Immunizations-Foreign Travel	20% Coinsurance after deductible	50% Coinsurance after deductible
Temporomandibular Joint Disorder (TMJ) No Hardware coverage	20% Coinsurance after deductible	50% Coinsurance after deductible
Infertility Treatment Includes: Care, services, supplies for the diagnosis and charges for surgical correction of physiological abnormalities of infertility. No coverage for assisted reproduction.	20% Coinsurance after deductible	50% Coinsurance after deductible
LABS AND SCANS		
Outpatient Lab, Pathology, X-Ray Non-Preventive Services	20% Coinsurance after deductible	50% Coinsurance after deductible
Complex Imaging: MRI/CT/PET Scans Requires precertification	20% Coinsurance after deductible	50% Coinsurance after deductible
HOSPITAL CHARGES		
Inpatient Hospital Services Requires precertification. Semi private room	20% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Surgery May require precertification	20% Coinsurance after deductible	50% Coinsurance after deductible

Maternity/Delivery Routine Prenatal care is covered under Preventive Care Services	20% Coinsurance after deductible	50% Coinsurance after deductible
Organ Transplants Must be provided at a Designated Center of Excellence for Transplants	20% Coinsurance after deductible	Not Covered
Emergency Room Care Covered at in-network benefit level in a true Emergency	$300/Visit then 20% Coinsurance	50% Coinsurance after deductible
Ambulance Covered at in-network benefit level in a true Emergency	20% Coinsurance after deductible	50% Coinsurance after deductible
Skilled Nursing Facility Requires precertification. 60 days per year maximum	20% Coinsurance after deductible	50% Coinsurance after deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES		
Inpatient Requires precertification	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient-Partial Hospitalization Requires precertification	20% Coinsurance after deductible	50% Coinsurance after deductible
Office Visit/Outpatient	No Charge	50% Coinsurance after deductible
Residential Treatment Requires precertification	20% Coinsurance after deductible	50% Coinsurance after deductible
Behavior Therapy/ Treatment – Autism Spectrum Screening covered under Well Child Care	Not Covered	Not Covered
REHABILITATIVE/ HABILITATIVE OUTPATIENT THERAPY		
Occupational, Speech, Physical Therapy Physical Therapy, Occupational Therapy, Speech Therapy, Manipulative Treatments, Pulmonary Therapy, Cognitive Rehabilitation Therapy: 20 visit limit per therapy per year. Cardiac Rehabilitation: 36 visit limit per year. Post-cochlear implant aural therapy: 30 visit limit per year. Preauthorization required for occupational or speech therapy. Preauthorization required for physical therapy visits in excess of annual limit.	$30/Visit	50% Coinsurance after deductible
Chiropractic Services 20 visit limit per year	$30/Visit	50% Coinsurance after deductible
ADDITIONAL ANCILLARY SERVICES		
Hospice Requires precertification. Bereavement counseling services within 6 months of death	20% Coinsurance after deductible	50% Coinsurance after deductible
Private Duty Nursing Care Requires precertification. Inpatient only when ICU unavailable	20% Coinsurance after deductible	50% Coinsurance after deductible
Home Health Care Requires precertification. 60 days per year maximum	20% Coinsurance after deductible	50% Coinsurance after deductible

DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment Requires precertification for charges in excess of $1,000. Plan Participants utilizing the Cigna network do not have to adhere to this precertification requirement.	20% Coinsurance after deductible	50% Coinsurance after deductible
Prosthetics	20% Coinsurance after deductible	50% Coinsurance after deductible
Orthotics Coverage only applies to the initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.	20% Coinsurance after deductible	50% Coinsurance after deductible
Wig after Chemotherapy or alopecia areata Limited to one (1) purchase per lifetime up to $350	$350 Limit	$350 Limit

PRESCRIPTION DRUG SERVICES		
	Retail (per 30-day supply)	**Mail Order (per 90-day Supply)**
Generic	$10/Prescription	$25/Prescription
Brand Formulary	$35/Prescription	$87.50/Prescription
Brand Non-Formulary	$60/Prescription	$150/Prescription
Specialty Drugs	$300/Prescription	(Only available up to a 30-day supply)

Covered Medical Expenses

Covered Expenses are the Usual and Customary Charges that are Incurred for the following items of service and supply. These charges are subject to the non-essential health benefit limits, exclusions and other provisions of this Plan. A charge is Incurred on the date that the service or supply is performed or furnished.

(1) Hospital Care. The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Expenses for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate. A Hospital's Maternity Section or stand-alone Birthing Center with only private rooms will not be subject to this reduction and are payable as described in the Schedule of Benefits.

(2) Coverage of Pregnancy. The Usual and Customary Charges for the care and treatment of Pregnancy are covered the same as any other Sickness. Routine Prenatal is covered as Preventive Care in accordance with the Affordable Care Act, including:

(a) Bacterial vaginosis in Pregnancy
(b) Gestational diabetes mellitus
(c) Home uterine activity monitoring
(d) Neural tube defects
(e) Preeclampsia
(f) Rh incompatibility
(g) Rubella
(h) Ultrasonography in Pregnancy

Group health plans generally may not, under the **"Newborns' and Mothers' Protection Act,"** restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital confined after birth and includes room, board and other normal care for which a Hospital makes a charge.This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn Child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Usual and Customary Charges for nursery care for the newborn Child while Hospital confined as a result of the Child's birth. Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Charges for Routine Physician Care. The benefit is limited to the Usual and Customary Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth. Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

(3) Skilled Nursing Facility Care. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) The patient is confined as a bed patient in the facility;
(b) The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Expenses for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Schedule of Benefits, if any.

(4) Physician Care. The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Expense subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Customary Charge that is allowed for the primary procedures; 50% of the Usual and Customary Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Customary percentage allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Customary allowance.

(5) Private Duty Nursing Care. Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Expenses for this service are covered as follows:

(a) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit; and,

(b) Outpatient Nursing Care. Outpatient private duty nursing care is not covered.

(6) Home Health Care Services and Supplies. Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care Services limit shown in the Schedule of Benefits.

A Home Health Care Services visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services, if any.

(7) Hospice Care Services and Supplies. Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Expenses for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Covered Expenses for **Bereavement counseling** services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children) are payable as described in the Schedule of Benefits. Bereavement services must be furnished within six months after the patient's death.

(8) Other Medical Services and Supplies. Services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Expense only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(e) Routine Patient Costs for Participation in an Approved **Clinical Trial.** Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, as defined under the PPACA, provided:

(i) The clinical trial is approved by:

a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
b. The National Institute of Health;
c. The U.S. Food and Drug Administration;
d. The U.S. Department of Defense;
e. The U.S. Department of Veterans Affairs; or
f. An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and

(ii) The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicabl Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

(i) The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
(ii) The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
(iii) The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
(iv) A cost associated with managing an Approved Clinical Trial;
(v) The cost of a health care service that is specifically excluded by the Plan; or
(vi) Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

(f) Initial **contact lenses** or glasses required following cataract surgery.

