COOPERATIVE SOLUTIONS

Trust. Transparency. Ownership.

40 Square Health Plan

(Medical and Prescription Drug Benefits)

Summary Plan Description and Plan Document

Effective: January 1, 2019

AMENDMENT #3
To the January 1, 2019
Summary Plan Description of
40 Square Health Plan

Effective March 1, 2020, for all enrolled employer groups , the following benefits are amended as follows:

I. Testing for COVID-19 (known as "Centers for Disease Control and Prevention (CDC 2019-Novel Coronavirus (2019-nCov) Real-Time Reserve Transcriptase (RT)-PCR Diagnostic Panel") at any CDC approved laboratory location within the plan design is covered at 100%, including the cost of a provider visit for the purpose of testing and diagnosis, without any member cost share applied.

II. Early refills of medication to ensure covered members have a 31-day supply.

III. 40 Square Health Plan Trust is temporarily changing its Definitions of "Employee" and "Actively at Work". If an employee was considered to be a "covered person" and actively at work the day prior to a COVID-19 related event that no longer allows them to meet the eligibility requirements of the plan, the group is permitted do the following:

a. Allow an employee to go onto short-term furlough and continue coverage through June 30, 2020 as long as monthly health care fees are paid, or
b. Temporarily lay off employees with the intention of rehiring employee at which time all benefits will be reinstated upon a reinstatement date without any waiting period applied, or
c. Until June 30, 2020, allow employees who no longer meet minimum number of hours per week worked to remain covered so long as their hours are reinstated back to full time status on or before June 30, 2020, and
d. Any employee that is not "Actively at Work" after the expiration date of this temporary definition change is considered terminated from the Plan and the termination provisions of the plan document will apply.

This temporary change does not alter or supersede the current "Reinstatement of Coverage" policy for any non-COVID-19 enrollment related member changes as listed in the Summary Plan Description, which currently states the following:

➢ ***Reinstatement of Coverage***

An Employee's coverage that has terminated due to termination of employment, Layoff, reduction to part-time status, or Employer approved Leave of Absence, may be reinstated under the following condition:

1. *The Employee returns to full-time active employment within six (6) months of the date such termination or leave commenced; and*

2. *The Employee re-enrolls for coverage within thirty-one (31) days of the return date to such active employment.*

The reinstated coverage will be effective on the date the Employee returns to active employment. "Reinstatement" means that any previous benefit limitations, maximums or waiting periods applied prior to such termination or leave, will be recognized under the reinstated coverage. In other words, coverage will continue as if no time has elapsed between the termination of coverage and reinstatement.

IV. 40 Square Health Plan Trust may adjust or extend its premium/Health Care Fee collection requirements and grace periods for enrolled groups during this crisis, and if it chooses to do so, this cannot be used as grounds for denying a stop loss claim for 40 Square Health Plan Trust.

This amendment is effective through June 30, 2020, at which time the Trust will review all updated guidance from the CDC and federal, state and local government directives related to the COVID-19 pandemic and reserves the right to extend this amendment as necessary.

SIGNED THIS 9th DAY OF April 2020, BY A PROPERLY AUTHORIZED OFFICER OF THE PLAN AS EVIDENCE OF ITS ADOPTION OF THIS AMENDMENT.

By_____ Date April 9, 2020
40 Square Health Plan Trust

Witness_____ Date_____

MASTER PLAN DOCUMENT AMENDMENT #2

Effective March 1, 2020, the Master Plan Document and Summary Plan Description for 40 Square Consortium Health Plan is hereby amended as follows:

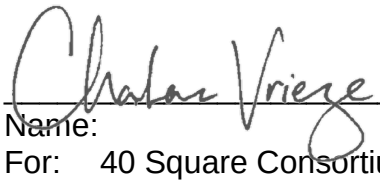
The Plan will provide enhanced health benefits associated with testing for the 2019 Novel Coronavirus (COVID-19). Diagnostic laboratory testing for COVID-19 shall be eligible and paid with no cost-sharing.

The above benefits are specific to Diagnosis of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

The following item has been added to each of the Plan's Schedules of Coverage:

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Testing for the 2019 Novel Coronavirus (COVID-19)	100%, Deductible waived	100%, Deductible waived	Subject to Medical Necessity guidelines

Accepted By:



Executive Director — March 19, 2020

Name: Title Date

For: 40 Square Consortium Health Plan

40 SQUARE HEALTH PLAN
(MEDICAL and PRESCRIPTION DRUG BENEFITS)

SUMMARY PLAN DESCRIPTION AND
PLAN DOCUMENT

Originally Effective: January 1, 2018

Revised and Restated January 1, 2019

TABLE OF CONTENTS

40 SQUARE HEALTH PLAN
(MEDICAL and PRESCRIPTION DRUG BENEFITS)

INTRODUCTION & GENERAL PLAN INFORMATION

INTRODUCTION

This 40 Square Health Plan (the "Plan") has been established for the purposes of providing comprehensive medical benefits, including prescription drug benefits, to certain employees (and their families) of employers that have met the requirements to participate ("Participating Employers") in this Plan. The Effective Date of this Plan is January 1, 2018.

40 Square Health Plan is a "bona fide association" for purposes of the definition of employer under Section 3(5) of Employee Retirement Income Protection Act of 1974 ("ERISA"). The 40 Square Health Plan sponsors the 40 Square Health Plan (the "Plan") as reflected in this written document (the "Plan Document") and serves as a Named Fiduciary of the Plan and the administrator of the Plan (the "Plan Administrator"), as those terms are defined under Sections 3(21) and 3(16)(A) of ERISA respectively.

NOTE: For purposes of ERISA, this document serves both as the written plan document and the summary plan description ("SPD").

The Plan is funded through the 40 Square Health Plan Trust (the "Trust") pursuant to the 40 Square Health Plan Trust Agreement (the "Trust Agreement"). The Plan is a multiple employer welfare arrangement ("MEWA") as that term is defined under Section 3(40)(A) of ERISA. This Plan operates as a large, single plan that provides Medical Benefits and Prescription Drug Benefits on a self-insured basis. Pursuant to the terms of the 40 Square Health Plan Trust bylaws, the Plan Document and Trust Agreement description of an employer eligible to participate, and the definition of Participating Employer contained in this Plan Document and the Trust Agreement, participation is limited to entities with sufficient commonality of interest independent from the provision of benefits. As further illustrated by the terms of the 40 Square Health Plan Trust bylaws, the Plan Document and the Trust Agreement, members of the 40 Square Health Plan exercise actual control over 40 Square Plan and the Trust, direct and indirect, both in form and substance. Only Participating Employers may provide benefits through the Plan and Trust.

The 40 Square Plan, and the Trust, are established and maintained so as to collectively be an "agricultural cooperative health plan" within the meaning of Minnesota Statute Section 62H.18. The Plan is a self-insured medical plan intended to meet the requirements of Section 106 and Section 105(h) of the Code.

READ THIS DOCUMENT. It is very important to review this Plan Document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under the Plan. The Plan Document should be read in its entirety because many of its provisions are interrelated.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for payment or reimbursement of all or a portion of certain medical expenses. The Schedules of Coverage are meant only as a summary of benefits. For more details about the benefits, check the Table of Contents and refer to the specific section of the Plan that describes the benefits. Certain words in this Plan have precise meanings and are capitalized and defined in the Section C. Other terms are defined where used in the text.

MENTAL HEALTH PARITY

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

GENETIC INFORMATION NONDISCRIMINATION ACT ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about any of the following:

1. Such individual's genetic tests.
2. The genetic tests of family members of such individual.
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

IDENTIFICATION CARDS

Each Covered Individual receives an identification card from the Plan. This identification card is very important to receiving coverage under this Plan. Please review the information on the card carefully. Failure to have an identification card, or failure to have accurate information on the identification card, may result in delay or denial of payments under this Plan. If information needs to be changed or

replacement cards are needed, please contact: 40 Square Health Plan Customer Service at 1-877-314-9737.

LANGUAGE ASSISTANCE

Language interpretation services are available to help you understand your benefits under this Plan. To request these services, please contact 40 Square Health Plan Customer Service at 1-877-314-9737.

NOTE: If this Plan is translated into another language or an alternative format is used, this written English version governs all coverage decisions.

If you need alternative formats (e.g., Braille or large print), please contact 40 Square Health Plan Customer Service at 1-877-314-9737.

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ERISA REQUIRED GENERAL PLAN INFORMATION

The information contained in this provision of the Plan provides general information regarding the Plan. It is important to remember that this provision of the Plan is only an overview. You also need to refer to the provision(s) that describes a particular Plan benefit in detail.

Name of Plan:	40 Square Health Plan
Plan Sponsor:	40 Square Health Plan 8011 34th Avenue South, Suite 148 Bloomington, MN 55425 Phone number: 844-205-9579
Plan Administrator and Named Fiduciary	40 Square Health Plan Trust 8011 34th Avenue South, Suite 148 Bloomington, MN 55425 Phone number: 844-205-9579
Plan Sponsor ID No. (EIN):	82-3859068
PPACA Plan Status:	Non-Grandfathered
Fiscal Year:	January 1 through December 31
Plan Number:	501
Type of Administration:	Benefits provided under this Plan are self-funded. Administration is through one or more contracts with third party service providers.
Sources and Methods of Contributions to the Plan:	The Plan Administrator determines the cost of coverage (a/k/a the applicable premium) under the Plan. The Participating Employer determines what portion of the cost of coverage is paid by the Covered Individual and what portion is paid by the Participating Employer. The Participating Employer is responsible for informing the Covered Individual the portion of the cost of coverage for which the Covered Individual is responsible. The Participating Employer pays to the Trust, from its general assets, the total cost of coverage for a month.

Funding Medium	Benefits under the Plan are funded through the 40 Square Health Plan Trust, a tax-exempt trust under § 501(c)(9) of the Code.
Claims Administrators:	
Medical Benefits:	EBSO, Inc. 215 Stanford Pkwy Findlay, OH 45840 Phone Number: 800-558-7798 EBSO, Inc. 2145 Ford Parkway, Suite 200 St. Paul, Minnesota 55116-1912 Phone Number: 651-695-2500 or 1-800-486-7664
Prescription Drug Benefits:	MedTrakRx 7101 College Boulevard, Suite 1000 Overland Park, KS 66210 Phone Number: 913-262-8939 or 800-771-4648
COBRA continuation coverage:	COBRA/Eligibility Department EBSO, Inc. 2145 Ford Parkway, Suite 200 St. Paul, Minnesota 55116-1912 Phone number: 651-695-2500 or 1-800-486-7664 Fax number: 651-695-1648
Agent(s) for Service of Legal Process:	40 Square Health Plan 8011 34th Avenue South, Suite 148 Bloomington, MN 55425 Phone number: 844-205-9579 Elected Trustees of the 40 Square Health Plan Trust Address: 8011 34th Avenue South, Suite 148 Bloomington, MN 55425

ERISA STATEMENT OF RIGHTS

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

Your Rights.

ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, by contacting your employer, all documents governing the Plan, including the Plan Document, and a copy of the latest annual report (Form 5500 Series), if any, 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, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including the Plan Document, and copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each Participant with a copy of any required summary annual report.

Prudent Actions by Plan Fiduciaries.

