PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

FOR THE ARNOLD & ASSOCIATES OF WICHITA, INC. COMPLIANCE MINIMUM VALUE GROUP HEALTH PLAN

EFFECTIVE: 1/1/2021

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TABLE OF CONTENTS

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INTRODUCTION

This document is a description of The ARNOLD & ASSOCIATES OF WICHITA, INC.Compliance Minimum Value Group Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, 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.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

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.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination Provisions. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Medical Benefits. Explains when the benefit applies, and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

How to Submit Pharmacy Claims. Explains the rules for filing claims and the claim appeal process.

How to Submit Medical Claims. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Important Notices of Plan Participant Rights. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. Employees of the Employer. Coverage becomes effective the day following completion of the Waiting Period, subject to completion of enrollment requirements.

Note: Independent Contractors and Leased Employees are <u>not</u> eligible for coverage under this Plan.

Ongoing Employees.
Once an Employee has completed the Plan's initial measurement period, eligibility will be based solely on the Employee's Hours of Service during the Plan's standard measurement period (e.g., weekly or monthly). Any Employee who averages 30 Hours of Service per week during the Plan's standard measurement period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next ongoing employee stability period, provided that the Ongoing Employee remains employed, and subject to the Plan's Break in Service rules. Coverage will be effective on the first day of the ongoing employee stability period, subject to completion of the enrollment requirements.

Impact of Breaks in Service.
If an Employee has a Break in Service and then returns to work, the Employee will be treated as a New Hire, and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. However, if an Employee is not actively at work for a period less the applicable Break in Service and returns to work or is otherwise credited with Hours of Service before the Employee incurs a Break in Service, the Employee will be treated as a continuous employee and will be eligible for coverage under the Plan upon return if the Employee was enrolled in coverage prior to the start of the period during which the Employee had no Hours of Service. The coverage will be effective on the first day of the standard measurement period that coincides with or follows the date the Employee resumes Hours of Service, subject to completion of enrollment requirements.

The “Waiting Period” is a period of 60 consecutive days as an Active Employee beginning on the first day of employment in an eligible class. The Waiting Period will be waived for any Employee whose Full-Time status was determined using the look-back measurement method with an initial measurement period of three months or more.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered **Employee's Child(ren)** from birth to the limiting age of 26 years.

The term “**Child(ren)**” shall include natural children, step-children, adopted children, foster children, and children placed with a covered Employee in anticipation of adoption.

If a covered Employee or his/her Spouse is a **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents.

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

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMSCO)** shall be considered as having a right to Dependent coverage under this Plan. A

participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

Benefits shall be provided in accordance with the applicable requirements of any QMCSO. However, the QMCSO shall not cause the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan.

(2) A **covered Dependent Child** who reaches the **limiting age and is Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and is unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Child's Total Disability and dependency.

These persons are excluded as Dependents: **Spouses of the Employee**, other individuals living in the covered Employee's home, but who are not eligible as defined; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both parents are Employees, their children will be covered as the Dependent of one or the other, but not of both.

Eligibility Requirements for Dependent Coverage. 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.

At any time, the Plan may require documentation proving dependency.

FUNDING

Cost of the Plan. Employer may require Employee to share the cost of Employee coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

The covered Employees may be required to pay a portion or the entire cost for coverage for their Dependents. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by following the enrollment procedures set forth by the Employer. The covered Employee is also required to enroll each Dependent for coverage.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

If the child is required to be enrolled and is not enrolled within 30 days of birth, the enrollment will be considered a Late Enrollment.

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 30 days after the person becomes eligible for the coverage initially, or under a Special Enrollment Period.

If two Employees covered under the Plan may each claim a Dependent Child, and the Employee who is covering the Dependent child(ren) 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 and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

Unless otherwise required by law, if an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins as stated in the Open Enrollment provision below or re-enrollment following an applicable Measurement Period:

(i) **Open Enrollment**. Each year there is an open enrollment period designated by the Employer: During the open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them. Additionally, during open enrollment, Employees and their covered Dependents, who are Late Enrollees, will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective 01/01/2021 and remain in effect until 12/31/2021 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse’s employment. To the extent previously satisfied, coverage of Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

(3) **Enrollment Following Measurement Periods**. Following an applicable Measurement Period, Qualified Employees/Ongoing Employees and their eligible Dependents may enroll in the Plan with coverage effective on the first day of the applicable Stability Period. Employees will be credited for time previously satisfied toward the employment Waiting Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents 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). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

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 30 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. **To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.**

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(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, so long as the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(b) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(c) The Employee or Dependent requests enrollment in this Plan no later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

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 or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Acquiring a newly eligible Dependent may create a Special Enrollment right. 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, or a QMCSO,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

The Special Enrollment Period for newly eligible Dependents is a period of 30 days that begins after 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 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(i) In the case of marriage, the first day of the standard measurement period beginning after the date of the completed request for enrollment is received, or

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

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

(iv) In the case of a QMCSO, no later than the first day of the calendar month following the date of the order.

(3) Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the standard measurement period following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the standard measurement period following completion of the Waiting Period, not to exceed 90 days following the date that the Eligibility requirements are met, the Active Employee requirements are met, and all Enrollment Requirements are met.

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, including in the event an Employee makes 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. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. 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.

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. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The end of the standard measurement period, within 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.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(4) 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.

(5) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, 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. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(6) As otherwise specified in the Eligibility section of this Plan.

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 work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance, not to exceed 90 days.

For leave of absence or layoff only: the date the Employer ends the continuance, not to exceed 90 days.

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. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor ("FMLA"), as well as any applicable state-mandated Family and Medical Leave.

During any leave taken under the FMLA, 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 the 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. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired after a Break in Service will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by the terms of the Plan and applicable law. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period.

Employees on Military Leave. 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 (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's covered Dependents 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 of 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.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator.

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:

(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) Coverage will end on the last day of the standard measurement period in which the Child(ren) ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) 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.

(5) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, 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. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(6) As otherwise specified in the Eligibility section.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are reasonable and customary (as defined as an Allowable Amount); that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services and/or supplies. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification of services is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefit.

ASSIGNMENT OF BENEFITS

A Plan Participant may assign benefits for medical expenses covered under this Plan to a provider as consideration in full for services rendered; however, whether such benefits are paid directly to the Plan Participant or to the provider, the Plan will be deemed to have fulfilled its obligations with respect to such benefits.

The Plan will not be responsible for determining whether any such Assignment of Benefits is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment has been received before proof of the loss is submitted.

The Plan Participant may not, at any time either during a period of participation in the Plan or following coverage termination, assign the Plan Participant’s right to recover benefits due under the Plan, to enforce rights due under the Plan, or to any other causes of action which the Plan Participant may have against the Plan or its fiduciaries.

A provider which accepts an Assignment of Benefits does so in accordance with this Plan and does so as consideration in full for services rendered. Any such provider is bound by the rules and provisions set forth within the terms of this document.

Deductibles payable by Plan Participants. Deductibles are dollar amounts that the Plan Participant must pay before the Plan pays.

A deductible is an amount of Allowable Amounts for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Plan Participant must meet the deductible shown in the Schedule of Benefits.

The deductible will apply to the maximum out-of-pocket amount.

There are no copayments.

Maximum out-of-pocket payments, per Calendar Year. Subject to the Plan’s Allowable Amount, the Plan will pay the designated percentage of Allowable Amounts until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Allowable Amounts for the rest of the Calendar Year unless stated otherwise. The maximums shown below are separate.

The out-of-pocket maximum limit will be applied to a family unit as follows. Once a Plan Participant within the family unit meets the Per Plan Participant limit, any additional Covered Charges for that person will be paid by the Plan at 100%. The out-of-pocket expenses paid by that Plan Participant for Covered Charges will be applied to (and reduce) the Per Family Unit limit. The Per Family Unit limit will be met when the total of Covered Charges incurred by the other covered family members, when added to the Plan Participant out-of-pocket Covered Charges, total the Per Family Unit limit.