(g) **Contraceptives.** The charges for all FDA approved contraceptive methods, except oral contraceptives, in accordance with Health Resources and Services Administration (HRSA) guidelines. Note: Oral contraceptives are covered under the Prescription Drug benefit.

(h) Medical-Related **Dental Services** recommended by a physician and received during a dental procedure for a child under age 5; or an individual who is severely disabled; or an individual who has a medical condition and requires hospitalization or general anesthesia for dental treatment or treatment related to cleft lip and palate.

Oral surgery for partially or completely unerupted impacted teeth; or tooth without the extraction of the entire tooth (this does not include root canal therapy); or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(i) **Inpatient Detoxification**. Medical observation and intervention to stabilize a Plan Participant who has developed substance intoxication due to the ingestion, inhalation, or exposure to one or more substances.

(j) **Diabetes Supplies, Equipment and Devices.** The charges for glucose meter, test strips, lancet, lancing devices and other items to help control diabetes.

(k) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(l) A facility or surgical implant provider billing (according to applicable PPO contract) for an **implantable device** shall include with the billing an invoice that represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable device. 135% of the documented invoice amount is the maximum allowable for consideration under the Plan.

In the event the implant invoice is not obtained by the Plan, the plan will have the discretionary authority to apply a Reasonable payment, the PPO discount and/or audit negotiation in place of the calculation based on the actual billing.

(m) Care, supplies and services for the diagnosis, and charges for surgical correction of physiological abnormalities of **infertility**.

(n) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome**.

(o) **Laboratory studies.**

(p) Treatment of **Mental Disorders and Substance Abuse**. Covered Expenses for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows: Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(q) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Expenses under Medical Benefits only if that care is for the following oral surgical procedures:

- **(i)** Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- **(ii)** Emergency repair due to Injury to sound natural teeth;
- **(iii)** Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
- **(iv)** Excision of benign bony growths of the jaw and hard palate;
- **(v)** External incision and drainage of cellulitis:
- **(vi)** Incision of sensory sinuses, salivary glands or ducts:
- **(vii)** Removal of impacted teeth: or
- **(viii)** Reduction of dislocations and excision of Temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(r) **Occupational therapy** by a licensed occupational therapist/physical therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(s) **Organ transplant**. Charges otherwise covered under the Plan that are Incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

- **(i)** The transplant must be performed to replace an organ or tissue and must be provided at a **Designated Center of Excellence for Transplants**. This is any health care provider, group or association of health care providers designated to provide services, supplies or drugs for transplants within the plan network; and,
- **(ii)** Transportation to the Designated Center of Excellence will be covered when Medically Necessary.

Charges for obtaining donor organs or tissues are Covered Expenses under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

(i) Evaluating the organ or tissue;
(ii) Removing the organ or tissue from the donor; and
(iii) Transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

(t) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(u) **Physical therapy** by a licensed physical therapist/occupational therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(v) **Prescription** Drugs (as defined).

(w) **Preventive Care.** Benefits mandated through the PPACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC). See http://www.uspreventiveservicestaskforce.org/ or https://www.healthcare.gov/preventive-care-benefits/for more details.

Important Note: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the provider of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered preventive.

Preventive and Wellness Services for Adults and Children. In compliance with section 2713 of the Patient Protection and Affordable Care Act, benefits are available for evidence-based items or services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/preventive-care-benefits/.

Women’s Preventive Services. With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA’s Women’s Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

(iii) Well-woman visits;
(iv) Gestational diabetes screening;
(v) HPV DNA testing;
(vi) Sexually transmitted infection counseling;
(vii) HIV screening and counseling;
(viii) FDA-approved contraception methods and contraceptive counseling;
(ix) Breastfeeding support, supplies and counseling; and
(x) Domestic violence screening and counseling.

A description of Women’s Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/preventive-care-benefits/.

(x) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(y) Reconstructive Surgery. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Expenses. This mammoplasty coverage will include reimbursement for:

(i) Reconstruction of the breast on which a mastectomy has been performed,
(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
(iii) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

(z) Smoking Cessation. Smoking Cessation treatment when determined Medically Necessary by the Plan Administrator and under the supervision of a physician. The length of treatment to be determined upon receipt of statement of medical necessity and to the extent required by the Patient Protection and Affordable Care Act (PPACA).

(aa) Speech therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

(bb) Spinal Manipulation/Chiropractic Services by a licensed M.D., D.O. or D.C.

(cc) Sterilization (Female). All FDA approved charges related to sterilization procedures, to the extent required by the Patient Protection and Affordable Care Act (PPACA). **Sterilization (Male).** All FDA approved charges related to sterilization procedures.

(dd) Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

(ee) Charges associated with the initial purchase of a **wig after chemotherapy or alopecia areata.**

(ff) Diagnostic **x-rays**.

Cost Management Services

Cost Management Services Phone Number: **1-844-804-8118**

The Cost Management Services phone number can also be found on your health insurance ID card.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after an emergency.

The following services must be precertified or reimbursement from the Plan may be reduced. If the Covered Person does not receive authorization as explained in the Cost Management Services section, the benefit payment will be reduced in accordance the penalty provision in the Plan Document and Summary Plan Document. The penalty for failure to pre-certify inpatient admissions will apply only to the facility charge for the inpatient stay.

(1) Hospital admissions and Inpatient confinements (including partial hospitalization programs for mental health).

(2) Select outpatient procedures and surgeries:

- **(a)** Any service that is potentially cosmetic
- **(b)** Any service that is potentially investigational/experimental
- **(c)** Maxillo-facial orthopedics and Mandibular surgical procedure
- **(d)** High risk maternal procedures
- **(e)** Oncology related procedures, including but not limited to chemotherapy and radiation therapy.
- **(f)** Select high volume or high risk procedures
- **(g)** Surgeries and procedures of the spine.

(3) Skilled Nursing and Sub-Acute facility admissions and confinements

(4) Renal Dialysis and select procedures for End Stage Renal Disease (ESRD)

(5) Home Health Care and In-Home services including IV therapy

(6) Select high cost injectables

(7) Select durable medical equipment (DME)

(8) All Air Ambulance and Inter-facility transport

(9) Transplant related services including initial consultation and evaluation

(10) Outpatient high tech radiology procedures (including CAT scan, MRI and PET scan)

The attending Physician does not have to obtain precertification from the Plan for prescribing a Hospital length of stay in connection with childbirth for the mother or her newborn child that is 48 hours or less following a vaginal delivery or 96 hours or less following a cesarean delivery.

Obstetric hospitalizations that exceed the 48 or 96-hour time periods following delivery and any services that are not associated with the delivery must be precertified.

NOTE: When the delivery occurs outside a Hospital, the Hospital length of stay begins at the time the mother or newborn is admitted as a Hospital inpatient in connection with childbirth. The attending Physician will determine whether the admission is in connection with childbirth

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

1. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

2. Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment.