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

Enforce Your Rights.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

Very Important: Exhaustion of Administrative Procedures Required. The right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. ***Failure to exhaust administrative procedures may preclude you from bringing an action in court***.

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

Assistance with Your Questions.

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

Plan Administrator: The Plan Administrator of the Plan is the 40 Square Health Plan. All notices and other communication should be directed to:

40 Square Health Plan
Attn: Executive Director
8011 34th Avenue South, Suite 148
Bloomington, MN 55425
Email: info@40Square.coop
Phone: 844-205-9579

SCHEDULES OF COVERAGE

This Plan consists of the following coverage options:

- $1,500 Deductible Option
- $2,500 Deductible Option
- $3,500 Deductible Option (HSA Compatible)
- $4,500 Deductible Option (HSA Compatible)
- $5,500 Deductible Option (HSA Compatible)
- $6,550 Deductible Option (HSA Compatible)
- $7,900 Deductible Option

A Covered Individual may only be covered under one coverage option at a time. Other than COBRA situations, all Covered Individuals in a family must be covered under the same coverage option. Each coverage option is shown in a Schedule of Coverage describing the key features for that coverage option, including the Medical Benefits and the Prescription Drug Benefits. Further details regarding the benefits available through the coverage options are described later in this Plan Document.

PPACA Compliance. The Plan will at all times operate in compliance with PPACA rules and regulations including:

- PPACA requires that Preventive Care be covered on a first dollar basis (e.g., no Deductible, no Copay, no Copayment Percentage) when provided through certain providers.
- PPACA requires that benefits offered by the Plan that are "Essential Health Benefits" (as defined by the United States Department of Health and Human Services) may not be subject to Plan maximums (e.g., annual or lifetime). If a major medical benefit of the Plan is subject to a Plan maximum, the Plan will continue to pay benefits for such Essential Health Benefits even though such payments would otherwise exceed the applicable Plan maximum(s).

SCHEDULE OF COVERAGE: $1,500 DEDUCTIBLE OPTION

NOTE: THIS IS ONLY A SUMMARY OF THE COVERAGE OPTION KEY FEATURES. SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER REQUIREMENTS AND/OR RESTRICTIONS DESCRIBED LATER IN THIS PLAN DOCUMENT. IT IS IMPORTANT TO READ THE SCHEDULE OF COVERAGE TOGETHER WITH THE SPECIFIC DESCRIPTION.

NOTE: Claims for benefits under this Plan are determined by the Plan Administrator with the assistance of the Claims Administrators.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

MEDICAL BENEFITS

THE MEDICAL BENEFITS PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: EBSO, INC.

DEDUCTIBLE PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$1,500	Individual	$10,000	Individual
$3,000	Family	$20,000	Family

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$3,000	Individual	$30,000	Individual
$6,000	Family	$60,000	Family

The PPO Out-of-Pocket Maximum and the Non-PPO Out-of-Pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Out-of-Pocket Maximum is the amount contributed toward the Out-of-Pocket Maximum by two or more family members; provided, the amount contributed toward the family Out-of-Pocket Maximum by any one family member cannot be more than the individual Out-of-Pocket Maximum.

The Out-of-Pocket Maximum takes into account amounts that satisfy the Deductible, Copayment Percentage, and Copays. The Out-of-Pocket Maximum does NOT include any charge in excess of the established Plan maximums/limitations or penalties for non-compliance with Plan provisions.

CALENDAR YEAR MAXIMUM PAYMENT AMOUNT: Unlimited

Important - Inpatient Admission and Outpatient Surgery: Authorization is required for all Inpatient admissions and certain Outpatient Surgeries. Refer to the Inpatient Admission and Outpatient Surgery Authorization Provision for a complete list of surgeries requiring authorization.

For Inpatient authorization call EBSO Review at 1-800-426-9317 within 2 business days after the admission. For Outpatient Surgery authorization, call EBSO Review at 1-800-426-9317 within 2 business days after the Outpatient Surgery. ***Non-compliance reduces benefits***. If a Covered Individual does not comply with authorization when required, Covered Expenses will be reduced by 50% up to a maximum penalty of $500 per confinement or Outpatient Surgery (this reduction is in addition to the Deductible). If there is a reduction in benefits due to non-compliance with these authorization requirements, the penalty that the Covered Individual has to pay is not counted towards the applicable Out-of-Pocket Maximum.

Preferred Provider Organization (PPO). The Plan has contracted with the PreferredOne Network for providers within Minnesota and with the MultiPlan Network for providers outside of Minnesota. This means you have access to Providers in the PreferredOne Network and the MultiPlan Network. A current listing of Minnesota PPO providers is available upon request at no charge at www.preferredone.com or by calling 1-800-451-9597. If you, or a covered family member, need providers outside of Minnesota, visit www.multiplan.com or call 1-888-342-7427.

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Ambulance Services - Air and Ground	80% after Deductible	Paid as PPO	
Acupuncture	80% after Deductible	50% after Deductible	
Ambulatory Surgical Centers	80% after Deductible	50% after Deductible	
Chiropractic Care	80% after Deductible	Paid as PPO	Includes x-rays, manipulations, and supportive care.
Durable Medical Equipment/Prosthetic Devices/Other	80% after Deductible	50% after Deductible	Wigs are limited to one per Calendar Year.
Emergency Care Physician Facility	 80% after Deductible 80% after Deductible	 80% after Deductible 80% after Deductible	In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Hearing Aids	80% after Deductible	50% after Deductible	Limited to one hearing aid for each ear every three years for children age 18 and younger.
Home Health Care	80% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 visits per Calendar Year.
Hospice Care	80% after Deductible	50% after Deductible	
Inpatient Facility services Physician Facility	 80% after Deductible 80% after Deductible	 50% after Deductible 50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Maternity			
Labor, delivery and post-delivery care	80% after Deductible	50% after Deductible	
Prenatal care	100% (Deductible waived)	50% after Deductible	Includes all lab work and ultrasounds.
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment	80% after Deductible	50% after Deductible	
Office Visits/Clinic	100% after a $40 Copay per visit (Deductible waived)	50% after Deductible	
Other Outpatient treatment	80% after Deductible	50% after Deductible	Includes group therapy
Outpatient Facility Services			The office visit Copay applies to the charge for the office visit **ONLY**. All other Covered Expenses are subject to the standard Deductible and Copayment Percentage
Physician/Clinic	100% after a $40 Copay per visit (Deductible waived)	50% after Deductible	
Facility	80% after Deductible	50% after Deductible	
Lab, pathology, advanced and standard imaging	80% after Deductible	50% after Deductible	
Physician Office Visits (other than for Mental/Nervous Disorders and/or Substance Abuse and Preventive Care)			The office visit Copay applies to the charge for the office visit **ONLY**. All other Covered Expenses are subject to the standard Deductible and Copayment Percentage.
Primary Care Physician/Clinic	100% after a $40 Copay per visit (Deductible waived)	50% after Deductible	
Specialist	100% after a $75 Copay per visit (Deductible waived)	50% after Deductible	
Retail Health Clinic	100% after a $20 Copay per visit (Deductible waived)	50% after Deductible	
Web Based Care (Online E-visits)/Telephone Consultations	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Other professional services in the office Lab, pathology, advanced and standard imaging	80% after Deductible	50% after Deductible	
Preventive Care Services	100% (Deductible waived)	50% after Deductible	Refer to benefit section for more information on Preventive Care. Refer to Prescription Drug Benefit for drugs considered Preventive Care.
Skilled Nursing Facility	80% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 days per Confinement.
Therapy services – Physical, Occupational, and Speech (habilitative and rehabilitative)	80% after Deductible	50% after Deductible	
Urgent Care Centers	100% after a $50 Copay per visit (Deductible waived)	50% after Deductible	
Routine Vision Exam, including refraction	100% (Deductible waived)	100% (Deductible waived)	***LIMITED*** to one Routine vision exam per Calendar Year.
All other Covered Expenses	80% after Deductible	50% after Deductible	

PRESCRIPTION DRUG BENEFIT

THE PRESCRIPTION DRUG BENEFIT PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: MedTrakRx

SPECIAL RULES FOR CERTAIN PRESCRIPTION MEDICATIONS – CONTRACEPTIVES AND PREVENTIVE CARE. Certain prescription contraceptives and certain prescriptions for Preventive Care medications, including smoking cessation medications, must be provided at no cost if provided through a Participating Pharmacy. In addition, if a Generic version is available and just as safe and effective, the prescription must be filled using the Generic version in order to be provided at no cost. A current list of contraceptives and Preventive Care medications is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacies. This Plan has contracted with MedTrakRx. MedTrakRx has a provider organization consisting of Participating Pharmacies, including Retail Pharmacies, Performance 90 Pharmacies, and Mail Service Pharmacies. ***This Plan only pays benefits obtained from Participating Pharmacies.*** A current list of Participating Pharmacies is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacy:	Retail	Performance 90	Mail Service
Maximum day supply allowed:	31	90	90
Generic* Copay:	$10	$25	$25
Formulary* Copay:	$40	$100	$100
Non-Formulary* Copay:	$100	$250	$250

*** Generic Incentive**. If a Formulary brand or Non-Formulary brand is dispensed ***at the Covered Individual's request*** when a Generic equivalent is available, the Covered Individual pays the difference in cost between the Generic and the Formulary or Non-Formulary plus the applicable Copay. The difference in cost does not apply towards satisfaction of the Deductible or the Out-of-Pocket Maximum. If a Formulary brand or Non-Formulary brand is dispensed ***at the provider's request*** when a Generic equivalent is available, the Covered Individual only pays the applicable Copay.

Specialty Medication. The Covered Individual pays 20% of the cost up to a maximum $350 for a 30-day supply allowed per fill.

Annual Rx / Medical Combined PPO Out-of-Pocket Maximum:	$3,000 per Covered Individual, $6,000 per family beginning every January 1st. Once you have met this amount, you will pay $0 Copay or Copayment Percentage until the end of the benefit year, December 31st.

SCHEDULE OF COVERAGE: $2,500 DEDUCTIBLE OPTION

NOTE: THIS IS ONLY A SUMMARY OF THE COVERAGE OPTION KEY FEATURES. SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER REQUIREMENTS AND/OR RESTRICTIONS DESCRIBED LATER IN THIS PLAN DOCUMENT. IT IS IMPORTANT TO READ THE SCHEDULE OF COVERAGE TOGETHER WITH THE SPECIFIC DESCRIPTION.

NOTE: Claims for benefits under this Plan are determined by the Plan Administrator with the assistance of the Claims Administrators.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

MEDICAL BENEFITS

THE MEDICAL BENEFITS PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: EBSO, INC.

DEDUCTIBLE PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$2,500	Individual	$10,000	Individual
$5,000	Family	$20,000	Family

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$7,150	Individual	$30,000	Individual
$14,300	Family	$60,000	Family

The PPO Out-of-Pocket Maximum and the Non-PPO Out-of-Pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Out-of-Pocket Maximum is the amount contributed toward the Out-of-Pocket Maximum by two or more family members; provided, the amount contributed toward the family Out-of-Pocket Maximum by any one family member cannot be more than the individual Out-of-Pocket Maximum.