Please keep in mind that Providers are not required to accept the Plan's Allowable Amount as payment in full and may balance bill you for the difference between the Plan's Allowable Amount and the provider's billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies, and procedures limited or excluded under the Plan, as well as any applicable deductibles, coinsurance, and/or copayment amounts.

The charges for the following do not apply to the 100% benefit limit and are never paid at 100%.

(1) Amounts over the Plan's Allowable Amount

	ALL HEALTH CARE PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR	
Per Plan Participant	$7,600
Per Family Unit	$15,200
MAXIMUM OUT OF POCKET, PER CALENDAR YEAR	
Per Plan Participant	$7,600
Per Family Unit	$15,200
ANNUAL MAXIMUM BENEFIT	Unlimited
LIFETIME MAXIMUM BENEFIT	Unlimited
Note: For Medically Necessary services, the benefits of this Plan will be provided after the deductible has been met, unless otherwise noted. After the maximum out of pocket amount has been reached, this Plan will provide benefits at 100% of the Allowable Amount for the remainder of the Calendar Year for all covered medical expenses. Any balances of charges not covered by this Plan will be your responsibility to pay. This includes but is not limited to balance billed amounts beyond the Allowable Amount as set forth in the plan. These amounts do not accumulate towards your Maximum Out of Pocket.	
COVERED CHARGES	
	ALL HEALTH CARE PROVIDERS
Hospital Services ***Pre-notification is strongly recommended.***	
Room and Board - Benefit limited to the average semi-private room rate	Covered 100% after Deductible Subject to the Plan Allowable Amount
Intensive Care Unit	Covered 100% after Deductible Subject to the Plan Allowable Amount
Emergency Room Services	Covered 100% after Deductible Subject to the Plan Allowable Amount
Outpatient Services	Covered 100% after Deductible Subject to the Plan Allowable Amount
Urgent Care Services	Covered 100% after Deductible Subject to the Plan Allowable Amount
Physician Services	
Inpatient visits	Covered 100% after Deductible Subject to the Plan Allowable Amount
Primary Care Visits	Covered 100% after Deductible Subject to the Plan Allowable Amount
Specialist Visits	Covered 100% after Deductible Subject to the Plan Allowable Amount
Surgery	Covered 100% after Deductible Subject to the Plan Allowable Amount

	ALL HEALTH CARE PROVIDERS
Allergy Testing and Treatment	Covered 100% after Deductible Subject to the Plan Allowable Amount
Ambulance Service	Covered 100% after Deductible Subject to the Plan Allowable Amount
Chemotherapy and Radiation Treatment ***Pre-notification is strongly recommended.***	Covered 100% after Deductible Subject to the Plan Allowable Amount
Chiropractic Services	Covered 100% after Deductible Subject to the Plan Allowable Amount
Diabetes Education Benefit Limited to 2 Programs per Lifetime Limited to 8 follow-up visits per Calendar Year	Covered 100% after Deductible Subject to the Plan Allowable Amount
Dialysis Services ***Pre-notification is strongly recommended.***	Covered 100% after Deductible Subject to the Plan Allowable Amount
Diagnostic Lab and X-Ray	Covered 100% after Deductible Subject to the Plan Allowable Amount
Durable Medical Equipment ***Pre-notification is strongly recommended.***	Covered 100% after Deductible Subject to the Plan Allowable Amount
Home Health Care	Covered 100% after Deductible Subject to the Plan Allowable Amount
Imaging (CT/PET Scans, MRIs)	Covered 100% after Deductible Subject to the Plan Allowable Amount
Mental Health Services ***Pre-notification is strongly recommended.***	Covered 100% after Deductible Subject to the Plan Allowable Amount
Inpatient and Outpatient Services	Covered 100% after Deductible Subject to the Plan Allowable Amount
Occupational Therapy	Covered 100% after Deductible Subject to the Plan Allowable Amount
Organ Transplants Limited to one transplant per Calendar Year ***Pre-notification is strongly recommended.***	Covered 100% after Deductible Subject to the Plan Allowable Amount
Physical Therapy	Covered 100% after Deductible Subject to the Plan Allowable Amount
Maternity Services Includes Covered Services other than Maternity Office Vistis, includes Birthing Center.	Covered 100% after Deductible Subject to the Plan Allowable Amount
Preventive Care	
Routine Well Care	No Charge

Routine Well Care Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF), *Unless specifically stated in this Schedule of Benefits*, and which can be located using the following website(s):
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Routine Well Care services will include, but will not be limited to, the following routine services:
Office visits, routine physical exams, prostate screening, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examinations.
Note: If applicable, this Plan may comply with a state vaccine assessment program

Women's Preventive Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Schedule of Benefits*, and which can be located using the following websites:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/; and
http://www.hrsa.gov/womens-guidelines

Women's Preventive Services, will include, but will not be limited to, the following routine services:
Office Visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency Virus (HIV), interpersonal and domestic violence, sterilization procedures patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

	ALL MEDICAL PROVIDERS
Private Duty Nursing Care ***Pre-notification is strongly recommended.***	Covered 100% after Deductible Subject to the Plan Allowable Amount
Prosthetics	Covered 100% after Deductible Subject to the Plan Allowable Amount
Therapy Services	
Physical Therapy	Covered 100% after Deductible Subject to the Plan Allowable Amount
Occupational Therapy	Covered 100% after Deductible Subject to the Plan Allowable Amount
Speech Therapy	Covered 100% after Deductible Subject to the Plan Allowable Amount
Rehabilitative Services	Covered 100% after Deductible Subject to the Plan Allowable Amount
Second Opinions	Covered 100% after Deductible Subject to the Plan Allowable Amount
Surgery ***Pre-notification is strongly recommended.*** Subject to various limitations and exclusions, see Medical Benefits Section for details.	Covered 100% after Deductible Subject to the Plan Allowable Amount
Skilled Nursing Facility ***Pre-notification is strongly recommended.***	Covered 100% after Deductible Subject to the Plan Allowable Amount
Substance Abuse Services ***Pre-notification is strongly recommended.***	
Inpatient and Outpatient Services	Covered 100% after Deductible Subject to the Plan Allowable Amount
Tempromandibular Joint ("TMJ") Services	Covered 100% after Deductible Subject to the Plan Allowable Amount
All Other Covered Services	Covered 100% after Deductible Subject to the Plan Allowable Amount

PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUGS	
	ALL MEDICAL PROVIDERS
Pharmacy Option (30 Day Supply)	
Generic Drugs	Covered 100% after Deductible Subject to the Plan Allowable Amount
Preferred Brand Name Drugs	
Non-Preferred Brand Name Drugs	Covered 100% after Deductible Subject to the Plan Allowable Amount
Specialty Drugs	Not Covered
Mail Order Option (90 Day Supply)	
Generic Drugs	Covered 100% after Deductible Subject to the Plan Allowable Amount
Preferred Brand Name Drugs	Covered 100% after Deductible Subject to the Plan Allowable Amount
Non-Preferred Brand Name Drugs	Covered 100% after Deductible Subject to the Plan Allowable Amount
Specialty Drugs	Not Covered

Coverage Required by the ACA

To the extent required by and in accordance with ACA preventive care guidelines, FDA-approved Generic contraceptives may be covered under the PRESCRIPTION DRUG PROGRAM and paid without cost-sharing for female Plan Participants with Reproductive Capacity when prescribed by the woman's health care Provider and obtained at retail or by mail-order in accordance with the terms of the Plan. Brand Name contraceptives may be subject to the applicable Brand Name cost-share. When no Generic exists, Brand Name contraceptives are paid without costsharing. Once a Generic becomes available, the Brand Name contraceptive will be subject to the applicable Brand Name cost share. Furthermore, the Brand Name cost-share may be waived for a female Plan Participant for whom the Generic contraceptive is determined to be medically inappropriate by the attending Provider, in consultation with the patient.