Concurrent review and Discharge Planning

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has received precertification, the attending Physician must request the additional services or days.

Second and/or Third Opinion Program

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an Emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.
The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

- Appendectomy
- Cataract surgery
- Cholecystectomy
- (gall bladder removal)
- Deviated septum
- (nose surgery)
- Hemorrhoidectomy
- Hernia surgery
- Hysterectomy
- Mastectomy surgery
- Prostate surgery
- Salpingo-oophorectomy
- (removal of tubes/ovaries)
- Spinal surgery
- Surgery to knee, shoulder, elbow or toe
- Tonsillectomy and adenoidectomy
- Tympanotomy
- (inner ear)
- Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) Performed on an outpatient basis within seven days before a Hospital confinement;

(2) Related to the condition which causes the confinement; and

(3) Performed in place of tests while Hospital confined.

Covered Expenses for this testing will be payable after deductible.

BOOST YOUR BABY (MATERNITY MANAGEMENT)

Maternity participants are identified through claims data, utilization review or Plan Participant's calls. Once a case is identified, a welcome packet is mailed to the Plan Participant and followed up with a telephone call by a Mom Mentor. The Mom Mentor completes a comprehensive maternity questionnaire with the Plan Participant, designed to identify risk factors. Plan Participants that screen as low or moderate risk are followed by a Mom Mentor via telephone call or email each month and are provided counseling and educational materials to support a healthy Pregnancy.

Participants that screen out as high risk are placed in case management and followed by a nurse case manager. Maternity cases in case management are contacted more frequently and also provided with education/materials and services that relate to their specific risk factor.

All maternity cases are followed monthly through six months post-delivery.

CASE MANAGEMENT

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

1. Personal support to the patient;
2. Contacting the family to offer assistance and support;
3. Monitoring Hospital or Skilled Nursing Facility;
4. Determining alternative care options; and
5. Assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Plan Exclusions

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered, except when stated as covered within this plan:

(1) Abortions. Non-spontaneous medically-induced abortions (by surgical or non-surgical means) except when deemed Medically Necessary to save the life of the mother or if caused by rape or incest when evidence is presented from medical records or police reports that a crime has been committed; or the fetus has been diagnosed with a lethal abnormality.

(2) Alcohol. Services, supplies, care, ordered evaluation or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

(3) Alternative Medicine/Therapies. This includes acupuncture, acupressure, aromatherapy, biofeedback, cognitive therapy, kinetic therapy, hypnotherapy, homeopathic medicine; massage therapy, activity/milieu, neurofeedback and other forms of holistic treatment or alternative therapies, unless otherwise specifically stated as a covered benefit herein or in the Schedule of Benefits.

(4) Behavior Therapy Treatment. Programs for the treatment of autism spectrum disorders. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (EIBTS, Intensive Behavior Intervention (IBI), and Lovaas therapy unless otherwise specifically stated in the Schedule of Benefits.

(5) Blood Products. Collection and/or storage of blood products to include stem cells for any unscheduled medical procedure, or non-covered medical procedures. Salvage and storage of umbilical cord and/or after birth are not covered.

(6) Breast Implants, Prostheses. Breast implants, including replacement, except when Medically Necessary, as determined by the Plan, and related to a Medically Necessary mastectomy. Removal of breast implants, except when Medically Necessary as determined by the Plan. Certain benefits under WHCRA will be covered.

(7) Communications and Accessibility Services. Provider charges for interpretation, translation, accessibility or special accommodations. Devices and computers to assist in communication and speech. Professional sign language or foreign language interpreter services in a Physician's office.

(8) Complications of Non-Covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(9) Cosmetic Surgery/Services. Medical, surgical, and mental health services for or related to cosmetic surgery or procedures

(10) Counseling Services. Counseling for educational, social, occupational, religious or other maladjustments. Marriage counseling unless otherwise specifically stated as Covered Service in the Schedule of Benefits. Counseling for behavior modification, biofeedback, or rest cures as treatment for Mental Disorders unless otherwise specifically stated in the Schedule of Benefits. Counseling services for the treatment of a gambling addiction. Sensitivity or stress management training, self-help training unless specifically stated in the Schedule of Benefits. Counseling services mandated through the PPACA legislation are covered as specifically stated in the Schedule of Benefits.

(11) Court or Police Ordered Services. Examinations, reports or appearances in connections with legal proceedings, including child custody, competency issues, parole and/or probation and other court ordered related issues. Services, supplies or accommodations pursuant to a court or police order, whether or not Injury or Sickness is involved.

(12) Custodial care. Any services, supplies, care or treatment provided mainly for rest cure, domiciliary, convalescent, maintenance or Custodial Care.

(13) Dental Services. The medical portion of the Plan covers only those dental services specifically stated in the section titled Medical Benefits. All other dental services are excluded. Non-covered Services under your medical benefit include dental services in connection with the care, treatment, filling, removal or replacement of teeth, or structures directly supporting the teeth, except as specifically described herein. Examples of non-covered services include:

- **(a)** routine dental care and dental x-rays
- **(b)** dental appliances and orthodontia
- **(c)** medical treatments relating to orthognathic and/or arthroplactic surgery
- **(d)** dental splints, implants and prostheses
- **(e)** dentures
- **(f)** medications needed prior to non-covered dental surgery
- **(g)** general anesthesia for routine dental services

(14) Diabetic Supplies, Equipment and Devices. Non-covered services include the following:

- **(a)** Supplies and equipment labeled "Caution- Limited by Federal Law to Investigational Use";
- **(b)** Supplies and equipment deemed Experimental, Unproved or Investigational by the Plan;
- **(c)** Over-the-counter supplies, medications and equipment, except as indicated under the benefit description titled Diabetic Supplies, Equipment and Device; or in the Schedule of Benefits;
- **(d)** Take home medications, supplies and equipment after discharge from a Hospital, Nursing Home, Skilled Nursing Facility or other Inpatient or Outpatient Facility. Supplies dispensed while in an Inpatient Facility will only be covered as part of the Inpatient benefit;
- **(e)** Supplies and equipment that are not Medically Necessary; as determined by the Plan.

(15) Durable Medical Equipment. Durable Medical Equipment that fails to meet the criteria as established by the Plan. Examples of Non-Covered Services include, but are not limited to, the following:

- **(a)** Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment;
- **(b)** Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds, and oxygen tents, unless these items have been Preauthorized by the Plan;
- **(c)** More than one DME device designed to provide essentially the same function;
- **(d)** Foot Orthotics, except when attached to a permanent brace; or as in stated in the Schedule of Benefits;
- **(e)** Deluxe, electric, model upgrades, specialized, customized or other non-standard equipment;
- **(f)** Repair or replacement of deluxe, electric, specialized or customized equipment, model upgrades, and portable equipment for travel;
- **(g)** Scooters and other powered operated vehicles;
- **(h)** Warning devices, stethoscopes, blood pressure cuffs, or other types of apparatus used for diagnosis or monitoring, except as specifically listed as being covered herein;
- **(i)** Repair, replacement or routine maintenance of equipment or parts due to misuse or abuse;
- **(j)** Over-the-counter braces and other DME devices, prophylactic braces; braces used primarily for sports activities, except as specifically listed as being covered herein;
- **(k)** Replacement of braces of the leg, arm back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- **(l)** Communication devices (speech generating devices) and/or training to use such devices.
- **(m)** Bionic and hydraulic devices, except when otherwise specifically described herein.
- **(n)** Oxygen when services are outside of the Service Area and non-emergent or urgent, or when used for convenience when traveling within or outside of the Service Area.
- **(o)** Personal comfort items such as compression stockings and Transcutaneous Electrical Nerve Stimulation (TENS) units.