The Out-of-Pocket Maximum takes into account amounts that satisfy the Deductible, Copayment Percentage, and Copays. The Out-of-Pocket Maximum does NOT include any charge in excess of the established Plan maximums/limitations and penalties for non-compliance with Plan provisions.

CALENDAR YEAR MAXIMUM PAYMENT AMOUNT: Unlimited

Important - Inpatient Admission and Outpatient Surgery: Authorization is required for all Inpatient admissions and certain Outpatient Surgeries. Refer to the Inpatient Admission and Outpatient Surgery Authorization Provision for a complete list of surgeries requiring authorization.

For Inpatient authorization call EBSO Review at 1-800-426-9317 within 2 business days after the admission. For Outpatient Surgery authorization, call EBSO Review at 1-800-426-9317 within 2 business days after the Outpatient Surgery. ***Non-compliance reduces benefits***. If a Covered Individual does not comply with authorization when required, Covered Expenses will be reduced by 50% up to a maximum penalty of $500 per confinement or Outpatient Surgery (this reduction is in addition to the Deductible). If there is a reduction in benefits due to non-compliance with these authorization requirements, the penalty that the Covered Individual has to pay is not counted towards the applicable Out-of-Pocket Maximum.

Preferred Provider Organization (PPO). The Plan has contracted with the PreferredOne Network for providers within Minnesota and with the MultiPlan Network for providers outside of Minnesota. This means you have access to Providers in the PreferredOne Network and the MultiPlan Network. A current listing of Minnesota PPO providers is available upon request at no charge at www.preferredone.com or by calling 1-800-451-9597. If you, or a covered family member, need providers outside of Minnesota, visit www.multiplan.com or call 1-888-342-7427.

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Ambulance Services - Air and Ground	75% after Deductible	Paid as PPO	
Acupuncture	75% after Deductible	50% after Deductible	
Ambulatory Surgical Centers	75% after Deductible	50% after Deductible	
Chiropractic Care	75% after Deductible	Paid as PPO	Includes x-rays, manipulations, and supportive care.
Durable Medical Equipment/Prosthetic Devices/Other	75% after Deductible	50% after Deductible	Wigs are limited to one per Calendar Year.
Emergency Care Physician Facility	 75% after Deductible 75% after Deductible	 75% after Deductible 75% after Deductible	In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Hearing Aids	75% after Deductible	50% after Deductible	Limited to one hearing aid for each ear every three years for children age 18 and younger.
Home Health Care	75% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 visits per Calendar Year.
Hospice Care	75% after Deductible	50% after Deductible	
Inpatient Facility services Physician Facility	 75% after Deductible 75% after Deductible	 50% after Deductible 50% after Deductible	
Maternity Labor, delivery and	 75% after Deductible	 50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
post-delivery care			
Prenatal care	100% (Deductible waived)	50% after Deductible	Includes all lab work and ultrasounds
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment	75% after Deductible	50% after Deductible	
Office Visits/Clinic	100% after a $40 Copay per visit (Deductible waived)	50% after Deductible	
Other Outpatient treatment	75% after Deductible	50% after Deductible	Includes group therapy
Outpatient Facility Services			The office visit Copay applies to the charge for the office visit **ONLY**. All other Covered Expenses are subject to the standard Deductible and Copayment Percentage
Physician/Clinic	100% after a $40 Copay per visit (Deductible waived)	50% after Deductible	
Facility	75% after Deductible	50% after Deductible	
Lab, pathology, advanced and standard imaging	75% after Deductible	50% after Deductible	
Physician Office Visits (other than for Mental/Nervous Disorders and/or Substance Abuse and Preventive Care)			The office visit Copay applies to the charge for the office visit **ONLY**. All other Covered Expenses are subject to the standard Deductible and Copayment Percentage.
Primary Care Physician/Clinic	100% after a $40 Copay per visit (Deductible waived)	50% after Deductible	
Specialist	100% after a $75 Copay per visit (Deductible waived)	50% after Deductible	
Retail Health Clinic	100% after a $20 Copay per visit (Deductible waived)	50% after Deductible	
Web Based Care (Online E-visits)/Telephone Consultations	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	
Other professional services in the office			

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Lab, pathology, advanced and standard imaging	75% after Deductible	50% after Deductible	
Preventive Care Services	100% (Deductible waived)	50% after Deductible	Refer to benefit section for more information on Preventive Care. Refer to Prescription Drug Benefit for drugs considered Preventive Care.
Skilled Nursing Facility	75% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 days per Confinement.
Therapy services – Physical, Occupational, and Speech (habilitative and rehabilitative)	75% after Deductible	50% after Deductible	
Urgent Care Centers	100% after a $50 Copay per visit (Deductible waived)	50% after Deductible	
Routine Vision Exam, including refraction	100% (Deductible waived)	100% (Deductible waived)	***LIMITED*** to one Routine vision exam per Calendar Year.
All other Covered Expenses	75% after Deductible	50% after Deductible	

PRESCRIPTION DRUG BENEFIT

THE PRESCRIPTION DRUG BENEFIT PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: MedTrakRx

SPECIAL RULES FOR CERTAIN PRESCRIPTION MEDICATIONS – CONTRACEPTIVES AND PREVENTIVE CARE. Certain prescription contraceptives and certain prescriptions for Preventive Care medications, including smoking cessation medications, must be provided at no cost if provided through a Participating Pharmacy. In addition, if a Generic version is available and just as safe and effective, the prescription must be filled using the Generic version in order to be provided at no cost. A current list of contraceptives and Preventive Care medications is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacies. This Plan has contracted with MedTrakRx. MedTrakRx has a provider organization consisting of Participating Pharmacies, including Retail Pharmacies, Performance 90 Pharmacies, and Mail Service Pharmacies. ***This Plan only pays benefits obtained from Participating Pharmacies.*** A current list of Participating Pharmacies is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacy:	Retail	Performance 90	Mail Service
Maximum day supply allowed:	31	90	90
Generic* Copay:	$10	$25	$25
Formulary* Copay:	$40	$100	$100
Non-Formulary* Copay:	$100	$250	$250
*** Generic Incentive**. If a Formulary brand or Non-Formulary brand is dispensed ***at the Covered***			

Individual's request when a Generic equivalent is available, the Covered Individual pays the difference in cost between the Generic and the Formulary or Non-Formulary plus the applicable Copay. The difference in cost does not apply towards satisfaction of the Deductible or the Out-of-Pocket Maximum. If a Formulary brand or Non-Formulary brand is dispensed ***at the provider's request*** when a Generic equivalent is available, the Covered Individual only pays the applicable Copay.

Specialty Medication. The Covered Individual pays 25% of the cost up to a maximum $350 for a 30-day supply allowed per fill.

Annual Rx / Medical Combined PPO Out-of-Pocket Maximum:	$7,150 per Covered Individual, $14,300 per family beginning every January 1st. Once you have met this amount, you will pay $0 Copay or Copayment Percentage until the end of the benefit year, December 31st.

SCHEDULE OF COVERAGE: $3,500 DEDUCTIBLE OPTION (HSA COMPATIBLE)

NOTE: THIS IS ONLY A SUMMARY OF THE COVERAGE OPTION KEY FEATURES. SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER REQUIREMENTS AND/OR RESTRICTIONS DESCRIBED LATER IN THIS PLAN DOCUMENT. IT IS IMPORTANT TO READ THE SCHEDULE OF COVERAGE TOGETHER WITH THE SPECIFIC DESCRIPTION.

NOTE: Claims for benefits under this Plan are determined by the Plan Administrator with the assistance of the Claims Administrators.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

MEDICAL BENEFITS

THE MEDICAL BENEFITS PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: EBSO, INC.

DEDUCTIBLE PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$3,500	Individual	$10,000	Individual
$7,000	Family	$20,000	Family

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$4,500	Individual	$30,000	Individual
$9,000	Family	$60,000	Family

The PPO Out-of-Pocket Maximum and the Non-PPO Out-of-Pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Out-of-Pocket Maximum is the amount contributed toward the Out-of-Pocket Maximum by two or more family members; provided, the amount contributed toward the family Out-of-Pocket Maximum by any one family member cannot be more than the individual Out-of-Pocket Maximum.

The Out-of-Pocket Maximum takes into account amounts that satisfy the Deductible, Copayment Percentage, and Copays. The Out-of-Pocket Maximum does NOT include any charge in excess of the established Plan maximums/limitations and penalties for non-compliance with Plan provisions.

CALENDAR YEAR MAXIMUM PAYMENT AMOUNT: Unlimited

Important - Inpatient Admission and Outpatient Surgery: Authorization is required for all Inpatient admissions and certain Outpatient Surgeries. Refer to the Inpatient Admission and Outpatient Surgery Authorization Provision for a complete list of surgeries requiring authorization.

For Inpatient authorization call EBSO Review at 1-800-426-9317 within 2 business days after the admission. For Outpatient Surgery authorization, call EBSO Review at 1-800-426-9317 within 2 business days after the Outpatient Surgery. ***Non-compliance reduces benefits***. If a Covered Individual does not comply with authorization when required, Covered Expenses will be reduced by 50% up to a maximum penalty of $500 per confinement or Outpatient Surgery (this reduction is in addition to the Deductible). If there is a reduction in benefits due to non-compliance with these authorization requirements, the penalty that the Covered Individual has to pay is not counted towards the applicable Out-of-Pocket Maximum.

Preferred Provider Organization (PPO). The Plan has contracted with the PreferredOne Network for providers within Minnesota and with the MultiPlan Network for providers outside of Minnesota. This means you have access to Providers in the PreferredOne Network and the MultiPlan Network. A current listing of Minnesota PPO providers is available upon request at no charge at www.preferredone.com or by calling 1-800-451-9597. If you, or a covered family member, need providers outside of Minnesota, visit www.multiplan.com or call 1-888-342-7427.