In addition, to the extent required by and in accordance with ACA preventive care guidelines, this Plan provides coverage for over-the-counter recommended items and services without cost-sharing (which may include FDA-approved contraceptive methods that are generally available over-the-counter), but only when prescribed by a health care Provider and obtained at a participating retail Pharmacy using the Plan Participant's Health Identification Card.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

SELF-AUDIT BILLING CREDIT

The Plan offers an incentive credit to all covered Employees to encourage examination and self-auditing of eligible medical bills to ensure the amounts billed by the provider or service accurately reflect the services and supplies received by the covered Employee or a covered Dependent.

The covered Employee is voluntarily asked to review all Hospital and doctor bills and verify that he or she has received each itemized service and the bill does not represent either an overcharge, or a charge for services never received, regardless of the reason.

The Claims Administrator agrees to assist the covered Employee (at his or her request) in determination of errors, and recovery attempts.

Plan Participants may receive a refund if they discover an overcharge on their medical bill that:

1. Was not detected by the provider of services; and
2. Was not detected by the Plan; and
3. Was part of the charges for services which are covered and paid under this Plan.

In the event a Plan Participant's self-audit results in elimination or reduction of charges, up to 20% of the amount eliminated or reduced may be paid directly to the Plan Participant provided savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Claims Administrator (e.g. a copy of the incorrect bill and a copy of the corrected billing).

- The credit could be up to a maximum of $200 refund based on an overcharge of $1,000.

If an overcharge is discovered by the Plan Participant, they should ask the provider to correct the overcharge and send the Plan Participant a revised itemized bill. The Plan Participant should clearly mark both itemized bills "Self-Audit Program" and send them to the Claims Administrator.

This self-audit credit is in addition to the payment of all other applicable Plan benefits for legitimate medical expenses.

Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Plan Participant, to avoid unnecessary payment of health care dollars and any subsequent remaining balance (the Plan Participant's liability) on an incorrect billing.

This credit will not be payable for charges in excess of the Plan Allowable Amount regardless of whether the charge is or is not reduced.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Illness and while the person is covered for these benefits under the Plan.

Please keep in mind Providers are not required to accept the Plan's Allowable Amount as payment in full and may balance bill you for the difference between the Plan's Allowable Amount and the provider's billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies and procedures limited or excluded under the Plan and any applicable deductibles, coinsurance amounts, and copayment amounts.

Claims must be received by the Claims Administrator within *90 days* from the date charges for the service(s) were incurred. A longer period of time will be allowed if required by applicable law or otherwise agreed to in writing between the Plan and the provider of services. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a Claim for benefits.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Plan Participant must meet the deductible shown in the Schedule of Benefits.

The deductible will apply to the maximum out-of-pocket amount.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Plan Participant after the Plan Participant has met his or her Calendar Year deductible, subject to the Plan's Allowable Amount.

Benefit payment made by the Plan will be at the rate shown in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable by the Plan at the percentages shown each Calendar Year until the maximum out-of-pocket amount shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

When a Family Unit reaches the maximum out-of-pocket amount, Covered Charges for that Family Unit will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

COVERED CHARGES

Covered Charges are the Reasonable and Necessary Fees that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan and are *subject to the Allowable Amount.* 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 Outpatient Surgical Center or a Birthing Center. Covered Charges 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.

Pre-notification of services, by the Plan Participant, for hospital care is strongly recommended. The pre-notification request must include the Plan Participant's plan of care and treatment protocol. Pre-notification of services should occur at least 7 days prior to the initiation of treatment. For pre-notification of services, call the Claims Administrator at (800) 521-2654.

A pre-notification of services is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan, in effect when charges are provided. A pre-notification is not required as a condition precedent to paying benefits.

(2) Coverage of Pregnancy. The Plan Allowable Amount for the care and treatment of Pregnancy, including complications of pregnancy, are covered the same as any other Illness.

Complications of pregnancy include physical effects directly caused by pregnancy, but which were not considered from a medical viewpoint to be the effect of a normal pregnancy, including conditions related to ectopic pregnancy, those that require an unplanned cesarean section, or spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

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).

When a discharge occurs within forty-eight (48) hours following an Inpatient admission for a normal vaginal delivery or within ninety-six (96) hours following an Inpatient admission for cesarean delivery, Covered Charges include one (1) home health care visit within forty-eight (48) hours of the discharge. At the discretion of the mother, a visit may occur at home or at the facility of the Provider. Home health care visits shall include parent education, assistance, and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments.

Note*: *You must immediately notify the Plan Administrator if you enter into an arrangement to provide surrogate parent services.

(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; and

(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; and

Covered Charges for a Plan Participant ‘s care in these facilities are payable as described in the Schedule of Benefits.

Pre-notification of services, by the Plan Participant, for skilled nursing facility care is strongly recommended. The pre-notification request must include the Plan Participant’s plan of care and treatment protocol. Pre-notification of services should occur at least 7 days prior to the initiation of treatment. For pre-notification of services, call the Claims Administrator at (800) 521-2654.

A pre-notification of services is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan, in effect when charges are provided. A pre-notification is not required as a condition precedent to paying benefits.

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

(a) Charges for **multiple surgical procedures** will be a Covered Charge 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 Plan Allowable Amount that is allowed for the primary procedures; 50% of the Plan Allowable Amount 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 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 Plan Allowable Amount 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 Plan Allowable Amount

(5) Private Duty Nursing Care. The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(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.

(b) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

Pre-notification of services, by the Plan Participant, for private duty nursing care is strongly recommended. The pre-notification request must include the Plan Participant’s plan of care and treatment protocol. Pre-notification of services should occur at least 7 days prior to the initiation of treatment. For pre-notification of services, call the Claims Administrator at (800) 521-2654.

A pre-notification of services is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan, in effect when charges are provided. A pre-notification is not required as a condition precedent to paying benefits.

(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 Illness 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.

A home health care 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.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Plan Participant'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 Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

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

(a) **Allergy Testing and Treatment.** Allergy testing consisting of percutaneous, intracutaneous, and patch tests, allergy extracts, and antigen injections performed at Physician's office visits.

(b) **Ambulance**. Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge 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.

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

(d) **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.

(e) **Chemotherapy and radiation treatment** with radioactive substances. The materials and services of technicians are included.

Pre-notification of services, by the Plan Participant, for chemotherapy and radiation treatment is strongly recommended. The pre-notification request must include the Plan Participant's plan of care and treatment protocol. Pre-notification of services should occur at least 7 days prior to the initiation of treatment. For pre-notification of services, call the Claims Administrator at (800) 521-2654.

A pre-notification of services is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan, in effect when charges are provided. A pre-notification is not required as a condition precedent to paying benefits.

(f) **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

- The clinical trial is registered on the National Institute of Health (NIH) maintained website www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial.

- The Plan Participant meets all inclusion criteria for the clinical trial and is not treated "off protocol"

- The Plan Participant has signed an Informed Consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent;

- The trial is approved by the Institutional Review Board of the institution administering the treatment;

- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physicians visits, Hospital stays, clinical laboratory tests and x-rays that a Plan Participant would receive whether or not he or she were participating in a clinical trial.

Routine patient services do not include, and reimbursement will not be provided for:

- The investigational service, supply, or drug itself;

- Services or supplies listed herein as Plan Exclusions;

- Services or supplies related to data collection for the clinical trial (i.e. protocol –induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Plan Participant (e.g. monthly CT scans for a condition usually requiring only a single scan);

- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g. device, drug, item or services applied by manufacturer and not yet FDA approved) without charge to the trial participant.