(16) Educational, evaluations or vocational testing. Services for educational or vocational testing or training. Evaluations or exams or other services for employment, insurance, licensure, judicial or administrative proceedings or research. This does not apply to initial diabetes education.

(17) Error/Never Event. Services required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense. This includes, but is not limited to surgery on wrong body part, foreign object left in patient after surgery, intravascular air embolism, blood incompatibility, stage 3 or 4 pressure ulcers, electric shock, burn, or fall while confined to facility.

(18) Excess charges. Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

(19) Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan, equipment, clothing or devices.

(20) Experimental or not Medically Necessary. Care and treatment that is Experimental/Investigational, not Medically Necessary or Cosmetic Services including surgery. Certain reconstructive procedures are covered when related to a qualifying medical diagnosis.

(21) Eye care. Radial keratotomy, Lasik or other eye surgery to correct refractive disorders. Refer to the Schedule of Benefits for Vision Benefits and coverage under the Vision Plan. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the Well Adult or Well Child sections of this Plan. Eyeglasses and contact lenses, except as a covered benefit herein.

(22) Facility Charges. Inpatient and outpatient facility charges for treatment provided at the following group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes. Residential treatment facilities are not covered unless specifically stated in the Schedule of Benefits.

(23) Fees, Collection Charges, Court Costs, Attorney Fees. Any late fees or collection charges that a Plan Participant incurs incidental to the payment of services received from providers. Court costs due to failure of the Plan Participant to disclose insurance information at the time of treatment. Charges incurred as a result of missed or canceled appointments, copying medical records, or completing claim forms. Charges by Plant Participants or providers for telephone consultations and clerical services for completion of special reports or forms of any type, including but not limited to disability certifications, unless otherwise specifically stated in the Schedule of Benefits.

(24) Foot care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease). Shoes; shoe lifts; corrective shoes; shoe orthotics; shoe inserts and arch supports are not covered unless Medically Necessary for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg unless specifically stated in the Schedule of Benefits. Foot Orthotics which is not an integral part of a leg brace.

(25) Foreign travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(26) Genetic Testing, Amniocentesis. Services or supplies in connection with genetic testing, except those which are determined to be Medically Necessary, as determined by the Plan. Genetic testing, amniocentesis, ultrasound, or any other procedure required solely for the purpose of determining the gender of a fetus. Not covered for an individual who is asymptomatic, unaffected, or not displaying signs or symptoms of a disorder for which the test is performed. Genetic testing services mandated through the PPACA legislation are covered as specifically stated in the Schedule of Benefits.

(27) Government Hospital Services coverage. Care, treatment or supplies furnished by a program or agency funded by any government except as required by federal law for treatment of veterans in Veterans Administration or armed forces Facilities for non-service related medical conditions. This does not apply to Medicaid or when otherwise prohibited by law.

(28) Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy or for alopecia areata.

(29) Hazardous Pursuit, Hobby or Activity. Care and treatment of an Injury or Sickness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Plan Participant's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm **including but not limited to**: hang-gliding, skydiving, bungee jumping, parasailing, use of all terrain vehicles, rock climbing, use of explosives, aircraft operation, automobile racing, motorcycle racing, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

(30) Hearing aids, Cochlear implants and exams. Charges for services or supplies in connection with hearing aids, cochlear implants or exams for their fitting, except as may be covered as stated in the Schedule of Benefits sections of this Plan, or for hearing loss due to Illness or Injury. Routine hearing exams are covered through the PPACA legislation as specifically stated in the Schedule of Benefits.

(31) Home Maternity Services. Services or supplies for maternity deliveries at home. Doula and birth coach expenses are not Covered Expenses.

(32) Hospital Confinement. Hospital confinement which precedes elective surgery by more than 24 hours, unless surgery is delayed by reason of medical necessity. Charges for Confinement on Friday, Saturday and/or Sunday will not be covered unless:

- **(a)** confinement is due to a medical emergency;
- **(b)** the Doctors confirms that a medical emergency exists;
- **(c)** tests other than routine admission are performed; or
- **(d)** surgery is scheduled for the next day.

(33) Hospital employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(34) Human Organ and Tissue Transplants. Human organ and tissue transplants, except as specified in the Schedule of Benefits.

(35) Illegal acts. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions). Services or supplies that are obtained by a Plan Participant or non-Covered Person by, through or otherwise due to fraud.

(36) Illegal drugs or medications. Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

(37) Impotence. Care, treatment, services, supplies or medication in connection with treatment for impotence. Any costs or charges for or related to penile implants, testicular prostheses regardless of the cause of the absence of the testicle.

(38) Infertility. Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation and charges for surgical correction of physiological abnormalities. The following services and treatments are not covered:

- **(a)** Infertility, fertility and family planning services
- **(b)** Reversal of voluntary sterilization procedures
- **(c)** In-vitro fertilization
- **(d)** Embryo freezing and transfer or tubal ovum transfer

(e) Zygote Intrafallopian transfers (ZIFT)
(f) Gamete Intrafallopian transfers (GIFT)
(g) Ovum storage or banking
(h) Cost of donor sperm or sperm banking
(i) Embryo or zygote banking
(j) Artificial insemination services
(k) Medications used to treat infertility or impotence
(l) Any other assisted reproductive techniques or cloning methods

(39) Maintenance Therapy. Expenses for maintenance therapy of any type when individual has reached the maximum level of improvement will not be considered eligible.

(40) Medical Supplies. Consumable or disposable medical supplies, except as specifically provided herein. Examples of non-Covered Services include bandages, gauze, alcohol swabs and dressings, foot coverings, leotards, elastic knee and elbow supports, not provided in the Primary Care Physician's office. Medical supplies necessary to operate a non-covered Prosthetic Device or item of DME.

(41) No Charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

(42) Non-Compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(43) Non-Emergency Ambulance Services. From hospital to hospital such as transfers and admissions to hospitals only performed for convenience.

(44) Non-Emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(45) No Obligation to Pay. Charges incurred for which the Plan has no legal obligation to pay.