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Ambulance Services - Air and Ground	80% after Deductible	Paid as PPO	
Acupuncture	80% after Deductible	50% after Deductible	
Ambulatory Surgical Centers	80% after Deductible	50% after Deductible	
Chiropractic Care	80% after Deductible	Paid as PPO	Includes x-rays, manipulations, and supportive care.
Durable Medical Equipment/Prosthetic Devices/Other	80% after Deductible	50% after Deductible	Wigs are limited to one per Calendar Year.
Emergency Care Physician Facility	 80% after Deductible 80% after Deductible	 80% after Deductible 80% after Deductible	In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Hearing Aids	80% after Deductible	50% after Deductible	Limited to one hearing aid for each ear every three years for children age 18 and younger.
Home Health Care	80% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 visits per Calendar Year.
Hospice Care	80% after Deductible	50% after Deductible	
Inpatient Facility services Physician Facility	 80% after Deductible 80% after Deductible	 50% after Deductible 50% after Deductible	
Maternity Labor, delivery and	 80% after Deductible	 50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
post-delivery care			
Prenatal care	100% (Deductible waived	50% after Deductible	Includes all lab work and ultrasounds
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment	80% after Deductible	50% after Deductible	
Office Visits/Clinic	80% after Deductible	50% after Deductible	
Other Outpatient treatment	80% after Deductible	50% after Deductible	Includes group therapy
Outpatient Facility Services			
Physician/Clinic	80% after Deductible	50% after Deductible	
Facility	80% after Deductible	50% after Deductible	
Lab, pathology, advanced and standard imaging	80% after Deductible	50% after Deductible	
Physician Office Visits (other than for Mental/Nervous Disorders and/or Substance Abuse and Preventive Care)			
Primary Care Physician	80% after Deductible	50% after Deductible	
Specialist	80% after Deductible	50% after Deductible	
Retail Health Clinic	80% after Deductible	50% after Deductible	
Web Based Care (Online E-visits)/Telephone Consultations	80% after Deductible	50% after Deductible	
Other professional services in the office			
Lab, pathology, advanced and standard imaging	80% after Deductible	50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Preventive Care Services	100% (Deductible waived)	50% after Deductible	Refer to benefit section for more information on Preventive Care. Refer to Prescription Drug Benefit for drugs considered Preventive Care.
Skilled Nursing Facility	80% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 days per Confinement.
Therapy services – Physical, Occupational, and Speech (habilitative and rehabilitative)	80% after Deductible	50% after Deductible	
Urgent Care Centers	80% after Deductible	50% after Deductible	
Routine Vision Exam, including refraction	100% (Deductible waived)	100% (Deductible waived)	***LIMITED*** to one Routine vision exam per Calendar Year.
All other Covered Expenses	80% after Deductible	50% after Deductible	

PRESCRIPTION DRUG BENEFIT

THE PRESCRIPTION DRUG BENEFIT PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: MedTrakRx

SPECIAL RULES FOR CERTAIN PRESCRIPTION MEDICATIONS – CONTRACEPTIVES AND PREVENTIVE CARE. Certain prescription contraceptives and certain prescriptions for Preventive Care medications, including smoking cessation medications, must be provided at no cost if provided through a Participating Pharmacy. In addition, if a Generic version is available and just as safe and effective, the prescription must be filled using the Generic version in order to be provided at no cost. A current list of contraceptives and Preventive Care medications is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacies. This Plan has contracted with MedTrakRx. MedTrakRx has a provider organization consisting of Participating Pharmacies, including Retail Pharmacies, Performance 90 Pharmacies, and Mail Service Pharmacies. ***This Plan only pays benefits obtained from Participating Pharmacies.*** A current list of Participating Pharmacies is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacy:	Retail	Performance 90	Mail Service
Maximum day supply allowed:	31	90	90
Generic Copayment Percentage*:	20% of cost	20% of cost	20% of cost
Formulary Copayment Percentage*:	20% of cost	20% of cost	20% of cost
Non-Formulary Copayment Percentage*:	20% of cost	20% of cost	20% of cost
*** Generic Incentive**. If a Formulary brand or Non-Formulary brand is dispensed ***at the Covered Individual's request*** when a Generic equivalent is available, the Covered Individual pays the difference in cost between the Generic and the Formulary or Non-Formulary plus the applicable Copay. The			

difference in cost does not apply towards satisfaction of the Deductible or the Out-of-Pocket Maximum. If a Formulary brand or Non-Formulary brand is dispensed ***at the provider's request*** when a Generic equivalent is available, the Covered Individual only pays the applicable Copay.			
Preventive Generic Copay+:	$10	$25	$25
Preventive Formulary Copay+:	$40	$100	$100
Preventive Non-Formulary Copay+:	$100	$250	$250
+ Preventive Copays are not subject to and do not count towards satisfaction of the Deductible.			

Specialty Medication. The Covered Individual pays 20% of the cost up to a maximum $350 for a 30-day supply allowed per fill.

Annual Rx / Medical Combined PPO Deductible:	$3,500 per Individual, $7,000 per family beginning every January 1st. Once you have met this amount, you will pay the above Copays and Copayment Percentages until the end of the benefit year, December 31st, or until you reach the Out-of-Pocket Maximum as stated below. *Note: Preventive Copays are not subject to and do not count towards Deductible.
Annual Rx / Medical Combined PPO Out-of-Pocket Maximum:	$4,500 per Individual, $9,000 per family beginning every January 1st. Once you have met this amount, you will pay $0 Copays and Copayment Percentages until the end of the benefit year, December 31st.

SCHEDULE OF COVERAGE: $4,500 DEDUCTIBLE OPTION (HSA COMPATIBLE)

NOTE: THIS IS ONLY A SUMMARY OF THE COVERAGE OPTION KEY FEATURES. SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER REQUIREMENTS AND/OR RESTRICTIONS DESCRIBED LATER IN THIS PLAN DOCUMENT. IT IS IMPORTANT TO READ THE SCHEDULE OF COVERAGE TOGETHER WITH THE SPECIFIC DESCRIPTION.

NOTE: Claims for benefits under this Plan are determined by the Plan Administrator with the assistance of the Claims Administrators.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

MEDICAL BENEFITS

THE MEDICAL BENEFITS PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: EBSO, INC.

DEDUCTIBLE PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$4,500	Individual	$10,000	Individual
$9,000	Family	$20,000	Family

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$6,550	Individual	$30,000	Individual
$13,100	Family	$60,000	Family

The PPO Out-of-Pocket Maximum and the Non-PPO Out-of-Pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Out-of-Pocket Maximum is the amount contributed toward the Out-of-Pocket Maximum by two or more family members; provided, the amount contributed toward the family Out-of-Pocket Maximum by any one family member cannot be more than the individual Out-of-Pocket Maximum.

The Out-of-Pocket Maximum takes into account amounts that satisfy the Deductible, Copayment Percentage, and Copays. The Out-of-Pocket Maximum does NOT include any charge in excess of the established Plan maximums/limitations and penalties for non-compliance with Plan provisions.

CALENDAR YEAR MAXIMUM PAYMENT AMOUNT: Unlimited

Important - Inpatient Admission and Outpatient Surgery: Authorization is required for all Inpatient admissions and certain Outpatient Surgeries. Refer to the Inpatient Admission and Outpatient Surgery Authorization Provision for a complete list of surgeries requiring authorization.

For Inpatient authorization call EBSO Review at 1-800-426-9317 within 2 business days after the admission. For Outpatient Surgery authorization, call EBSO Review at 1-800-426-9317 within 2 business days after the Outpatient Surgery. ***Non-compliance reduces benefits***. If a Covered Individual does not comply with authorization when required, Covered Expenses will be reduced by 50% up to a maximum penalty of $500 per confinement or Outpatient Surgery (this reduction is in addition to the Deductible). If there is a reduction in benefits due to non-compliance with these authorization requirements, the penalty that the Covered Individual has to pay is not counted towards the applicable Out-of-Pocket Maximum.

Preferred Provider Organization (PPO). The Plan has contracted with the PreferredOne Network for providers within Minnesota and with the MultiPlan Network for providers outside of Minnesota. This means you have access to Providers in the PreferredOne Network and the MultiPlan Network. A current listing of Minnesota PPO providers is available upon request at no charge at www.preferredone.com or by calling 1-800-451-9597. If you, or a covered family member, need providers outside of Minnesota, visit www.multiplan.com or call 1-888-342-7427.

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Ambulance Services - Air and Ground	80% after Deductible	Paid as PPO	
Acupuncture	80% after Deductible	50% after Deductible	
Ambulatory Surgical Centers	80% after Deductible	50% after Deductible	
Chiropractic Care	80% after Deductible	Paid as PPO	Includes x-rays, manipulations, and supportive care.
Durable Medical Equipment/Prosthetic Devices/Other	80% after Deductible	50% after Deductible	Wigs are limited to one per Calendar Year.
Emergency Care Physician Facility	 80% after Deductible 80% after Deductible	 80% after Deductible 80% after Deductible	In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Hearing Aids	80% after Deductible	50% after Deductible	Limited to one hearing aid for each ear every three years for children age 18 and younger.
Home Health Care	80% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 visits per Calendar Year.
Hospice Care	80% after Deductible	50% after Deductible	
Inpatient Facility services Physician Facility	 80% after Deductible 80% after Deductible	 50% after Deductible 50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Maternity			
Labor, delivery and post-delivery care	80% after Deductible	50% after Deductible	
Prenatal care	100% (Deductible waived)	50% after Deductible	Includes all lab work and ultrasounds
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment	80% after Deductible	50% after Deductible	
Office Visits/Clinic	80% after Deductible	50% after Deductible	
Other Outpatient treatment	80% after Deductible	50% after Deductible	Includes group therapy
Outpatient Facility Services			
Physician/Clinic	80% after Deductible	50% after Deductible	
Facility	80% after Deductible	50% after Deductible	
Lab, pathology, advanced and standard imaging	80% after Deductible	50% after Deductible	
Physician Office Visits (other than for Mental/Nervous Disorders and/or Substance Abuse and Preventive Care)			
Primary Care Physician/Clinic	80% after Deductible	50% after Deductible	
Specialist	80% after Deductible	50% after Deductible	
Retail Health Clinic	80% after Deductible	50% after Deductible	
Web Based Care (Online E-visits)/Telephone Consultations	80% after Deductible	50% after Deductible	
Other professional services in the office			
Lab, pathology, advanced and standard imaging	80% after Deductible	50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Preventive Care Services	100% (Deductible waived)	50% after Deductible	Refer to benefit section for more information on Preventive Care. Refer to Prescription Drug Benefit for drugs considered Preventive Care.
Skilled Nursing Facility	80% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 days per Confinement.
Therapy services – Physical, Occupational, and Speech (habilitative and rehabilitative)	80% after Deductible	50% after Deductible	
Urgent Care Centers	80% after Deductible	50% after Deductible	
Routine Vision Exam, including refraction	100% (Deductible waived)	100% (Deductible waived)	***LIMITED*** to one Routine vision exam per Calendar Year.
All other Covered Expenses	80% after Deductible	50% after Deductible	

PRESCRIPTION DRUG BENEFIT

THE PRESCRIPTION DRUG BENEFIT PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: MedTrakRx

SPECIAL RULES FOR CERTAIN PRESCRIPTION MEDICATIONS – CONTRACEPTIVES AND PREVENTIVE CARE. Certain prescription contraceptives and certain prescriptions for Preventive Care medications, including smoking cessation medications, must be provided at no cost if provided through a Participating Pharmacy. In addition, if a Generic version is available and just as safe and effective, the prescription must be filled using the Generic version in order to be provided at no cost. A current list of contraceptives and Preventive Care medications is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacies. This Plan has contracted with MedTrakRx. MedTrakRx has a provider organization consisting of Participating Pharmacies, including Retail Pharmacies, Performance 90 Pharmacies, and Mail Service Pharmacies. ***This Plan only pays benefits obtained from Participating Pharmacies.*** A current list of Participating Pharmacies is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacy:	Retail	Performance 90	Mail Service
Maximum day supply allowed:	31	90	90
Generic Copayment Percentage*:	20% of cost	20% of cost	20% of cost
Formulary Copayment Percentage*:	20% of cost	20% of cost	20% of cost
Non-Formulary Copayment Percentage*:	20% of cost	20% of cost	20% of cost

*** Generic Incentive**. If a Formulary brand or Non-Formulary brand is dispensed ***at the Covered Individual's request*** when a Generic equivalent is available, the Covered Individual pays the difference in cost between the Generic and the Formulary or Non-Formulary plus the applicable Copay. The difference in cost does not apply towards satisfaction of the Deductible or the Out-of-Pocket Maximum. If a Formulary brand or Non-Formulary brand is dispensed ***at the provider's request*** when a Generic

equivalent is available, the Covered Individual only pays the applicable Copay.			
Preventive Generic Copay*+:	$10	$25	$25
Preventive Formulary Copay+:	$40	$100	$100
Preventive Non-Formulary Copay+:	$100	$250	$250
+ Preventive Copays are not subject to and do not count towards satisfaction of the Deductible.			