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

(h) **Diabetes Education**. Inpatient and outpatient self-management training and education services for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes, will be payable up to the limits as stated in the Schedule of Benefits.

Pre-notification of services, by the Plan Participant, for diabetes education is strongly recommended. The pre-notification request must include the Plan Participant's plan of care and treatment protocol. Pre-notification of services should occur at least 7 days prior to the initiation of treatment. For pre-notification of services, call the Claims Administrator at (800) 521-2654.

A pre-notification of services is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan, in effect when charges are provided. A pre-notification is not required as a condition precedent to paying benefits.

(i) **Durable Medical Equipment (DME**). Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;
- Is NOT primarily for the comfort and convenience of the Plan Participant;

- Does NOT have significant non-medical use (i.e. air conditioners, air filters, humidifiers, and environmental control devices.

If more than one item of Durable Medical Equipment can meet a Plan Participant's needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Plan Participant.

Subject to prior approval by the Plan Administrator, a Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Plan Participant if the Plan Participant were to purchase the item directly.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every 4 calendar years.

- Subject to prior approval of the Plan Administrator, replacement for a purchase Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Plan Participant's medical condition occurs sooner than the 4-calendar year period.

- Subject to prior approval of the Plan Administrator, replacement for a rented Durable Medical Equipment item may be available when a change in the Plan Participant's medical condition occurs sooner than the 4-calendar year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the 4-calendar year limit.

The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.

Pre-notification of services, by the Plan Participant, for durable medical equipment (DME) is strongly recommended. The pre-notification request must include the Plan Participant's plan of care and treatment protocol. Pre-notification of services should occur at least 7 days prior to the initiation of treatment. For pre-notification of services, call the Claims Administrator at (800) 521-2654.

A pre-notification of services is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan, in effect when charges are provided. A pre-notification is not required as a condition precedent to paying benefits.

(j) **Imaging**. Covered Charges for diagnostic imaging services, including Magnetic Resonance Imaging ("MRI"), Magnetic Resonance Angiography ("MRA"), Computed Tomography ("CT")

scan, Positron Emission Tomography ("PET") scan, nuclear cardiology studies, and other diagnostic imaging procedures approved by the Plan Administrator.

(k) **Infertility.** Care, supplies and services for the diagnosis of infertility only.

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

(m) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing, x-rays and services.

(n) **Mental Disorders and Substance Abuse treatment**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse.

(o) 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 Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth when treatment is completed within 12 months of the injury.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Removal of impacted teeth only when hospitalization is required due to a medical condition of the Plan Participant.
- 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.

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

(q) **Organ transplant** benefits. Medically Necessary charges otherwise incurred for the care and treatment due to an organ or tissue transplant that are not considered Experimental or Investigational, are subject to the following criteria (and are subject to the limits as stated in the Schedule of Benefits):

- The transplant must be performed to replace an organ or tissue.
- Organ transplant benefit period: A period of 365 continuous days beginning five (5) days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of

- the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.

- Organ procurement limits: Charges for obtaining donor organs or tissues, once a donor has been located, are Covered Charges under the Plan when the recipient is a Plan Participant. When the donor has medical coverage, his or her plan will pay first. The donor 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 to the place where the transplant is to take place.

No charge will be covered for (i) non-human; artificial; or mechanical transplants; (ii) donor and procurement services and costs incurred outside of the United States; (iii) transplants when government funding of any kind is provided; (iv) expenses related to the purchase of any organ; and (v) costs of lodging, food or transportation.

Pre-notification of services, by the Plan Participant, for organ transplants is strongly recommended. The pre-notification request must include the Plan Participant's plan of care and treatment protocol. Pre-notification of services should occur at least 7 days prior to the initiation of treatment. For pre-notification of services, call the Claims Administrator at (800) 521-2654.

A pre-notification of services is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan, in effect when charges are provided. A pre-notification is not required as a condition precedent to paying benefits.

Transplant Exclusions. Coverage for the following procedures, when Medically Necessary, will be provided under the regular medical benefits provision under this Plan, subject to any Plan provisions and applicable benefits limitations as stated in the Schedule of Benefits:

(1) Cornea transplantation

(2) Skin grafts

(3) Artery

(4) Vein

(5) Valve

(6) Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

(r) **Physical therapy** by a licensed 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.

(s) **Prescription** Drugs (as defined) and will be payable as stated in the Schedule of Benefits.

(t) **Routine Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Preventive Care shall be provided as

required by applicable law and included serviced with an "A" or "B" rating from the United States Preventive Services Task Force.

Charges for Routine Well Care. Routine well care is care by a Physician that is not for an Injury or Illness.

(u) **Prosthetic devices.** The initial purchase, fitting and repair of fitted prosthetic devices which replace body parts if deemed Medically Necessary. Coverage Charges for deluxe prosthetics and computerized limbs will be based on the Plan Allowable Amount for a standard prothesis.

Computer-assisted communication devices and replacement of lost or stolen prosthesis *will not* be a Covered Charge.

(v) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

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.

(w) **Rehabilitative Therapy.** Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness or surgery.

(i) Inpatient Care. Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished by a rehabilitation facility approved by the Plan. This benefit only covers care the Plan Participant received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

(x) **Renal Dialysis Services**. Renal dialysis visits shall include dialysis, facility services, supplies and medications provided during treatment in either a Hospital or Medicare-approved dialysis center. Laboratory testing and Physician visits will be payable per normal Plan provisions.

Pre-notification of services, by the Plan Participant, for renal dialysis services is strongly recommended. The pre-notification request must include the Plan Participant's plan of care and treatment protocol. Pre-notification of services should occur at least 7 days prior to the initiation of treatment. For pre-notification of services, call the Claims Administrator at (800) 521-2654.

A pre-notification of services is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan, in effect when charges are provided. A pre-notification is not required as a condition precedent to paying benefits.

(y) **Second Opinions**. Charges for a second opinion on the diagnosis and treatment of a Plan Participant's Illness or Injury. Such covered services must be performed and billed by a Physician other than the one who initially made the diagnosis and recommended the treatment.

(z) **Speech Therapy** by a licensed 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) an Illness.

(aa) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O., or D.C. subject to Medical Necessity and non-maintenance care and will be payable up to the limits as stated in the Schedule of Benefits.

(bb) **Sterilization** procedures. Sterilization procedures for female Plan Participants will be payable as shown under the Preventive Care benefit as shown in the Schedule of Benefits section. The following charges will be payable per normal Plan provisions:

- Hysterectomies; and
- Sterilization procedures for male Plan Participants.

(cc) **Surgical dressings**. Splints, casts and other devices used in the reduction of fractures and dislocations. Charges for elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription are not covered.

(dd) **Tobacco Cessation Programs** shall be covered with no cost sharing as a Standard Preventive Care benefit.

(ee) Coverage of **Well Newborn Nursery/Physician Care**.

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, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an **eligible** Dependent and a parent (1) is a Plan Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to the Plan Allowable Amount 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 newborn child, provided the newborn child is enrolled on a timely basis.

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).

Charges for Routine Physician Care. The benefit is limited to the Plan Allowable Amount made by a Physician for normal newborn child, including circumcision, 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 newborn child, provided the newborn child is enrolled on a timely basis.

(ff) **Other Ancillary Products.** In addition to benefits under this plan, you have other service options including telehealth and other service providers. Please see your enrollment guide or HR Representative for more information.

(9) **Telehealth** visits include a visit with a provider that uses telecommunication systems between a provider and a patient; these visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

(10) **Virtual Check-In** includes a brief (5-10) minutes) check in with your practitioner via telephone or other telecommunications devices to decide whether an office visit or other service is needed. These visits are considered the same as in-person and are paid at the same rate as regular, in-person visits.