(46) No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(47) Not Specified as Covered. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(48) Nutritional Supplements. Non-covered Services include the following: Expenses for nutritional supplementation ordered primarily to boost protein-caloric intake or the mainstay of a daily nutritional plan in the absence of other pathology, except as otherwise stated herein or in the Schedule of Benefits. This includes those nutritional supplements given between meals to increase daily protein and caloric intake. Special infant formulas; or other internal supplementation will not be considered eligible unless received in an inpatient hospital. Services of nutritionists and dietitians, except as incidentally provided in connection with other Covered Services.

(49) Obesity. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary charges for Morbid Obesity, as defined, as well as preventive health services required by the Patient Protection and Affordable Care Act, will be covered.

(50) Occupational. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(51) Orthotics. Foot orthotics which are not an integral part of a leg brace. Examples of non-Covered Services include shoes; shoe lifts; corrective shoes; shoe orthotics; shoe inserts and arch supports, except as specifically listed as being covered herein. This exclusion does not apply to Medically Necessary orthotics for the treatment of metabolic or peripheral-vascular disease.

(52) Over-the-Counter Items and Medications. Over-the-counter items and medications, except as specifically listed as a covered benefit herein or in the Schedule of Benefits. For purposes of the Plan, over-the counter is defined as any item, supply or medication which can be purchased or obtained from a vendor or without a prescription. Over-the counter drugs related to Preventive and Wellness Services are covered if prescribed by a physician.

(53) Paternity Testing. Diagnostic Testing to establish paternity of a child.

(54) Personal Comfort Items. Personal comfort or convenience items, including services such as guest meals and accommodations, telephone charges, travel expenses, take-home supplies, barer or beauty services, radio, television and private rooms unless the private room is Medically Necessary. Equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or compression stockings, Transcutaneous Nerve Stimulation (TENS) units, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(55) Physical and Psychiatric Exams. Physical health examinations in connection with, obtaining or maintaining employment, obtaining or maintaining school or camp attendance and obtaining or maintaining insurance qualification. Psychiatric or psychological examinations, testing and/or other services in connection with obtaining or maintaining employment, insurance or any type of license, medical research and competency issues.

(56) Private duty nursing. Charges in connection with care, treatment or services of outpatient private duty nurse.

(57) Relative Giving Services. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person such as a Spouse, parent, grandparent, child, brother or sister, whether the relationship is by blood or exists in law.

(58) Reconstructive Surgery. Reconstructive surgery to correct an abnormal structure resulting from trauma or disease for cosmetic reasons or when there is no restorative function expected.

(59) Rehabilitation/Habilitative Services. Rehabilitation services, Maintenance and/or non-Acute therapies, or therapies where a significant and measureable improvement of condition cannot be expected in a reasonable and generally predictable period of time. Any combination of therapies (including rehabilitation and speech and language therapies) that exceed the maximum allowable number of days per Year, as specified in the Schedule of Benefits, except when Medically Necessary. Rehabilitative/Habilitative services related to 1.) Developmental delay; 2.) Maintaining physical condition; 3.) Maintenance therapy for a Chronic Condition are not Covered Services.

(60) Self-Inflicted. Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

(61) Sex Changes. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical, or psychiatric treatment.

(62) Sexual Dysfunction. Behavioral treatment or drug therapy for sexual dysfunction and sexual function regardless if cause of dysfunction is due to physical or psychological reasons.

(63) Sleep Disorders. Care, supplies, appliances and treatment for sleep disorders unless deemed Medically Necessary.

(64) Smoking Cessation. Care and treatment for smoking cessation programs, including smoking deterrent patches, except when determined by the Plan Administrator to be Medically Necessary and to the extent required by the Patient Protection and Affordable Care Act.

(65) Subrogation, Reimbursement, and/or Third Party Responsibility. Of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

(66) Surgical sterilization reversal. Care and treatment for reversal of surgical sterilization.

(67) Surrogate Mother Pregnancies. Maternity charges, which are Incurred by a covered person, who acts as a Surrogate Mother, are not Covered Expenses. For the purposes of this plan the child/children of a Surrogate Mother will not be considered as being dependent of either the Surrogate Mother or her husband/boyfriend/domestic partner, if there is any, in any case if the Surrogate Mother has signed the surrogacy contract, pursuant to which she is to relinquish her child/children right after delivery.

(68) Temporomandibular Joint Disorder (Treatment of). Covered services under the medical portion of the Plan do not include the following:

a. Services for Temporomandibular joint syndrome, except for Medically necessary services in connection with Acute dislocation of the mandible (but not dislocation of the cartilage without dislocation of the mandible) from direct and immediate extrinsic trauma, fractures, neoplasms, rheumatoid arthritis, ankylosing spondylitis and disseminated lupus erythematous;
b. Dental splints, dental prosthesis or any treatment on or to the teeth, gums, or jaws and other services customarily provided by a dentist or dental Specialist;
c. Treatment of pain or infection due to a dental cause, surgical correction of malocclusion, maxilla facial orthognathic and prognathic surgery, orthodontia treatment, including Hospital and related costs resulting for these services when determined to relate to malocclusion;
d. Services related to injuries caused by or arising out of the act of chewing.

(69) Thermography. Infrared thermography (temperature gradient studies) or thermograms and related expenses.

(70) Transportation, Travel or Accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Expense. See Medical Benefits for additional information.

(71) Varicose veins or telangiectatic dermal veins (spider veins); sclerotherapy; intense pulsed-light source (photothermal sclerosis) treatment of a varicose vein. Experimental, investigational or unproven treatment including but not limited to non-compressive sclerotherapy, transdermal laser therapy, transilluminated powered phlebectomy (TIPP, TriVex), SEPS for the treatment of venous insufficiency as a result of post-thrombotic syndrome, sclerotherapy (i.e., liquid, foam, ultra-sound guided, endovenous chemical ablation); endomechanical ablation or cryostripping including cryoablation and cryofreezing of any vein.

(72) War, Riots, Misdemeanor, Felony. Illness or injury sustained by a Plan Participant caused by or arising out of riots, war (whether declared or undeclared), insurrection, rebellion, armed invasion or aggression. Illness or injury sustained by a Plan Participant while in the act of committing a misdemeanor, felony, any illegal act regardless of whether Plan Participant is arrested or convicted or while engaging in an illegal occupation, unless the condition was an injury resulting for an act of domestic violence or an Injury resulting from a medical condition.

Defined Terms

The following terms have special meanings and when used in this Plan Document will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis as defined by the Plan under the section entitled Eligibility Summary.

Adverse Benefit Determination means any of the following:

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

Allowable Expenses means the Usual and Customary charge for any Medically Necessary, Reasonable eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had Claim been duly made therefore.

AMA means the American Medical Association.

Ambulatory Surgical Center means a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Approved Clinical Trial means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

The Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of-network benefits are otherwise provided under the Plan.

Assignment of Benefits means an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a provider. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Plan Participant as the sole beneficiary.

Balance Billed Charges mean charges a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider (i.e. preferred provider) may not balance bill you for Covered Expenses.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Centers of Excellence means medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Plan Participant in need of an organ transplant may contact the Claims Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admissions taking place at a Center of Excellence.