Specialty Medication. The Covered Individual pays 20% of the cost up to a maximum $350 for a 30-day supply allowed per fill.

Annual Rx / Medical Combined PPO Deductible:	$4,500 per Individual, $9,000 per family beginning every January 1st. Once you have met this amount, you will pay the above Copays and Copayment Percentages until the end of the benefit year, December 31st, or until you reach the Out-of-Pocket Maximum as stated below. *Note: Preventive Copays are not subject to and do not count towards Deductible.
Annual Rx / Medical Combined PPO Out-of-Pocket Maximum:	$6,550 per Individual, $13,100 per family beginning every January 1st. Once you have met this amount, you will pay $0 Copay and Copayment Percentages until the end of the benefit year, December 31st.

SCHEDULE OF COVERAGE: $5,500 DEDUCTIBLE OPTION (HSA COMPATIBLE)

NOTE: THIS IS ONLY A SUMMARY OF THE COVERAGE OPTION KEY FEATURES. SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER REQUIREMENTS AND/OR RESTRICTIONS DESCRIBED LATER IN THIS PLAN DOCUMENT. IT IS IMPORTANT TO READ THE SCHEDULE OF COVERAGE TOGETHER WITH THE SPECIFIC DESCRIPTION.

NOTE: Claims for benefits under this Plan are determined by the Plan Administrator with the assistance of the Claims Administrators.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

MEDICAL BENEFITS

THE MEDICAL BENEFITS PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: EBSO, INC.

DEDUCTIBLE PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$5,500	Individual	$10,000	Individual
$11,000	Family	$20,000	Family

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$6,750	Individual	$30,000	Individual
$13,500	Family	$60,000	Family

The PPO Out-of-Pocket Maximum and the Non-PPO Out-of-Pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Out-of-Pocket Maximum is the amount contributed toward the Out-of-Pocket Maximum by two or more family members; provided, the amount contributed toward the family Out-of-Pocket Maximum by any one family member cannot be more than the individual Out-of-Pocket Maximum.

The Out-of-Pocket Maximum takes into account amounts that satisfy the Deductible, Copayment Percentage, and Copays. The Out-of-Pocket Maximum does NOT include any charge in excess of the established Plan maximums/limitations and penalties for non-compliance with Plan provisions.

CALENDAR YEAR MAXIMUM PAYMENT AMOUNT: Unlimited

Important - Inpatient Admission and Outpatient Surgery: Authorization is required for all Inpatient admissions and certain Outpatient Surgeries. Refer to the Inpatient Admission and Outpatient Surgery Authorization Provision for a complete list of surgeries requiring authorization.

For Inpatient authorization call EBSO Review at 1-800-426-9317 within 2 business days after the admission. For Outpatient Surgery authorization, call EBSO Review at 1-800-426-9317 within 2 business days after the Outpatient Surgery. ***Non-compliance reduces benefits***. If a Covered Individual does not comply with authorization when required, Covered Expenses will be reduced by 50% up to a maximum penalty of $500 per confinement or Outpatient Surgery (this reduction is in addition to the Deductible). If there is a reduction in benefits due to non-compliance with these authorization requirements, the penalty that the Covered Individual has to pay is not counted towards the applicable Out-of-Pocket Maximum.

Preferred Provider Organization (PPO). The Plan has contracted with the PreferredOne Network for providers within Minnesota and with the MultiPlan Network for providers outside of Minnesota. This means you have access to Providers in the PreferredOne Network and the MultiPlan Network. A current listing of Minnesota PPO providers is available upon request at no charge at www.preferredone.com or by calling 1-800-451-9597. If you, or a covered family member, need providers outside of Minnesota, visit www.multiplan.com or call 1-888-342-7427.

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Ambulance Services - Air and Ground	75% after Deductible	Paid as PPO	
Acupuncture	75% after Deductible	50% after Deductible	
Ambulatory Surgical Centers	75% after Deductible	50% after Deductible	
Chiropractic Care	75% after Deductible	Paid as PPO	Includes x-rays, manipulations, and supportive care.
Durable Medical Equipment/Prosthetic Devices/Other	75% after Deductible	50% after Deductible	Wigs are limited to one per Calendar Year.
Emergency Care Physician Facility	 75% after Deductible 75% after Deductible	 75% after Deductible 75% after Deductible	In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Hearing Aids	75% after Deductible	50% after Deductible	Limited to one hearing aid for each ear every three years for children age 18 and younger.
Home Health Care	75% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 visits per Calendar Year.
Hospice Care	75% after Deductible	50% after Deductible	
Inpatient Facility services Physician Facility	 75% after Deductible 75% after Deductible	 50% after Deductible 50% after Deductible	
Maternity Labor, delivery and	 75% after Deductible	 50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
post-delivery care			
Prenatal care	100% (Deductible waived)	50% after Deductible	Includes all lab work and ultrasounds
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment	75% after Deductible	50% after Deductible	
Office Visits/Clinic	75% after Deductible	50% after Deductible	
Other Outpatient treatment	75% after Deductible	50% after Deductible	Includes group therapy
Outpatient Facility Services			
Physician/Clinic	75% after Deductible	50% after Deductible	
Facility	75% after Deductible	50% after Deductible	
Lab, pathology, advanced and standard imaging	75% after Deductible	50% after Deductible	
Physician Office Visits (other than for Mental/Nervous Disorders and/or Substance Abuse and Preventive Care)			
Primary Care Physician/Clinic	75% after Deductible	50% after Deductible	
Specialist	75% after Deductible	50% after Deductible	
Retail Health Clinic	75% after Deductible	50% after Deductible	
Web Based Care (Online E-visits)/Telephone Consultations	75% after Deductible	50% after Deductible	
Other professional services in the office			
Lab, pathology, advanced and standard imaging	75% after Deductible	50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Preventive Care Services	100% (Deductible waived)	50% after Deductible	Refer to benefit section for more information on Preventive Care. Refer to Prescription Drug Benefit for drugs considered Preventive Care.
Skilled Nursing Facility	75% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 days per Confinement.
Therapy services – Physical, Occupational, and Speech (habilitative and rehabilitative)	75% after Deductible	50% after Deductible	
Urgent Care Centers	75% after Deductible	50% after Deductible	
Routine Vision Exam, including refraction	100% (Deductible waived)	100% (Deductible waived)	***LIMITED*** to one Routine vision exam per Calendar Year.
All other Covered Expenses	75% after Deductible	50% after Deductible	

PRESCRIPTION DRUG BENEFIT

THE PRESCRIPTION DRUG BENEFIT PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: MedTrakRx

SPECIAL RULES FOR CERTAIN PRESCRIPTION MEDICATIONS – CONTRACEPTIVES AND PREVENTIVE CARE. Certain prescription contraceptives and certain prescriptions for Preventive Care medications, including smoking cessation medications, must be provided at no cost if provided through a Participating Pharmacy. In addition, if a Generic version is available and just as safe and effective, the prescription must be filled using the Generic version in order to be provided at no cost. A current list of contraceptives and Preventive Care medications is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacies. **Participating Pharmacies**. This Plan has contracted with MedTrakRx. MedTrakRx has a provider organization consisting of Participating Pharmacies, including Retail Pharmacies, Performance 90 Pharmacies, and Mail Service Pharmacies. ***This Plan only pays benefits obtained from Participating Pharmacies.*** A current list of Participating Pharmacies is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacy:	Retail	Performance 90	Mail Service
Maximum day supply allowed:	31	90	90
Generic Copayment Percentage*:	25% of cost	25% of cost	25% of cost
Formulary Copayment Percentage*:	25% of cost	25% of cost	25% of cost
Non-Formulary Copayment Percentage*:	25% of cost	25% of cost	25% of cost
*** Generic Incentive**. If a Formulary brand or Non-Formulary brand is dispensed ***at the Covered***			

Individual's request when a Generic equivalent is available, the Covered Individual pays the difference in cost between the Generic and the Formulary or Non-Formulary plus the applicable Copay. The difference in cost does not apply towards satisfaction of the Deductible or the Out-of-Pocket Maximum. If a Formulary brand or Non-Formulary brand is dispensed ***at the provider's request*** when a Generic equivalent is available, the Covered Individual only pays the applicable Copay.			
Preventive Generic Copay*+:	$10	$25	$25
Preventive Formulary Copay+:	$40	$100	$100
Preventive Non-Formulary Copay+:	$100	$250	$250
+ Preventive Copays are not subject to and do not count towards satisfaction of the Deductible.			

Specialty Medication. The Covered Individual pays 20% of the cost up to a maximum $350 for a 30-day supply allowed per fill.

Annual Rx / Medical Combined PPO Deductible:	$5,500 per Individual, $11,000 per family beginning every January 1st. Once you have met this amount, you will pay the above Copays and Copayment Percentages until the end of the benefit year, December 31st, or until you reach the Out-of-Pocket Maximum as stated below. *Note: Preventive Copays are not subject to and do not count towards Deductible.
Annual Rx / Medical Combined PPO Out-of-Pocket Maximum:	$6,750 per Individual, $13,500 per family beginning every January 1st. Once you have met this amount, you will pay $0 Copay and Copayment Percentage until the end of the benefit year, December 31st.

SCHEDULE OF COVERAGE: $6,550 DEDUCTIBLE OPTION (HSA COMPATIBLE)

NOTE: THIS IS ONLY A SUMMARY OF THE COVERAGE OPTION KEY FEATURES. SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER REQUIREMENTS AND/OR RESTRICTIONS DESCRIBED LATER IN THIS PLAN DOCUMENT. IT IS IMPORTANT TO READ THE SCHEDULE OF COVERAGE TOGETHER WITH THE SPECIFIC DESCRIPTION.

NOTE: Claims for benefits under this Plan are determined by the Plan Administrator with the assistance of the Claims Administrators.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

MEDICAL BENEFITS

THE MEDICAL BENEFITS PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: EBSO, INC.

DEDUCTIBLE PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$6,550	Individual	$10,000	Individual
$13,100	Family	$20,000	Family

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR:

PPO:		**NON-PPO:**	
$6,750	Individual	$30,000	Individual
$13,500	Family	$60,000	Family

The PPO Out-of-Pocket Maximum and the Non-PPO Out-of-Pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Out-of-Pocket Maximum is the amount contributed toward the Out-of-Pocket Maximum by two or more family members; provided, the amount contributed toward the family Out-of-Pocket Maximum by any one family member cannot be more than the individual Out-of-Pocket Maximum.

The Out-of-Pocket Maximum takes into account amounts that satisfy the Deductible, Copayment Percentage, and Copays. The Out-of-Pocket Maximum does NOT include any charge in excess of the established Plan maximums/limitations and penalties for non-compliance with Plan provisions.

CALENDAR YEAR MAXIMUM PAYMENT AMOUNT: Unlimited

Important - Inpatient Admission and Outpatient Surgery: Authorization is required for all Inpatient admissions and certain Outpatient Surgeries. Refer to the Inpatient Admission and Outpatient Surgery Authorization Provision for a complete list of surgeries requiring authorization.