(11) **E-Visits** include a communication between a patient and their provider through an online patient portal. These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

(12) **Teledentistry** connects the patient and clinician using a telecommunication system, and can be used to deliver such care as the diagnosis, consultation, treatment, education, care management and self-management of patients. These visits are considered the same as in-person and are paid at the same rate as regular, in-person visits.

(13) **Contraceptive Methods.** All Food and Drug Administration approved contraceptive methods when prescribed by a physician, including but not limited to, intrauterine devices (IUDs), implants, and injections, and any related Physician and facility charges, and will be payable under the Preventive Care benefits as shown in the Schedule of Benefits.

COST MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Plan Participants in understanding and becoming involved with their diagnosis and medical plan of care, and advocates patient involvement in choosing a medical plan of care. Utilization Management begins with the Pre-notification process.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services and/or supplies. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification of services is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefit.

Examples of when the Physician and Plan Participant should notify the Claims Administrator prior to treatment include but are not necessarily limited to:

- Inpatient admissions to a Hospital
- Cancer treatment plan of care, administered on an inpatient or outpatient basis
- Inpatient or outpatient Surgeries
- Outpatient services such as:
    - Diagnostic Testing, Laboratory and/or Radiology
    - Durable Medical Equipment and Supplies
    - Physical Therapy
    - Chemotherapy, Radiation, and/or IV Therapy
    - Home Health Care
    - Hospice

This list is not exhaustive. Please see Schedule of Benefits above.

All Claims are subject to the terms and conditions, limitations and exclusions of the Plan at the time services are provided and all claims are subject to the Internal and External Claims Review Procedures.

The Physician or Plan Participant should notify the Claims Administrator at least seven (7) days before certain services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number and address of the Plan Participant
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The plan of care, treatment protocol and/or informed consent, if applicable

If there is an emergency admission to the Hospital, the Plan Participant, Plan Participant's family member, Hospital or attending Physician should notify the Claims Administrator within twenty-four (24) hours after the admission.

Hospital Observation Room stays in excess of 23 hours are considered an admission for purposes of this program, therefore the Care Management Administrator should be notified.

Contact the Claims Administrator at:

Claims Administrator
c/o Breckpoint Inc.
5130 South Fort Apache # 215-365
Las Vegas, NV 89148
(844) 798-4878

CARE ADVOCACY PATHWAY (CAP): This program is a strategy of delivering health care services using interdisciplinary clinical teams involving multiple medical specialties operating as a health care team in conjunction with your advocacy coordinator. This team's function is to provide continuous analysis of relevant data and cost-effective technology to improve the health outcomes of patients with specific diseases.

CAP enhances communication between practitioners and patients, facilitates feedback necessary for behavior modification (which may prevent or delay disease progression), and measures the effectiveness of interventions. When properly structured, CAP involves an integrated, comprehensive approach to patient care.

Care Advocacy Pathway (CAP):

(a) Improves health outcomes and better measures the "value" of provided services.

(b) Takes a patient-centered approach to providing care by addressing psychological aspects, caregiver issues, and treatment of multiple diseases using nationally recognized standards of care.

(c) Encourages patient participation by covering specific services under this benefit as approved by the care managers.

(d) May lower costs by reducing the use of unnecessary or redundant services or avoiding costs associated with poor outcomes.

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 under CAP 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 Plan Participant, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of 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 cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: CAP is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

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.

DEFINED TERMS

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

Active Employee means 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.

Allowed Amount means the maximum amount payable by the Plan for a service, supply and/or treatment that is considered a Covered Service. The Allowed Amount will always be a negotiated rate, if one exists. In the absence of the negotiated rate, the Allowable Amount shall be the *lesser of*: 1) the charge made by the provider that furnished the care, service, or supply; or 2) an amount equivalent to the following:

(1) For Hospital and Facility Claims, an amount equivalent to 145% of the current Medicare equivalent allowable amount.

(2) For Physician Claims, an amount equivalent to 125% of the current Medicare equivalent allowable amount.

If and only if none of the factors above are applicable, the Plan Administrator will exercise its discretion to determine the Allowable Amount based on any of the following: Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Allowable Amount.

The Allowable Amount will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

For Covered Services rendered by a provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowed Amount shall not exceed the amount established by applicable law for that Covered Service.

The Plan Administrator has the ultimate discretionary authority to determine the Allowed Amount, including establishing the negotiated terms of a provider arrangement as the Allowed Amount even if such negotiated terms do not satisfy the lesser of test described above.

Assignment of Benefits is an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Covered Services, in accordance with the terms of this Plan, to a provider.

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.

Break in Service means a period of at least 13 consecutive weeks during which the Employee has no Hours of Service; provided, however, that a Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves).

Calendar Year is January 1st through December 31st of the same year.

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

Cosmetic Dentistry is dentally unnecessary procedures.

Covered Charge(s) are those Medically Necessary services or supplies that are covered under this Plan.

Custodial Care means 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.

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.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer Relationship.

Enrollment Date is the first day of coverage or, if there is a Waiting period, the first day of the Waiting Period.

Employer is ARNOLD & ASSOCIATES OF WICHITA, INC.

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

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the Claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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

(2) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) Except as provided under the Clinical Trial benefit in the Medical Benefits section of the Covered Charges section, if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum

tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

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

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

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.

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 is 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 is 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, home care, and family counseling during the bereavement period.

Hospice Unit is 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 is 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 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 b 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 has received accreditation from CARF (Commission of Accreditation of Rehabilitation Facilities) or The Joint Commission (TJC) or 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 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.

Hospital and Facility Claims: Post-service Claims for charges by any Hospital, Medical Care Facility, or Urgent Care (individually referred to each as a **"Hospital or Facility Claim"**).

Hours of Service means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

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

Infertility means incapable of producing offspring.

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

Intensive Care Unit is 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.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

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

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the patient's condition; is approved by the FDA, if applicable, and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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 is a serious disease associated with a high incidence of medical complications and a significantly shortened life span. The current clinical standard measure for Morbid Obesity is a Body Mass Index (BMI) of 40+. The BMI is a factor produced by dividing a person's weight (in kilograms) by his or her height squared (in meters).

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

Outpatient Care and/or Services is 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 Outpatient Surgical Center, or the patient's home.

Outpatient Surgical Center is 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.

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, 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 the ARNOLD & ASSOCIATES OF WICHITA, INC.Compliance Minimum Value (MV) Group Health Plan, which is a benefits plan for certain Employees of the Employer and is described in this document.

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

Plan Year is the 12-month period beginning on 01/01/2021 and ending on 12/31/2021.

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

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 an Illness or Injury.

Skilled Nursing Facility is 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 Illness. 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 hours 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, Custodial or educational care or care of Mental Disorders.
(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.

Special Unpaid Leave of Absence means any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (i) leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the Employer).

Spinal Manipulation/Chiropractic Care 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.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco/nicotine and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of 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.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Utilization is the use of services by persons for the purpose of preventing and curing health problems, promoting maintenance of health and well-being, or obtaining information about one's health status and prognosis. Examples of Utilization are the number of office visits a person makes per year, the number of prescription drugs taken, or the number of testing a person receives by a provider.

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:

(1) Abortion. Services, supplies, care or treatment in connection with an abortion.

(2) Acupuncture. Services, supplies, care or treatment in connection with acupuncture.

(3) Administrative or Adjunctive Charges. Charges for administrative fees; completion, filing or copying of claim forms, itemized billed or medical reports; reports or appearances in legal proceedings, mail, postage or shipping and handling, missed or broken appointments; late fees; sales tax; interest or penalties; travel time or expenses.

a. Charges for email consultations, completion of claim forms, and charges associated with missed appointments.

(4) Bariatric Surgery. Services, supplies, care or treatment in connection with a bariatric surgery.