If a Plan Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Child means in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible Foster Child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

CHIPRA refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Chiropractic Services means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Claim means any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for making benefit Claims.

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

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

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Expense means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or participant's health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

Covered Person is an Employee or Dependent who is covered under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dependent – see "Eligible Classes of Dependents" in the Eligibility, Effective Date and Termination.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

(1) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee shall mean a person who is employed by the Employer on a full-time basis and regularly scheduled to work at least thirty (30) hours per week (i.e. Non-variable Hour Employee) or a Variable Hour Employee who has averaged at least thirty (30) hours per week for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Patient Protection and Affordable Care Act (as amended).

The following definitions are associated with the Code Section 4980H (Employer Shared Responsibility) as enacted under the Affordable Care Act:

Administrative Period shall mean a period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage. An Administrative Period may not exceed 90 days. The Employer may choose not to use an Administrative Period.

Full-time Employee or Full-Time Employment shall mean with respect to a calendar month, an Employee who is employed an average of at least 30 hours of service per week with the Employer.

Hour of Service shall mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the employer; and each hour for which an Employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Measurement Period shall mean a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's hours of service are tracked to determine the Employee's employment status for benefit purposes.

Initial Measurement Period: For a newly hired Variable Hour Employee, this Measurement Period will start from the date of hire and ends after a period of 3 to 12 consecutive months of service. The Employer determines the Initial Measurement Period and provides that information through its own internal procedures and documents, such as the Employee Handbook.

Standard Measurement Period: For Ongoing Employees, this Measurement Period will start at a time designated by the Employer and will last for a period of 3 to 12 consecutive months of service. The Employer determines the Standard Measurement Period and provides that information through its own internal procedures and documents, such as the Employee Handbook.

New Employee shall mean an Employee who has not been employed by the Employer for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero hours of service.

Non-variable Hour Employee shall mean an Employee reasonably expected at the time of hire to work 30 or more hours per week.

Ongoing Employee shall mean an Employee who has been employed by the Employer for at least one complete Measurement Period.

Seasonal Employee shall mean an Employee who is hired into a position for which the customary annual employment is six months or less.

Stability Period shall mean a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period and, if elected by the Employer, the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period. The Stability Period is used by the Employer as part of the Look-back Measurement Method. The Stability Period is a period of time equal to the Measurement Period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

Variable Hour Employee shall mean an Employee, based on the facts and circumstances at the Employee's start date, for whom a reasonable expectation of average hours per week cannot be determined.

Employer is ABILITIES SERVICES, INC., and its affiliates.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits means, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

(1) Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

(2) Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

(2) If reliable evidence shows that the drug, device or medical treatment or procedure is subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
- **(a)** maximum tolerated dose;
- **(b)** toxicity;
- **(c)** safety;
- **(d)** efficacy; and
- **(e)** efficacy as compared with the standard means of treatment or diagnosis; or

(3) If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies are necessary to determine its:
- **(a)** maximum tolerated dose;
- **(b)** toxicity;
- **(c)** safety;
- **(d)** efficacy; and
- **(e)** efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

(1) Only published reports and articles in the authoritative medical and scientific literature;

(2) The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or

(3) The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the FDA but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug; provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

(1) The American Medical Association Drug Evaluations;

(2) The American Hospital Formulary Service Drug Information;

(3) The United States Pharmacopeia Drug Information; or

(4) A clinical study or review article in a reviewed professional journal.

-or-

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Plan Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

FMLA means the Family and Medical Leave Act of 1993, as amended.

FMLA Leave means a leave of absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

A covered Foster Child is not a child temporarily living in a covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

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

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

GINA means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

Habilitative means health care services that help keep, learn, or improve skills and functioning for daily living. This includes therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency means an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan means a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, and home care. See the Schedule of Benefits to determine whether this includes family counseling during the bereavement period.

Hospice Unit means a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital means an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by The Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

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

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit means defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

Maximum Amount and/or **Maximum Allowable Charge** means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

(1) The Usual and Customary amount;

(2) The allowable charge specified under the terms of the Plan;

(3) The Reasonable charge specified under the terms of the Plan;

(4) The negotiated rate established in a contractual arrangement with a provider; or

(5) The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

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

Medical Care Necessity, **Medically Necessary**, **Medical Necessity** and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition.

(1) It must not be maintenance therapy or maintenance treatment;

(2) Its purpose must be to restore health;

(3) It must not be primarily custodial in nature;

(4) It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare);

(5) The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Plan Participant is receiving or the severity of the Plan Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medical Record Review means the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, and then the Plan Administrator may determine the **Maximum Allowable Charge** according to the medical record review and audit results.

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

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance or No Fault Coverage means the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Other Plan shall include, but is not limited to:

(1) Any primary payer besides the Plan;

(2) Any other group health plan;

(3) Any other coverage or policy covering the Plan Participant;

(4) Any first party insurance through medical payment coverage, personal injury protection, No-Fault Coverage, uninsured or underinsured motorist coverage;

(5) Any policy of insurance from any insurance company or guarantor of a responsible party;

(6) Any policy of insurance from any insurance company or guarantor of a third party;

(7) Worker's compensation or other liability insurance company; or

(8) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

Partial Hospitalization means services provided by a hospital or health care treatment facility in which patients do not reside for a full 24 hour period for a comprehensive and intensive interdisciplinary psychiatric treatment for a minimum of 5 hours a day, 5 days per week; that treat social, psychological and rehabilitative training programs with a focus on a reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and that has physicians and appropriately licensed behavioral practitioners readily available for emergent and urgent needs of the patients. The program must be accredited by The Joint Commission on Accreditation of Hospitals or in compliance with an equivalent standard. Partial hospitalization does not include services for custodial care of day care.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means ABILITIES SERVICES, INC. Medical Plan, which is a benefits plan for certain Employees of ABILITIES SERVICES, INC. and is described in this document.

Plan Participant means any Employee or Dependent who is covered under this Plan.

Plan Year means the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy means childbirth and conditions associated with Pregnancy, including complications.

Prenatal means existing or occurring before birth.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Preventive Care means certain Preventive Care services.

This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

(1) Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;

(2) Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;

(3) Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and

(4) Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org/ or at https://www.healthcare.gov/preventive-care-benefits. For more information, you may contact the Claims Administrator / Employer at 1-800-948-9450 or service@healthez.com.

Prior Plan means the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the effective date of this Plan and replaced by this Plan.

Reasonable and/or **Reasonableness** means in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Rehabilitative means treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible.

Sickness means a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility means a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided;

(2) Its services are provided for compensation and under the full-time supervision of a Physician;

(3) It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse;

(4) It maintains a complete medical record on each patient;

(5) It has an effective utilization review plan;

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled or defective, Custodial Care or educational care, or care of Mental Disorders; and,

(7) It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation see definition for Chiropractic Services

Substance Abuse means any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

(1) A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

- **(a)** Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
- **(b)** Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
- **(c)** Craving or a strong desire or urge to use a substance; or
- **(d)** Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

(2) The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Abuse Treatment Center means an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

(1) Affiliated with a Hospital under a contractual agreement with an established system for patient referral;

(2) Accredited as such a facility by The Joint Commission on Accreditation of Hospitals; or

(3) Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence means substance use history which includes the following: (1) Substance Abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

Temporomandibular Joint (TMJ) syndrome means jaw joint disorders, including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular joint.