For Inpatient authorization call EBSO Review at 1-800-426-9317 within 2 business days after the admission. For Outpatient Surgery authorization, call EBSO Review at 1-800-426-9317 within 2 business days after the Outpatient Surgery. ***Non-compliance reduces benefits***. If a Covered Individual does not comply with authorization when required, Covered Expenses will be reduced by 50% up to a maximum penalty of $500 per confinement or Outpatient Surgery (this reduction is in addition to the Deductible). If there is a reduction in benefits due to non-compliance with these authorization requirements, the penalty that the Covered Individual has to pay is not counted towards the applicable Out-of-Pocket Maximum.

Preferred Provider Organization (PPO). The Plan has contracted with the PreferredOne Network for providers within Minnesota and with the MultiPlan Network for providers outside of Minnesota. This means you have access to Providers in the PreferredOne Network and the MultiPlan Network. A current listing of Minnesota PPO providers is available upon request at no charge at www.preferredone.com or by calling 1-800-451-9597. If you, or a covered family member, need providers outside of Minnesota, visit www.multiplan.com or call 1-888-342-7427.

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Ambulance Services - Air and Ground	70% after Deductible	Paid as PPO	
Acupuncture	70% after Deductible	50% after Deductible	
Ambulatory Surgical Centers	70% after Deductible	50% after Deductible	
Chiropractic Care	70% after Deductible	Paid as PPO	Includes x-rays, manipulations, and supportive care.
Durable Medical Equipment/Prosthetic Devices/Other	70% after Deductible	50% after Deductible	Wigs are limited to one per Calendar Year.
Emergency Care Physician Facility	 70% after Deductible 70% after Deductible	 70% after Deductible 70% after Deductible	In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Hearing Aids	70% after Deductible	50% after Deductible	Limited to one hearing aid for each ear every three years for children age 18 and younger.
Home Health Care	70% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 visits per Calendar Year.
Hospice Care	70% after Deductible	50% after Deductible	
Inpatient Facility services Physician Facility	 70% after Deductible 70% after Deductible	 50% after Deductible 50% after Deductible	
Maternity Labor, delivery and	 70% after Deductible	 50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
post-delivery care			
Prenatal care	100% (Deductible waived)	50% after Deductible	Includes all lab work and ultrasounds
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment	70% after Deductible	50% after Deductible	
Office Visits/Clinic	70% after Deductible	50% after Deductible	
Other Outpatient treatment	70% after Deductible	50% after Deductible	Includes group therapy
Outpatient Facility Services			
Physician/Clinic	70% after Deductible	50% after Deductible	
Facility	70% after Deductible	50% after Deductible	
Lab, pathology, advanced and standard imaging	70% after Deductible	50% after Deductible	
Physician Office Visits (other than for Mental/Nervous Disorders and/or Substance Abuse and Preventive Care)			
Primary Care Physician/Clinic	70% after Deductible	50% after Deductible	
Specialist	70% after Deductible	50% after Deductible	
Retail Health Clinic	70% after Deductible	50% after Deductible	
Web Based Care (Online E-visits)/Telephone Consultations	70% after Deductible	50% after Deductible	
Other professional services in the office			
Lab, pathology, advanced and standard imaging	70% after Deductible	50% after Deductible	
Preventive Care Services	100% (Deductible waived)	50% after Deductible	Refer to benefit section for more information on Preventive Care. Refer to

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
			Prescription Drug Benefit for drugs considered Preventive Care.
Skilled Nursing Facility	70% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 days per Confinement.
Therapy services – Physical, Occupational, and Speech (habilitative and rehabilitative)	70% after Deductible	50% after Deductible	
Urgent Care Centers	70% after Deductible	50% after Deductible	
Routine Vision Exam, including refraction	100% (Deductible waived)	100% (Deductible waived)	***LIMITED*** to one Routine vision exam per Calendar Year.
All other Covered Expenses	70% after Deductible	50% after Deductible	

PRESCRIPTION DRUG BENEFIT

THE PRESCRIPTION DRUG BENEFIT PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: MedTrakRx

SPECIAL RULES FOR CERTAIN PRESCRIPTION MEDICATIONS – CONTRACEPTIVES AND PREVENTIVE CARE. Certain prescription contraceptives and certain prescriptions for Preventive Care medications, including smoking cessation medications, must be provided at no cost if provided through a Participating Pharmacy. In addition, if a Generic version is available and just as safe and effective, the prescription must be filled using the Generic version in order to be provided at no cost. A current list of contraceptives and Preventive Care medications is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacies. **Participating Pharmacies**. This Plan has contracted with MedTrakRx. MedTrakRx has a provider organization consisting of Participating Pharmacies, including Retail Pharmacies, Performance 90 Pharmacies, and Mail Service Pharmacies. ***This Plan only pays benefits obtained from Participating Pharmacies.*** A current list of Participating Pharmacies is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacy:	Retail	Performance 90	Mail Service
Maximum day supply allowed:	31	90	90
Generic Copayment Percentage*:	30% of cost	30% of cost	30% of cost
Formulary Copayment Percentage*:	30% of cost	30% of cost	30% of cost
Non-Formulary Copayment Percentage*:	30% of cost	30% of cost	30% of cost

*** Generic Incentive**. If a Formulary brand or Non-Formulary brand is dispensed ***at the Covered Individual's request*** when a Generic equivalent is available, the Covered Individual pays the difference in cost between the Generic and the Formulary or Non-Formulary plus the applicable Copay. The difference in cost does not apply towards satisfaction of the Deductible or the Out-of-Pocket Maximum. If a Formulary brand or Non-Formulary brand is dispensed ***at the provider's request*** when a Generic equivalent is available, the Covered Individual only pays the applicable Copay.

Preventive Generic Copay*+:	$10	$25	$25
Preventive Formulary Copay+:	$40	$100	$100
Preventive Non-Formulary Copay+:	$100	$250	$250
+ Preventive Copays are not subject to and do not count towards satisfaction of the Deductible.			

Specialty Medication. The Covered Individual pays 20% of the cost up to a maximum $350 for a 30-day supply allowed per fill.

Annual Rx / Medical Combined PPO Deductible:	$6,550 per Individual, $13,100 per family beginning every January 1st. Once you have met this amount, you will pay the above Copays and Copayment Percentages until the end of the benefit year, December 31st, or until you reach the Out-of-Pocket Maximum as stated below. *Note: Preventive Copays are not subject to and do not count towards Deductible.
Annual Rx / Medical Combined PPO Out-of-Pocket Maximum:	$6,750 per Individual, $13,500 per family beginning every January 1st. Once you have met this amount, you will pay $0 Copay and Copayment Percentages until the end of the benefit year, December 31st.

SCHEDULE OF COVERAGE: $7,900 DEDUCTIBLE OPTION

NOTE: THIS IS ONLY A SUMMARY OF THE COVERAGE OPTION KEY FEATURES. SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER REQUIREMENTS AND/OR RESTRICTIONS DESCRIBED LATER IN THIS PLAN DOCUMENT. IT IS IMPORTANT TO READ THE SCHEDULE OF COVERAGE TOGETHER WITH THE SPECIFIC DESCRIPTION.

NOTE: Claims for benefits under this Plan are determined by the Plan Administrator with the assistance of the Claims Administrators.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

MEDICAL BENEFITS

THE MEDICAL BENEFITS PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: EBSO, INC.

DEDUCTIBLE PER CALENDAR YEAR:

PPO:	**NON-PPO:**
$ 7,900 Individual	$10,000 Individual
$15,800 Family	$20,000 Family

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR:

PPO:	**NON-PPO:**
$ 7,900 Individual	$30,000 Individual
$15,800 Family	$60,000 Family

The PPO Out-of-Pocket Maximum and the Non-PPO Out-of-Pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Out-of-Pocket Maximum is the amount contributed toward the Out-of-Pocket Maximum by two or more family members; provided, the amount contributed toward the family Out-of-Pocket Maximum by any one family member cannot be more than the individual Out-of-Pocket Maximum.

The Out-of-Pocket Maximum takes into account amounts that satisfy the Deductible, Copayment Percentage, and Copays. The Out-of-Pocket Maximum does NOT include any charge in excess of the established Plan maximums/limitations and penalties for non-compliance with Plan provisions.

CALENDAR YEAR MAXIMUM PAYMENT AMOUNT: Unlimited

Important - Inpatient Admission and Outpatient Surgery: Authorization is required for all Inpatient admissions and certain Outpatient Surgeries. Refer to the Inpatient Admission and Outpatient Surgery Authorization Provision for a complete list of surgeries requiring authorization.

For Inpatient authorization call EBSO Review at 1-800-426-9317 within 2 business days after the admission. For Outpatient Surgery authorization, call EBSO Review at 1-800-426-9317 within 2 business days after the Outpatient Surgery. ***Non-compliance reduces benefits***. If a Covered Individual does not comply with authorization when required, Covered Expenses will be reduced by 50% up to a maximum penalty of $500 per confinement or Outpatient Surgery (this reduction is in addition to the Deductible). If there is a reduction in benefits due to non-compliance with these authorization requirements, the penalty that the Covered Individual has to pay is not counted towards the applicable Out-of-Pocket Maximum.

Preferred Provider Organization (PPO). The Plan has contracted with the PreferredOne Network for providers within Minnesota and with the MultiPlan Network for providers outside of Minnesota. This means you have access to Providers in the PreferredOne Network and the MultiPlan Network. A current listing of Minnesota PPO providers is available upon request at no charge at www.preferredone.com or by calling 1-800-451-9597. If you, or a covered family member, need providers outside of Minnesota, visit www.multiplan.com or call 1-888-342-7427.