(5) Coding Guidelines. Charges for inappropriate coding in accordance to the industry standard guidelines in effect at the time services were received.

(6) 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.

(7) Cosmetic Procedures. Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by injury, disease, trauma, congenital/developmental Anomalies, or previous covered therapeutic processes.

(8) Custodial care. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care except as specifically stated as a benefit under this Plan.

(9) Educational or vocational testing. Services for educational or vocational testing or training, except as stated as a specific benefit of this Plan.

(10) Excess charges. The part of an expense for care and treatment of an Injury or Illness that is in excess of the Plan Allowable Amount.

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

(12) Experimental/Investigational or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(13) Eye care. Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be specifically stated as a benefit under this Plan.

(14) 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).

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

(16) Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(17) 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.

(18) Hazardous activities. Charges for services received that result 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 activities commonly considered as involving unusual or exceptional risks, characterized by a threat of danger or risk of bodily harm including reckless operation of machinery, travel to countries with advisory warnings, use of weapons and explosives, and other activities reasonably deemed hazardous by the Plan Administrator, in its sole discretion.

(19) Hearing aids and exams. Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.

(20) 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.

(21) Illegal acts. Charges for services received as a result of an Illness or Injury occurring directly, or indirectly, as a result of a serious criminal act, or a riot or public disturbance, regardless of causation. if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan Participant, or by the Plan Participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, 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, 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.

This Plan also excludes charges for services, supplies, care or treatment to a Plan Participant for an Injury or Illness which occurred as a result of that Plan Participant operating a motor vehicle while under the influence of alcohol or drugs or a combination thereof or operating a motor vehicle with a blood or breath alcohol content (BAC) above the legal limit. The arresting officer's determination of inebriation will be sufficient for this exclusion. Such charges will be excluded regardless of whether such motor vehicle operation rises to the level of a Serious Illegal Act. Expenses will be covered for injured Plan Participants other than the person operating the vehicle while under the influence or a BAC above the legal limit, and expenses may be covered for chemical dependency treatment as specified in this Plan.

This exclusion does not apply if the injury resulted from being the victim of an act of domestic violence or from a medical (including both physical and mental health) condition whether or not diagnosed before the incident.

(22) Illegal drugs or medications. Services, supplies, care or treatment to a Plan Participant for Illness or Injury resulting from that Plan Participant'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 Plan Participants 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 resulted from being the victim of an act of domestic violence or a medical (including both physical and mental health) condition whether or not diagnosed before the incident.

(23) Infertility. Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation.

(24) Mailing or Sales Tax. Charges for mailing, shipping, handling, postage, conveyance and sales tax.

(25) Marital or pre-marital counseling. Care and treatment for marital or pre-marital counseling.

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

(27) 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.

(28) 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.

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

(30) No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant 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 Illness.

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

(32) Occupational Injury. Care and treatment of an Injury or Illness that is occupational - that is, arises from work for wage or profit including self-employment. This exclusion applies regardless of the availability of or coverage by Workers' Compensation or occupational disease benefits, even if the Plan Participant:

a. Has waived his/her rights to Workers' Compensation benefits
b. Was eligible for Workers' Compensation benefits and failed to properly file a Claim for such benefits;
c. The Plan Participant is permitted to elect not to be covered under Workers' Compensation but has failed to properly file for such election; or
d. Executed a disputed liability settlement with Workers' Compensation.

(33) Orthotics. Charges in connection with orthotics.

(34) Personal comfort items. Personal comfort items, patient convenience, or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines and first-aid supplies and nonhospital adjustable beds.

(35) Plan design excludes. Charges excluded by the Plan design as mentioned in this document.

(36) Relative giving services. Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(37) Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

(38) Routine care. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Illness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

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

(40) Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(41) 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.

(42) Specialty Medications. Care and treatment for any prescribed specialty medications classified as a specialty medication by the Pharmacy Benefit Management (PBM) administrator of the pharmacy drug plan.

(43) Surgical sterilization reversal. Care and treatment for reversal of surgical sterilization for men and women.

(44) Tobacco cessation. Tobacco cessation care and treatment is excluded except to the extent (1) Medically Necessary due to a severe active lung Illness such as emphysema or asthma, or (2) required under Standard Preventive Care.

(45) Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined or as otherwise specifically stated as a Covered Charge.

(46) War. Any loss that is due to or aggravated by a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

This Plan includes an independent prescription drug program, separate from medical coverage. Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. In order to receive the full benefit of the Prescription Drug Program, Plan Participants must use participating pharmacies and present their ID card.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

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 Plan Participants significant savings on their prescriptions.

Covered Prescription Drugs

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law. This includes preventive medications unless otherwise specifically excluded, 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.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

Limits to This Benefit

This benefit applies only when a Plan Participant 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.

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

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 Plan Participant.

(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.

(9) **Immunization.** Immunization agents or biological sera.

(10) **Infertility.** A charge for infertility medication.

(11) **Inpatient medication.** A drug or medicine that is to be taken by the Plan Participant, 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) **Nutritional and Dietary Supplements.** A charge for nutritional or dietary supplements including, but not limited to: special dietary formulas, herbal products, minerals, fish oil products, supplementary vitamin preparations or multi-vitamins.

(16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

(17) **Off-label drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(18) **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.

(19) **Specialty Medications.** Care and treatment for any prescribed specialty medications classified as a specialty medication by the Pharmacy Benefit Management (PBM) administrator of the pharmacy drug plan.

HOW TO SUBMIT PHARMACY CLAIMS

When obtaining a prescription, a Plan Participant should show his or her ID card to the pharmacist. Participating pharmacies may submit claims on the Plan Participant's behalf. If the pharmacy provider is unable to submit the claim, the Plan Participant should request a receipt.

For prescription claims questions or to obtain a claim form please call:

Breckpoint Inc.
5130 South Fort Apache # 215-365
Las Vegas, NV 89148
(844) 798-4878

HOW TO SUBMIT MEDICAL CLAIMS

When services are received from a health care provider, a Plan Participant should show his or her ID card to the Provider. Providers may submit Claims on a Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a Claim, he or she should request an itemized bill **which includes procedure (CPT) and diagnostic (ICD) codes** from his or her health care provider, and complete a medical claim form. Plan Participants can obtain a proper medical claim form from the Claims Administrator by visiting www.bactpa.com. The form must be completed in its entirety to avoid delays in processing.

To assist the Claims Administrator in processing the Claim, the following information must be provided when submitting the Claim for processing:

- A copy of the itemized bill
- Group name and number
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date(s) of service(s)
- Place of service
- Amount billed

WHERE TO SUBMIT CLAIMS

Breckpoint Inc is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

Breckpoint Inc.
5130 South Fort Apache # 215-365
Las Vegas, NV 89148
(844) 798-4878

WHEN CLAIMS SHOULD BE FILED

Claims must be received by the Claims Administrator within *90 days* from the date charges for the service(s) were incurred. A longer period of time will be allowed if required by applicable law or otherwise agreed to in writing between the Plan and the provider of services. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a Claim for benefits.

The Plan reserves the right to have a Plan Participant seek a second medical opinion.

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Claimant (Plan Participant or an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit claims). A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request made by a Claimant or his Physician for pre-notification of benefits on a medical treatment. Pre-notification is recommended for certain Covered Services, but is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is **not** an authorized representative simply by virtue of an Assignment of Benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are three types of claims:

i. **Urgent Care Claims.** These are claims where failing to make a quick determination of coverage could seriously jeopardize the life or health of a claimant, or his or her ability to regain maximum function, or could subject a claimant to severe pain that could not be managed without the treatment that is the subject of the claim. Any claim that a physician (with knowledge of a Claimant's condition) considers to be urgent is deemed an Urgent Care Claim.

ii. **Post-Service Claims**. These are claims where service has already been rendered. Many, if not most, claims will fall into this category.

iii. **Concurrent Claims**. These claims occur when claims are reconsidered for ongoing treatment after the initial approval was made. An example of this would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

Initial Benefit Determination

Urgent Care Claims. For "Urgent Care Claims," the Plan shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

(A) The Plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with the Notification of Adverse Benefits section below.