Usual and Customary (U&C) means Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates.

The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is Incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of a person of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

Prescription Drug Benefits

Copayments or Coinsurance

The copayment or coinsurance is applied to each covered pharmacy drug or mail order drug charge and is shown in the Schedule of Benefits. The copayment/coinsurance amount is not a covered charge under the Plan; however, the Prescription Drug copayment/coinsurance applies toward the Plan's total out-of-pocket maximum. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply unless the Schedule of Benefits states otherwise.

If a drug is purchased from a non-participating pharmacy or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan;

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity; or,

(3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables may not be covered.

Limits to This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician; or

(2) Refills up to one year from the date of order by a Physician.

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Product(s) or Pharmaceutical Products(s) you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

Quantity Limits

A quantity limit is the highest amount of a prescription drug that can be given to you by your pharmacy in a period of time (for example, 30 tablets per month). Some drugs have quantity limits to help encourage appropriate usage, ensure effectiveness and reduce costs. Both preferred and non-preferred drugs may have quantity limits.

Prior Authorization

Certain prescription drugs require a Prior Authorization. This means a review of a medication prescribed will be done before the plan will cover it. A prior authorization may be required for drugs listed or not listed on the Prescription Benefit Provider's (PBM's) formulary, including, but not limited to, the following:

- Drugs that have dangerous side effects
- Drugs that are harmful when combined with other drugs
- Drugs that you should use only for certain health conditions
- Drugs that are often misused or abused

- Drugs that a doctor prescribes when less expensive drugs might work the same or better

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for Prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance. Human Growth Hormone except when it is deemed eligible by Medical Necessity or for children or adolescents who have one of the following conditions or deemed eligible by Medical Necessity:
- **(a)** Documented growth hormone deficiency causing slow growth;
- **(b)** Documented growth hormone deficiency causing infantile hypoglycemia;
- **(c)** SHOX
- **(d)** Short stature and growth due to Turner syndrome, Prader-Willi syndrome, chronic renal insufficiency prior to transplantation, central nervous system tumor treated with radiation;
- **(e)** Documented growth hormone deficiency due to a hypothalamic or pituitary condition.

(9) **Impotence.** A charge for impotence medication.

(10) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

(11) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(15) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

How to Submit a Claim

For the purposes of this section “claimant” shall mean any Plan Participant or his or her authorized representative submitting a Claim to the Plan and thereby seeking to receive Plan benefits.

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Typically, Providers will submit Claims directly to the Claims Administrator. However, when a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office or the Plan Administrator;

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED;

(3) Have the Physician complete the provider's portion of the form;

(4) For Plan reimbursements, attach bills for services rendered, ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges; and

(5) Send the above to the Claims Administrator at this address:

HealthEZ
P.O. Box 398220
Minneapolis, Minnesota 55439-8820

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the services were Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. Claims filed later than that date may be denied payment or reduced unless:

(a) It's not reasonably possible to submit the Claim in that time; and

(b) The Claim is submitted within one year from the date Incurred. This one year period will not apply when the person is not legally capable of submitting the Claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the Claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. The timetables listed below are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are three different categories of Claims: urgent care Claims, pre-service Claims, and post-service Claims.
Each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this document for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification to claimant, orally or in writing	15 days
Response by claimant, orally or in writing	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days

Request to extend course of treatment	15 days
Review of Adverse Benefit Determination	15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim. In other words, it is a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:	
Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of Adverse Benefit Determination	30 days per benefit appeal

Notice to claimant of Adverse Benefit Determinations

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

(1) Information sufficient to allow the Plan Participant to identify the Claim involved (including date of service, the healthcare provider, the Claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
(2) A reference to the specific portion(s) of the plan provisions upon which a denial is based;
(3) Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim, and a discussion of the decision;
(4) A description of any additional information necessary for the Plan Participant to perfect the Claim.
(5) A description of available appeals, including information regarding how to initiate an appeal;
(6) A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Plan Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;
(7) A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Plan Participant's Claim for benefits;
(8) The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
(9) Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Plan Participant, free of charge, upon request;
(10) In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Plan Participant, free of charge, upon request; and
(11) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Appeals

When a claimant receives an Adverse Benefit Determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

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

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

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

External Review Process

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

The Federal external review process applies only to:

(1) An Adverse Benefit Determination (including a First Level Appeal Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
(2) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the “expedited external review” paragraph in this section).

(1) Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within 180 days after the date of receipt of a notice of an Adverse Benefit Determination. Claimant can only file a request for external review after a First Level Appeal determination has been issued.

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

(a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
(b) The Adverse Benefit Determination or the First Level Appeal Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
(c) The claimant has exhausted the Plan's First Level Appeal process; and
(d) The claimant has provided all the information and forms required to process an external review.

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

(3) Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

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

Expedited external review

(1) Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
(b) A First Level Appeal Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the First Level Appeal Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

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

(3) Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or First Level Appeal Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the Claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(4) Notice of final external review decision. The Plan's (or Claims Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48

hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A claimant will not be required to exhaust the internal Claims and appeals procedures described above if the Plan fails to adhere to the Claims procedures requirements. In such an instance, a claimant may proceed immediately to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the claimant must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant, and the violation is not reflective of a pattern or practice of non-compliance.

If a claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis exception" described above, the Plan will provide the claimant with notice of an opportunity to resubmit and pursue an internal appeal of the Claim.

Recovery of Payments

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

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

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

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

Further, Plan Participants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired

condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

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

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

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

If the Plan seeks to recoup funds from a provider, due to a Claim being made in error, a Claim being fraudulent on the part of the Provider, and/or the Claim that is the result of the Provider's misstatement, said Provider shall, as part of its Assignment of Benefits from the Plan, abstain from billing the Plan Participant for any outstanding amount(s).

Coordination of Benefits

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's covered Dependent children are covered under two or more plans, the plans will coordinate benefits when a Claim is received.

The plan that pays first according to the rules will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

Excess Insurance*.* If at the time of Injury, Sickness, disease or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan's benefits will be excess to, whenever possible:

(1) Any primary payer besides the Plan;
(2) Any first party insurance through medical payment coverage, personal injury protection, No-Fault Coverage, uninsured or underinsured motorist coverage;
(3) Any policy of insurance from any insurance company or guarantor of a third party;
(4) Worker's compensation or other liability insurance company; or
(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Allowable charge. For a charge to be allowable it must be the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had Claim been duly made therefore.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan Deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before Other Plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

5. The Plan will pay primary to Tricare to the extent required by federal law.

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

Coordination of the benefit plans. If a Covered Person is eligible for benefits under this Plan and Other Plan(s), the benefits payable under this Plan will be reduced to the extent of benefits that would have been payable under the Other Plan(s) had the Claims been made thereof. This reduction is regardless of coordination payment order. Simplistically, this Plan will not pay more than the reimbursement that the medical provider accepts from another plan.