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Ambulance Services - Air and Ground	100% after Deductible	Paid as PPO	
Acupuncture	100% after Deductible	50% after Deductible	
Ambulatory Surgical Centers	100% after Deductible	50% after Deductible	
Chiropractic Care	100% after Deductible	Paid as PPO	Includes x-rays, manipulations, and supportive care.
Durable Medical Equipment/Prosthetic Devices/Other	100% after Deductible	50% after Deductible	Wigs are limited to one per Calendar Year.
Emergency Care Physician Facility	 100% after Deductible 100% after Deductible	 100% after Deductible 100% after Deductible	In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Hearing Aids	100% after Deductible	50% after Deductible	Limited to one hearing aid for each ear every three years for children age 18 and younger.
Home Health Care	100% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 visits per Calendar Year.
Hospice Care	100% after Deductible	50% after Deductible	
Inpatient Facility services Physician Facility	 100% after Deductible 100% after Deductible	 50% after Deductible 50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Maternity			
Labor, delivery and post-delivery care	100% after Deductible	50% after Deductible	
Prenatal care	100% (Deductible waived)	50% after Deductible	Includes all lab work and ultrasounds
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment	100% after Deductible	50% after Deductible	
Office Visits/Clinic	100% after Deductible	50% after Deductible	
Other Outpatient treatment	100% after Deductible	50% after Deductible	Includes group therapy
Outpatient Facility Services			
Physician/Clinic	100% after Deductible	50% after Deductible	
Facility	100% after Deductible	50% after Deductible	
Lab, pathology, advanced and standard imaging	100% after Deductible	50% after Deductible	
Physician Office Visits (other than for Mental/Nervous Disorders and/or Substance Abuse and Preventive Care)			
Primary Care Physician/Clinic	100% after Deductible	50% after Deductible	
Specialist	100% after Deductible	50% after Deductible	
Retail Health Clinic	100% after Deductible	50% after Deductible	
Web Based Care (Online E-visits)/Telephone Consultations	100% after Deductible	50% after Deductible	
Other professional services in the office			
Lab, pathology, advanced and standard imaging	100% after Deductible	50% after Deductible	

Benefit Description	PPO pays	Non-PPO pays	Additional Limitations and Explanations
Preventive Care Services	100% (Deductible waived)	50% after Deductible	Refer to benefit section for more information on Preventive Care. Refer to Prescription Drug Benefit for drugs considered Preventive Care.
Skilled Nursing Facility	100% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 120 days per Confinement.
Therapy services – Physical, Occupational, and Speech (habilitative and rehabilitative)	100% after Deductible	50% after Deductible	
Urgent Care Centers	100% after Deductible	50% after Deductible	
Routine Vision Exam, including refraction	100% (Deductible waived)	100% (Deductible waived)	***LIMITED*** to one Routine vision exam per Calendar Year.
All other Covered Expenses	100% after Deductible	50% after Deductible	

PRESCRIPTION DRUG BENEFIT

THE PRESCRIPTION DRUG BENEFIT PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: MedTrakRx

SPECIAL RULES FOR CERTAIN PRESCRIPTION MEDICATIONS – CONTRACEPTIVES AND PREVENTIVE CARE. Certain prescription contraceptives and certain prescriptions for Preventive Care medications, including smoking cessation medications, must be provided at no cost if provided through a Participating Pharmacy. In addition, if a Generic version is available and just as safe and effective, the prescription must be filled using the Generic version in order to be provided at no cost. A current list of contraceptives and Preventive Care medications is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacies. **Participating Pharmacies**. This Plan has contracted with MedTrakRx. MedTrakRx has a provider organization consisting of Participating Pharmacies, including Retail Pharmacies, Performance 90 Pharmacies, and Mail Service Pharmacies. ***This Plan only pays benefits obtained from Participating Pharmacies.*** A current list of Participating Pharmacies is available upon request at no charge at www.medtrakrx.com or by calling 1-800-771-4648.

Participating Pharmacy:	Retail	Performance 90	Mail Service
Maximum day supply allowed:	31	90	90
	Plan Pays:	Plan Pays:	Plan Pays:
Generic	100% after Deductible	100% after Deductible	100% after Deductible
Formulary	100% after Deductible	100% after Deductible	100% after Deductible
Non-Formulary	100% after Deductible	100% after Deductible	100% after Deductible

Preventive Generic Copay*+:	$10	$25	$25
Preventive Formulary Copay+:	$40	$100	$100
Preventive Non-Formulary Copay+:	$100	$250	$250
+ Preventive Copays are not subject to and do not count towards satisfaction of the Deductible.			

Specialty Medication. The Plan pays 100% of the cost after satisfaction of the Deductible. A 30-day supply is allowed per fill.

Annual Rx / Medical Combined PPO Deductible:	$7,900 per Individual, $15,800 per family beginning every January 1st. *Note: Preventive Copays are not subject to and do not count towards Deductible.
Annual Rx / Medical Combined PPO Out-of-Pocket Maximum:	$7,900 per Individual, $15,800 per family beginning every January 1st. Once you have met this amount, you will pay $0 until the end of the benefit year, December 31st.

DEFINITIONS OF GENERAL TERMS

The following words and phrases used in this Plan Document have the following meanings, except where otherwise specifically provided.

Other Defined Terms. Throughout the Plan Document, other terms are defined within particular Sections for use in those Sections.

NOTE: The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate Sections of the Plan Document for that information.

ADVERSE BENEFIT DETERMINATION means any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

AMBULATORY SURGICAL CENTER means a facility with an organized staff of Physicians which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
2. Provides treatment by and under the supervision of Physicians and nursing services when the patient is in the facility;
3. Does not provide Inpatient accommodations;
4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician.

BIRTHING CENTER means a facility operating as part of a Hospital, or as a free-standing facility solely engaged in providing an alternative to conventional obstetrics which:

1. Is licensed as such and is operating within the scope of its license; and

2. Is directed by a Physician specializing in obstetrics or gynecology; and

3. Has a Physician or certified nurse mid-wife, present at all births and during the immediate post-partum; and

4. Is equipped and has a trained staff, or has a written agreement with the Hospital to handle emergencies including the transfer of a patient or child; and

5. Maintains medical records on each patient and provides an ongoing quality assurance program.

BRAND DRUG means a Drug Product that is not classified as Generic.

CALENDAR YEAR means the period from January 1 through the following December 31.

CLAIMANT means a Covered Individual pursuing payment of a claim under this Plan.

CLAIMS ADMINISTRATOR means a third party retained by the Plan Administrator and the Plan Sponsor. The Claims Administrator's responsibilities typically consist of initially determining the validity of the Claims and administering benefit payments under this Plan. The actual responsibilities of the Claims Administrator are described in the contract between the Plan Administrator, Plan Sponsor, and Claims Administrator. The Claims Administrator for the Medical Benefits is EBSO, Inc. The Claim Administrator for the Prescription Drug Benefit is MedTrakRx. The Claims Administrator for COBRA Continuation Coverage is EBSO, Inc.

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

CODE means the Internal Revenue Code of 1986, as amended from time to time.

CONFINEMENT means the period of time between admission to a covered facility on an Inpatient basis and discharge from that facility or from another similar facility to which the Covered Individual was transferred for continued treatment of the same condition. Successive Confinements are considered part of the same Confinement unless they are separated by at least 30 days between discharge and readmission as an Inpatient to any covered facility.

COPAY refers to the amount, typically a set dollar amount, the Covered Individual must pay for a particular type of Covered Expense regardless of whether the applicable Deductible has been met. The Copay is also described in Section J.

COPAYMENT PERCENTAGE means the portion of the Covered Expense for which the Covered Individual is responsible following satisfaction of the applicable Deductible. The Copayment Percentage is also described in Section J.

COSMETIC PROCEDURE means a procedure performed solely for the improvement of a Covered Individual's appearance rather than for the improvement or restoration of bodily function. Breast reconstruction or a breast prosthesis following a mastectomy is ***NOT*** considered a Cosmetic Procedure.

COVERED DEPENDENT means a Dependent who is participating under this Plan in accordance with the Section D (Eligibility and Effective Date of Coverage) and whose coverage has not terminated.

COVERED EMPLOYEE means an Employee who is participating under this Plan in accordance with the Section D (Eligibility and Effective Date of Coverage) and whose coverage has not terminated.

COVERED EXPENSES are charges for services that are covered under the Plan. Some charges, although eligible for payment under this Plan, may be subject to Deductible, Copay and Copayment Percentage provisions where applicable and, therefore, are the Covered Individual's responsibility to pay. Charges for non-covered expenses are also the Covered Individual's responsibility.

COVERED INDIVIDUAL means a Covered Employee or Covered Dependent who is participating under this Plan in accordance with Section D (Eligibility and Effective Date of Coverage) and whose coverage has not terminated. Covered Individual also includes former Covered Employees and former Covered Dependents who are otherwise entitled to coverage and properly enrolled under this Plan such as those persons under COBRA Continuation Coverage described in Section E (COBRA Continuation Coverage).

COVERED MEDICATION means any Drug Product prescribed by a Physician for a Covered Individual that meets the requirements for coverage as described in the Plan.

CUSTODIAL CARE means the type of care that is designed chiefly to help a person meet activities of daily living. It does not entail or need the continuing attention of trained medical personnel such as registered nurses and licensed practical nurses. Custodial Care includes services which make up personal care such as help in walking and getting in and out of bed; help in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision of medication which usually can be self-administered. Care may still be custodial even though it involves the use of technical medical skills if those skills can be easily taught to a lay person.

DAY HOSPITALIZATION means the continuous treatment of a Mental/Nervous Disorders and/or Substance Abuse at a Hospital, intermediate care facility or other covered facility for not less than five hours and not more than eighteen hours in any 24-hour period. It does not include an Inpatient stay in the Hospital.

DEDUCTIBLE means the amount of Covered Expenses that must be paid by the Covered Individual each Calendar Year before benefits, other than Preventive Care, are paid by the Plan. The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the

amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount. The Deductible is also described in Section J.

DEPENDENT includes only an Employee's:

1. Lawful spouse, who resides in the United States, and who is not Legally Separated from the Employee; and

   For purposes of this definition, the term "spouse" shall mean the person who cohabites with and is recognized as the Covered Employee's husband or wife under the laws of the state where the Covered Employee lives or was married, and shall include common law and same sex marriages. The Plan may require documentation proving a legal marital relationship.

2. Unmarried or married children (defined below) less than 26 years of age.

3. Unmarried children age 26 or older who are incapable of self-sustaining employment because of a developmental disability or physical disability and are chiefly dependent upon the Employee for support and maintenance. Proof of such incapacity must be furnished within 31 days of the children reaching the limiting age and annually thereafter.

   For purposes of this definition, "developmental disability" means substantial handicap which results from mental retardation, cerebral palsy, or other neurological disorder.

   For purposes of this definition, "physical disability" means a physical impairment that substantially limits one or more major life activities such as hearing; breathing; mobility (ability to move); learning; or receptive (understanding) and expressive language. Physical disabilities include, but are not limited to: blindness/visual impairment; cancer; diabetes; head injury; heart disease; and mobility impairments. An individual with a minor, non-chronic condition of short duration, such as a sprain, broken limb, or the flu, is not considered disabled.

For purposes of this definition, the term "children" includes the following:

1. A biological child;

2. An adopted child, including a child placed for adoption. Placement for adoption occurs when an Employee, in anticipation of adopting a child, assumes and retains legal obligation for the total or partial support of that child. Adoptive placement ceases when or if legal obligation ceases;

3. A stepchild;

4. Any child for whom the Employee has obtained legal guardianship;

5. Any child for whom coverage is required by a Qualified Medical Child Support Order or by an administrative process established under state law;

6. A child of a covered Dependent child (the Employee's grandchild);

7. A foster child.

At any time, the Plan may require proof that a spouse or child qualifies or continues to qualify as a Dependent as defined by the Plan.

No person may be covered under this Plan as both a Covered Employee and as a Dependent of an Employee, or as a Dependent of more than Covered Employee. The term Dependent does not include any person serving in the active duty of any country, unless required by federal law.

DIAGNOSTIC means a test or procedure performed because the Covered Individual has specific symptoms or which is required to detect or monitor a certain condition or disease. Such test or procedure must be ordered by a Physician or Health Care Professional, and it must be related to the Covered Individual's symptoms.

DRUG PRODUCT means a drug whose active ingredient(s), strength(s), and dosage form are listed in the "Approved Drug Products with Therapeutic Equivalence Evaluations" (commonly known as the "Orange Book"), which is an official publication of the U.S. Food and Drug Administration (FDA).