Post-Service Claims. For "Post-Services Claims," the Plan shall notify the claimant, in accordance with the Notification of Adverse Benefits section below, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with the Notification of Adverse Benefits section below.

Concurrent Claims. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

(A) Any reduction or termination by the Plan of such course of treatment (other than by an amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan shall notify the claimant, in accordance with the Notification of Adverse Benefits section below, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Notification of any adverse benefit determination concerning a request to extend the course of treatment whether involving urgent care or not, shall be made in accordance with the Notification of Adverse Benefits section below.

Notice to Claimant of Adverse Benefit Determinations. If a Claim is denied in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination." The Plan shall provide written or electronic notice of the determination that will include the following:

(1) Information to identify the Claim involved.

(2) Specific reason(s) for the denial, including the denial code and its meaning.

(3) Reference to the specific Plan provisions on which the denial was based.

(4) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

(5) Description of the Plan's Internal Appeal Procedures and External Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once Claimant has exhausted all available internal and external review procedures.

(6) Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

(7) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.

(9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively or is a retroactive cancellation or discontinuance because of the Plan Participant’s failure to timely pay required premiums.

In the case of an adverse benefit determination by the Plan concerning a claim involving urgent care, the information described in the above section may be provided to the claimant orally within the time frame prescribed in the Urgent Care Claims section above, provided that a written or electronic notification in accordance with this section is furnished to the claimant not later than 3 days after the oral notification.

Claims Review Procedure – General. A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level internal review procedure and an external review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the individual who made the determination on a prior level of review, nor a subordinate of that individual. Additionally, if an External Review is requested, that review will be conducted by

an Independent Review Organization that was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the Claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

INTERNAL APPEAL PROCEDURE

First Level of Internal Review. The written request for review must be submitted within 180 days of the Claimant's receipt of a Notice of the Initial Benefit Determination (or 15 days for an appeal of a Concurrent Care Determination). The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Claims Administrator
c/o Breckpoint Inc.
5130 South Fort Apache # 215-365
Las Vegas, NV 89148
(844) 798-4878
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination. In the case of an Urgent Care Claim, the Plan shall notify the Claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.

The Notice of Determination shall meet the requirements as stated above.

Second Level of Internal Review. If the Claimant does not agree with the Claims Administrator's determination from the first Level of Internal Review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Internal Review (or 15 days for an appeal of a Concurrent Care Determination), along with any additional supporting information to:

Claims Administrator
c/o Breckpoint Inc.
5130 South Fort Apache # 215-365
Las Vegas, NV 89148
(844) 798-4878
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination).

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The Claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review, unless the Plan Administrator did not comply fully with the Plan's Internal Review Procedure for the first level of review. In certain circumstances, the Claimant may also request an expedited External Review.

External Review Procedure. This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within 4 months from the date of receipt of the notice of the final internal adverse benefit determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

(1) Determination that a treatment or service is not Medically Necessary, or

(2) Determination that a treatment is Experimental or Investigational, or

(3) Rescission of coverage, whether or not the rescission involved a Claim.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information. If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

Within 5 days following the date of receipt of the complete request, the Plan Administrator will determine whether the Claim is eligible for review under the External Review process based on the criteria described above and whether:

(1) The Claimant is or was covered under the Plan at the time the Claim was made or incurred;
(2) The denial relates to the Claimant's failure to meet the Plan's eligibility requirements;
(3) The Claimant has exhausted the Plan's internal Claims and Appeal Procedures; and
(4) The Claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the Claimant of whether the claim is eligible for External Review.

If the Claimant's request is determined ineligible for external review, the notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process the Claimant's request, Claimant may submit the additional information within the four-month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. ***Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.***

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans - including Medicare - are paying. When a Plan Participant is covered by this Plan and another plan, or the Employee's Covered 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 due up to 100% of the total Plan Allowable Amount

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or nongroup insurance contracts and subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group and nongroup coverage through closed panel plans;

(4) Group-type contracts;

(5) The medical components of long-term care contracts, such as skilled nursing care;

(6) Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;

(7) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;

(8) Any third party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long term care coverage.

Allowable Charge. For a charge to be allowable it must be an Allowable Charge and at least part of it must be covered under this Plan.

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 Plan Participant 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 Plan Participant 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 any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

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

(A) 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.

(B) Plans with a coordination provision will pay their benefits up to the Plan Allowable Amount. The first rule that describes which plan is primary is the rule that applies:

(1) 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").

For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

Special Rule: If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay first.

(2) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

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

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

When a child's parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's Spouse does, the plan of that parent's Spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree.

- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);

- 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 married or living together.

If there is no court decree allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

1st The plan covering the custodial parent,
2nd The plan covering the Spouse of the custodial parent,
3rd The plan covering the non-custodial parent, and
4th The plan covering the Spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a Spouse's plan, Rule (5) applies. If the Dependent child 's coverage under the Spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's Spouse.

(3) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or as a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or Retired Member/Employee. This rule does not apply if Rule (1) can be used to determine the order of benefits 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.

(4) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (1) can be used to determine the order of benefits.

(5) 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 the Plan Allowable Amount when paying secondary.

(C) 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. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(D) 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.

(E) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis, as shown in the Schedule of Benefits section. This is called the Claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

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

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Plan Allowable Amount. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

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 Plan Participant under the Plan.

THIRD PARTY RECOVERY PROVISION

By enrollment in the Plan, a Plan Participant agrees to the provisions of this Section as a condition precedent to receiving benefits under this Plan. If the Plan Participant fails to comply with the requirements of this Section, the Plan may reduce or deny benefits otherwise available under the Plan.

Payment Condition

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

2. 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 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 Participant(s) agrees the Plan shall have an equitable lien on any funds received by the 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 Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the 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 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 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 Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any Claim, which any Participant(s) may have against any Coverage and/or party causing the Illness 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 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 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;
c. Any policy of insurance from any insurance company or guarantor of a third party;
d. Workers' 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;

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

Excess Insurance

If at the time of Injury, Illness, 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:

1. The responsible party, its insurer, or any other source on behalf of that party;
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. Workers' 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.

Separation of Funds

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

Wrongful Death

In the event that the 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 Participant(s) and all others that benefit from such payment.

Obligations

1. It is the 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 Illness, 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 Participant may have against any responsible party or Coverage.

2. If the 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 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 Participant(s).

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

Offset

If timely repayment is not made, or the 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 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 Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan.

Minor Status

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

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

Language Interpretation

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

Severability

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

Reimbursement Due to Surrogacy Arrangement. If a Plan Participant's enters into a Surrogacy Arrangement, the Plan Participant must reimburse the Plan for Covered Services received related to conception, pregnancy, delivery, or postpartum care in connection with that Surrogacy Arrangement. The reimbursed amount shall not exceed the payments or other compensation the Plan Participant's, or another person is entitled to receive under the Surrogacy Arrangement.

A **Surrogacy Arrangement** is one in which a Plan Participant agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the Plan Participant receives payment for being a surrogate.

A Surrogacy Arrangement does not affect a Plan Participant's obligation to pay any and all patient responsibility amounts for these services. These amounts will be taken into account at the time of reimbursement.