Right to receive or release necessary information. The Plan may request or provide information from another insurer or any other organization or person for purposes of determining allowable charges. This information may be provided or obtained without consent or notice to any other person. A Covered Person will give this Plan the information it asks for about Other Plans and their payment of allowable charges. This Plan will not pay Claims that appear to be the liability of another plan or person without having all documentation and guarantee of Plan Rights to Recovery formally agreed to by the Plan Participant and/or his or her legal representative

End Stage Renal Disease. When an individual is covered under this plan as an Employee or as a Dependent, the Plan will reimburse treatment for End Stage Renal Disease (ESRD) for the initial 30 months at a rate not to exceed 135% of the Medicare allowable for Incurred expenses. This clarifies that in this instance, 135% of Medicare is Reasonable and Usual & Customary in this instance.

The immediately preceding paragraph does not apply to Plan Participants who are utilizing the CIGNA network for treatment related to End Stage Renal Disease. For Plan Participants utilizing the Cigna network, the Plan will reimburse treatment for ESRD at a rate consistent with Cigna's national dialysis agreements.

CMS Billing Guidelines

UCR. The Plan Reimbursement to a medical provider is, regardless of PPO Agreement, limited to the Reasonable Reimbursement for the treating Medical Provider. We define Reasonable reimbursement as the dominant Commercial Payor Reimbursement at the treating Medical Provider.

Network Provider – In-Network Specialty Facilities, Teaching Facilities and Tertiary Facilities are not considered "Network" and subject to Reasonable Reimbursement.

Facility of payment. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of recovery. In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Plan Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

Third Party Recovery Provision

Payment Condition

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

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

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

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

Subrogation

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

(2) If a Plan Participant(s) received or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any Claim, which any Plan Participant(s) may have against any Coverages and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

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

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

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

then the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such Claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such

Claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a Claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

(1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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

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

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

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

Excess Insurance

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

The Plan's benefits shall be excess to:

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

Separation of Funds

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

Wrongful Death

(1) In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

Obligations

(1) It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
- **(a)** To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- **(b)** To provide the Plan with pertinent information regarding the Sickness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
- **(c)** To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- **(d)** To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- **(e)** To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- **(f)** To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

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

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

Offset

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

Minor Status

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

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

Language Interpretation

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

Severability

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

Continuation Coverage Rights Under COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under ABILITIES SERVICES, INC. Medical Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law employees (whether part-time, ¾ time, or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent Child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee;

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment;

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation;

(4) A covered Employee's enrollment in any part of the Medicare program; or,

(5) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. If you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment;

(2) death of the employee;

(3) commencement of a proceeding in bankruptcy with respect to the employer; or

(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the Plan Administrator (i.e. Employer).

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period;

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary;

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee;

(4) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier); or,

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent Claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension;

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment;

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption; or

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18-month or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability

determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Responsibilities for Plan Administration

PLAN ADMINISTRATOR. ABILITIES SERVICES, INC. Medical Plan is the benefit plan of ABILITIES SERVICES, INC., and its affiliates, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by ABILITIES SERVICES, INC. to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, ABILITIES SERVICES, INC. shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a Claim for benefits and to review Claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay Claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves

and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

FUNDING THE PLAN AND PAYMENT OF BENEFITS. Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

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

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

AMENDING AND TERMINATING THE PLAN. If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination. The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

SUMMARY OF MATERIAL REDUCTION (SMR). A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in deductibles or copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Plan Participant. The 60-day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

SUMMARY OF MATERIAL MODIFICATION (SMM). A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Note: The Patient Protection and Affordable Care Act (PPACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Covered Persons at least 60 days before the effective date of the Material Modification.

Certain Plan Participants Rights under ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

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

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a Claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Important Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

(1) All stages of reconstruction of the breast on which the mastectomy was performed;
(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) Prostheses; and Treatment of physical complications of mastectomy, including lymphedemas.

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

GINA NOTICE

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information. GINA expands on the provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in a number of ways:

(1) Group health plans and health insurers cannot base health care premiums for plans or a group of similarly situated individuals on Genetic Information;
(2) Plans and insurers are prohibited from requesting or requiring an individual to undergo a genetic test; and
(3) Plans and insurers are prohibited from collecting Genetic Information (including family history) prior to or in connection with enrollment, or for underwriting purposes.

NOTICE OF RIGHTS UNDER THE MOTHERS & NEWBORNS HEALTH PROTECTION ACT

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

MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY AND PORTABILITY REQUIREMENTS

The Plan intends to comply with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), including special enrollment rights and privacy rights and responsibilities. The Plan provides each Plan Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. **Additional copies of our Notice of Privacy Practices are available by contacting the HIPAA Compliance Officer listed in the section entitled General Plan Information and Establishment of the Plan.**

Qualified Medical Child Support Orders (QMCSCOs)

The Plan has written procedures to determine whether a medical child support order qualifies for coverage under the plan by meeting certain requirements. The Plan will provide coverage pursuant to a medical child support order that does not qualify. Please contact 1-844-804-8118 to request of a copy of the written procedures used by the Plan Administrator to determine QMCSCOs.

General Plan Information & Establishment of the Plan

Name of Plan:	**ABILITIES SERVICES, INC.** **Medical Plan**
Plan Sponsor:	**ABILITIES SERVICES, INC.** **1237 Concord Road** **Crawfordsville, IN 47933**
Plan Administrator: **(Named Fiduciary)**	**ABILITIES SERVICES, INC.** **1237 Concord Road** **Crawfordsville, IN 47933** **Ph: 765-362-4020**
Plan Sponsor ID No. (EIN):	**35-1266320**
Source of Funding:	**Self-Funded**
Applicable Law:	**ERISA**
Plan Year:	**October 1st to September 30th**
Plan Number:	**501**
Plan Status:	**Non-Grandfathered**
Plan Type:	**Medical** **Prescription Drug**
Claims Administrator:	**America's TPA dba HealthEZ** **PO Box 398220** **Minneapolis, Minnesota 55439-8220**
Participating Employer(s):	**ABILITIES SERVICES, INC.**
Agent for Service of Process:	**ABILITIES SERVICES, INC.**
HIPAA Officer(s):	**Cathy Stephens** **Ph: 765-362-4020**

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by ABILITIES SERVICES, INC. (the "Company" or the "Plan Sponsor") as of October 1, 2017, hereby sets forth the provisions of the ABILITIES SERVICES, INC. Medical Plan (the "Plan").

Effective Date
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this non-grandfathered Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

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

ABILITIES SERVICES, INC.

By: M Smith

Name: Michelle Smith

Title: CEO/Exec Dir

Date: 11/9/17