After a Plan Participant surrenders a baby to the legal parents, the Plan is not obligated to pay for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

As set forth above, as a condition precedent to the Plan Participant receiving benefits under the Plan, the Plan Participant automatically assign to the Plan any right to receive payments that are payable to the Plan Participant or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy the Plan's lien.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement to the Plan, including all of the following information:

- Names, addresses, and telephone numbers of all parties to the arrangement;
- Names, addresses, and telephone numbers of any escrow agent or trustee;
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for the services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive;
- A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and
- Any other information the Plan requests in order to satisfy its rights.

You must send this information to:

Claims Administrator
c/o Breckpoint Inc.
5130 South Fort Apache # 215-365
Las Vegas, NV 89148
(844) 798-4878
Attn: Claims Appeals

The Plan Participant must complete and send the Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for the Plan to determine the existence of any rights the Plan may have under this Surrogacy Arrangement and to satisfy those rights. The Plan Participant may not agree to waive, release, or reduce the Plan's rights without the Plan's prior, written consent.

If a Plan Participant's estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the Plan Participant had asserted the claim against the third party. The Plan may assign its rights to enforce its liens and/or other rights.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

COBRA Continuation Coverage under the Plan is administered by the COBRA Administrator. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees. You can learn more about many of these options at www.healthcare.gov.

What is COBRA continuation coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA

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 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.

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

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

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

If the Qualifying Event causes the covered Employee 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, as amended ("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.

When is COBRA Continuation Coverage available?
The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.
For all 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 must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

COBRA Administrator
Breckpoint Inc.
8918 Spanish Ridge Ave #200
Las Vegas, NV 89148
Attn: COBRA Department

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.
In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Dependents may be entitled to an extension of the 18-month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination of employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18-month period.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

COBRA Administrator
Breckpoint Inc.
8918 Spanish Ridge Ave #200
Las Vegas, NV 89148
Attn: COBRA Department

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

COBRA Administrator
Breckpoint Inc.
8918 Spanish Ridge Ave #200
Las Vegas, NV 89148
Attn: COBRA Department

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

Plan Administrator
ARNOLD & ASSOCIATES OF WICHITA, INC.
530 S. Topeka
Wichita, KS 67202

COBRA Administrator
Breckpoint Inc.
8918 Spanish Ridge Ave #200
Las Vegas, NV 89148
Attn: COBRA Department

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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) in your area or visit www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about 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. The ARNOLD & ASSOCIATES OF WICHITA, INC.Compliance Minimum Value (MV) Group Health Plan is the benefit plan of ARNOLD & ASSOCIATES OF WICHITA, INC, 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 or committee may be appointed by ARNOLD & ASSOCIATES OF WICHITA, INC.to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, ARNOLD & ASSOCIATES OF WICHITA, 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. The duties of the Plan Administrator include the following:

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

(2) To determine all questions of eligibility, status and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Plan Participant’s rights;

(6) To prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials;

(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(8) To appoint and supervise a third-party administrator to pay Claims;

(9) To perform all necessary reporting as required by ERISA;

(10) To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;

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

(12) To perform each and every function necessary for or related to the Plan’s administration.

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.

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.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: 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 Employer. 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.

Plan is not an Employment Contract. The Plan is not to be construed as a contract for or of employment.

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 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, the amount of overpayment may 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 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.

Review Authority. The Plan Administrator shall have complete authority to review all denied claims for benefits under the Plan (including, but not limited to, the denial of certification of the medical necessity of hospital or medical treatment). In exercising its responsibilities, the Plan Administrator shall have discretionary authority (1) to determine whether and to what extent Plan Participants are eligible for benefits; and, (2) to construe disputed or doubtful Plan terms. The Plan Administrator shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

Legal Disputes. This Plan, and all matters relating either directly or indirectly to the operation and administration of this Plan, are governed exclusively by ERISA, which operates to preempt any and all state laws and regulations purporting to regulate this and similar plans. If the Plan Participant makes any legal claim against the Plan or any Plan Fiduciary, all benefits provided under the Plan shall cease as to the complaining employee, until such time as the employee's legal action is resolved. This provision shall not be read as providing any more rights than any legal judgment in favor of the employee and against the Plan or any Plan Fiduciary. Should the Plan Participant obtain a legal judgment against the Plan or the Plan Sponsor, the amount of any such judgment shall be offset against the amount of benefits previously paid to the Participant for the disputed claim. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

Fraud and Misstatements. All coverage provided under the Plan is based on the truthfulness of statements made to the Plan by the Plan Participants, either in a written enrollment form or otherwise. Coverage can be voided for any Plan Participant, and/or any or all members of that Participant's covered family unit, for any misrepresentation or fraudulent misstatement made to the Plan, the Plan Fiduciaries or Claims Administrator by the Plan Participant or any or all members of that Participant's covered family unit.

Plan Participant/Provider Relationship. The Plan does not furnish covered services, but only helps pay for covered services Plan Participants receive. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's failure or refusal to give covered services to Plan Participants.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS') ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the Claims history, Claims expenses or the type of Claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

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

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

(7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

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

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504 (f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

- Executive Director, ARNOLD & ASSOCIATES OF WICHITA, INC.
- Human Resource Benefits, ARNOLD & ASSOCIATES OF WICHITA, INC.
- Insurance Agent

(b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non- compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.
"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, Claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit Claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

(c) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

(d) Report to the Plan any security incident of which it becomes aware.

IMPORTANT NOTICES OF PLAN PARTICIPANT RIGHTS

Please carefully read the following important notices, which describe certain rights under federal law.

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 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/agencies/ebsa/ (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)
The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998.

In the case of an Employee or Dependent who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

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

Benefits will be subject to the same cost-sharing (deductible, co-payment, co-insurance) provisions as apply to the mastectomy.

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

USERRA. If you are absent from employment because you are in the uniformed service, you may elect to continue your coverage under this Plan for up to 24 months. To continue your coverage, you must comply with the terms of the Plan, including election during the Plan's Open Enrollment Period, and pay your contributions, if any. In addition, USERRA also requires that, regardless of whether you elected to continue your coverage under the Plan, your coverage and your Dependents' coverage be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in USERRA. Contact your Employer for information concerning your eligibility for USERRA and any requirements of the Plan.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

FMLA. The Plan will at all times comply with FMLA. During any leave taken under FMLA, an Employee may maintain coverage under this Plan on the same conditions as if he or she had been continuously employed during the entire leave period. To continue coverage during FMLA, the Employee must comply with the terms of the Plan, including election during the Plan's annual Open Enrollment Period, and pay any required contributions. Contact the Employer for information concerning eligibility for FMLA and any requirements of the Plan.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan and the administration is provided through a Third-Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME: ARNOLD & ASSOCIATES OF WICHITA, INC.Compliance Minimum Value Group Health Plan

PLAN NUMBER: 2026

TAX ID NUMBER: 48-0887019

PLAN EFFECTIVE DATE: 01/01/2021

PLAN YEAR ENDS: 12/31/2021

EMPLOYER INFORMATION:
ARNOLD & ASSOCIATES OF WICHITA, INC.
530 S. Topeka
Wichita, KS 67202
(316) 263-9283

PLAN ADMINISTRATOR:
ARNOLD & ASSOCIATES OF WICHITA, INC.
530 S. Topeka
Wichita, KS 67202
(316) 263-9283

NAMED FIDUCIARY:
ARNOLD & ASSOCIATES OF WICHITA, INC.
530 S. Topeka
Wichita, KS 67202

AGENT FOR SERVICE OF LEGAL PROCESS
ARNOLD & ASSOCIATES OF WICHITA, INC.
530 S. Topeka
Wichita, KS 67202

CLAIMS ADMINISTRATOR
Breckpoint Inc.
5130 South Fort Apache # 215-365
Las Vegas, NV 89148
(844) 798-4878

COBRA ADMINISTRATOR:
Breckpoint Inc.
8918 Spanish Ridge Ave #200
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(844) 657-1575