DURABLE MEDICAL EQUIPMENT means equipment prescribed by a Physician and is primarily that customarily used to serve a medical purpose, able to withstand repeated use, and not generally useful to a person in the absence of an Injury or Sickness.

EBSO means EBSO, Inc.

EFFECTIVE DATE means the date on which a Covered Individual's coverage under this Plan begins.

ELIGIBLE EMPLOYEE means an Employee of a Participating Employer who is regularly scheduled to actively perform the principle duties of his/her occupation for a minimum of 30 hours per week. Part-time, seasonal, and temporary employees (determined pursuant to Section 1.105-11(c)(2)(iii)(C) of the Treasury Regulations) are not eligible for coverage under the Plan. This Plan does not provide retiree coverage.

ELIGIBLE ORGAN/TISSUE TRANSPLANT PROCEDURE(S) means any human-to-human organ/tissue transplant which is not Experimental/Investigational/Investigative.

EMERGENCY/EMERGENCY CONDITION means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

2. Serious impairment to such person's bodily functions;

3. Serious dysfunction of any bodily organ or part of such person; or

4. Serious disfigurement of such person.

EMERGENCY SERVICES means with respect to an Emergency Condition:

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as required to stabilize the patient.

EMPLOYEE means any person employed by a Participating Employer and on the Participating Employer's W-2 payroll on or after the Effective Date, except that it shall not include:

1. Any self-employed individual as described in Section 401(c) of the Code;

2. Any employee included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this Plan;

3. Any employee who is a nonresident alien and receives no earned income from the Participating Employer from sources within the United States;

4. Any employee who is a leased employee as defined in Section 414(n)(2) of the Code;

5. Any individual classified by the Participating Employer as a contract worker, independent contractor, temporary employee, or casual employee, whether or not any such persons are on the Participating Employer's W-2 payroll or are determined by the IRS or others to be common-law employees of the Firm; or

6. Any individual who performs services for the Participating Employer but who is paid by a temporary or other employment or staffing agency such as "Kelly," "Manpower," etc., whether or not such individuals are determined by the IRS or others to be common-law employees of the Participating Employer.

All employees who are treated as employed by a single employer under subsections (b), (c) or (m) of Section 414 of the Code are treated as employed by a single employer for purposes of this Plan. For purposes of this Plan, Employee includes an owner of a Participating Employer.

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

ESSENTIAL HEALTH BENEFITS means:

1. Ambulatory patient services;

2. Emergency services;

3. Hospitalization;

4. Maternity and newborn care;

5. Mental health and substance use disorder services, including behavioral health treatment;

6. Prescription drugs;

7. Rehabilitative and habilitative services and devices;

8. Laboratory services;

9. Preventive and wellness services and chronic disease management; and

10. Pediatric services, including oral and vision care.

EXPERIMENTAL/INVESTIGATIONAL/INVESTIGATIVE means a drug, device, medical treatment or procedure that meets any of the following:

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

2. 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 and approval; or

3. 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. 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.

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

The Plan Administrator has the discretionary authority to make determinations as which drugs, services, supplies, care and/or treatments shall be considered Experimental or Investigational.

EXTERNAL REVIEW means an External Review be made available in certain circumstances under applicable state or federal procedures. The specifics of External Review are being determined through regulatory guidance. External Review decisions are binding on the Plan and Claimant except to the extent other remedies are available under applicable state and/or federal law.

FORMULARY means a standard preferred list of Covered Medications, as determined by the MedTrakRx Pharmacy & Therapeutics Committee (or such other Pharmacy & Therapeutics Committee as designated by MedTrakRx and agreed to by the Plan), and provided, as necessary, to Physicians, Participating

Pharmacies, and/or Covered Individuals as a guide to the prescribing, dispensing, and purchasing of Covered Medications.

GENERIC means a drug that (i) has a Multisource Code field in Medi-Span of “Y” (generic), (ii) has a Multisource Code is “I” and there is a DAW code of 3,4,5,6, or 9, (iii) is a multisource Brand Drug that adjudicates at MAC, (iv) is a Brand Drug that are treated as “house” generic drugs (DAW 5) by the dispensing pharmacy, or (v) is a Single-Source Generic Drug Product.

HEALTH CARE PROFESSIONAL means a licensed health care practitioner, other than a Physician (as defined by this Plan), who is legally licensed or certified and, within the scope of that license or certificate, is permitted to perform the services for which benefits are provided under this Plan. The term "Health Care Professional" includes, but is not limited to: acupuncturist, a registered dietician, nurse midwife, audiologist, Physician's assistant, psychologist, nurse anesthetist, certified nurse practitioner, physical therapist, occupational therapist, speech therapist, respiratory therapist, social worker, and an operating room technician (only when an assistant surgeon is not present). The Health Care Professional may be an independent Health Care Professional, however, his/her services must be recommended and approved by the Covered Individual's attending Physician. The Health Care Professional may not be a member of the Covered Individual's Immediate Family or a person who normally resides with the Covered Individual.

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

HOME HEALTH CARE means care and treatment of a Covered Individual provided by or coordinated through:

1. A Home Health Care Agency; or
2. A certified rehabilitation agency.

The care and treatment must be included in a “Plan of Home Health Care” approved in writing by the attending Physician. The “Plan of Home Health Care” must be revised every two months unless the attending Physician indicates in writing that a longer review period is sufficient. If the Covered Individual was Hospital confined immediately prior to requiring home care, the “Plan of Home Health Care” must be approved by the Physician who was the primary provider of services during the confinement.

HOME HEALTH CARE AGENCY means a home health agency or a visiting nurses' association which meets all of the following requirements:

1. Is licensed by the state;
2. Qualifies as a Home Health Care Agency under Medicare;
3. Meets the standards of the applicable area-wide health care planning agency;
4. Provides skilled nursing services and other services on a visiting basis in the patient's home;
5. Is responsible for administering the Plan of Home Health Care; and

6. Supervises the delivery of a “Plan of Home Health Care” as prescribed and approved in writing by the patient's attending Physician.

HOME HEALTH CARE SERVICES means nursing services; dietary advice; social service guidance; physical, occupational, speech or respiratory therapy; laboratory services; drugs; dressings and medical supplies; and related services under the direction of a licensed Physician or surgeon provided in the place of and as an extension of care in a Hospital.

HOSPICE AGENCY means a public agency or private organization which meets all of the following requirements:

1. Is primarily engaged in providing care to Terminally Ill patients;

2. Provides 24-hour care to control the symptoms associated with Terminal Illness;

3. Has on its staff an interdisciplinary team which includes at least one Physician, one registered professional nurse (R.N.), one social worker, and at least one pastoral or other counselor, and volunteers;

4. Must be a licensed organization whose standards of care meet those of the National Hospice Organization;

5. Maintains central clinical records on all patients;

6. Provides appropriate methods of dispensing drugs and medicines; and

7. Offers a coordinated program of home care and Inpatient care for a Terminally Ill patient.

The term "Hospice" does ***NOT*** include an organization or part thereof which:

1. Is primarily engaged in providing:

   a. Custodial Care;

   b. Care for Substance Abusers; or

   c. Domestic services;

2. Is a place of rest;

3. Is a place for the aged; or

4. Is a hotel or similar institution.

HOSPITAL means a place that meets all of the following requirements:

1. It is accredited as a general Hospital by the Joint Commission on Accreditation of Hospitals;

2. It is open at all times;

3. It is operated chiefly for the treatment of sick or injured persons as Inpatients;

4. It has a staff of one or more Physicians available at all time;

5. It provides 24-hour nursing service by graduate registered nurses; and

6. It includes areas designed for diagnosis and major surgical procedures. Or, if it is chiefly a place for the treatment of mentally handicapped persons, it has an agreement, by contract or otherwise, with an accredited Hospital to perform Surgery which may be required.

For treatment of Substance Abuse, a residential treatment facility specializing in the care and treatment of alcoholism, drug addiction or chemical dependency will be considered a Hospital provided the facility is licensed as a treatment facility in the state in which it is operating.

The term "Hospital" does ***NOT*** include: a convalescent, nursing, rest, or Skilled Nursing Facility.

HOSPITAL MISCELLANEOUS EXPENSES means the actual charges made by a Hospital, other than room and board, on its own behalf for services and supplies rendered to the Covered Individual, on an Inpatient or Outpatient basis, which are Medically Necessary for the treatment of such Covered Individual. This includes Hospital admission kits, but all other personal or convenience items are excluded.

IMMEDIATE FAMILY means the Covered Individual's spouse, children, brothers, sisters, grandparents, or the parents of the Covered Individual or his/her spouse.

INCURRED means the day and time of day Covered Expenses are provided. It does not include the date on which a Covered Individual contracts for future delivery of supplies or services or the date on which they are billed or paid.

INJURY means a condition caused by accidental means which results in damage to the Covered Individual's body from an external force and independently of all other causes and which is ***NOT*** related to occupation or employment. Chewing accidents are ***NOT*** considered Injuries. Muscle strain due to athletic activity or other exertion is considered a Sickness under the Plan.

INPATIENT means that a Covered Individual is confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or other covered facility.

INTENSIVE CARE UNIT means a specialized section, ward or wing, within a Hospital which is operated exclusively for critically ill patients (other than Hospice patients) and provides special supplies, equipment and constant observation and care by registered professional nurses or other highly trained Hospital personnel, excluding any Hospital facility maintained for the purposes of providing normal post-operative recovery treatment or service.

LAYOFF means a temporary release from duties, subject to recall at such time as the need arises.

LEAVE OF ABSENCE means a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work,

generally requested by an Employee and having been approved by his or her Employer, and as provided for in the Employer's rules, policies, procedures and practices where applicable.

LEGAL SEPARATION means an arrangement to remain married but live apart, following a court order.

MAINTENANCE CARE means continued care to maintain the optimum state of health after the Covered Individual has reached a maximum level of recovery.

MEDICAID means the medical benefits provided by Title XIX of the Social Security Act, as amended.

MEDICAL BENEFIT means the portion of this Plan that pays as Covered Expenses certain charges for health related costs.

MEDICAL RECORD REVIEW is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the maximum allowable charge according to the Medical Record Review and audit results.

MEDICALLY NECESSARY or **MEDICAL NECESSITY** means that a service, medicine or supply is necessary and appropriate for the diagnosis or active treatment of an Injury or Sickness based on generally accepted current medical practice.

To be Medically Necessary, Covered Expenses must:

1. Be rendered in connection with an Injury or Sickness;

2. Be consistent with the diagnosis and treatment of the Covered Individual's condition; and

3. Be in accordance with the standards of good medical practice.

To be Medically Necessary, Covered Expenses must also be provided at the most appropriate level of care and in the most appropriate type of health care facility. Only the Covered Individual's medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care facility is appropriate. Medically Necessary is the criterion by which the Plan determines the necessity of medical service and treatment under this Plan.

A service, medicine or supply will ***NOT*** be considered Medically Necessary if:

1. It is provided only as a convenience to the Covered Individual or provider;

2. It is not appropriate treatment for the Covered Individual's diagnosis or symptoms;

3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;

4. It is part of a plan of treatment that is considered to be Experimental/Investigational/Investigative in the diagnosis or treatment of an Injury or Sickness;

5. It involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

MEDICARE means the medical benefits provided by Title XVIII of the Social Security Act, as amended.

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

MORBID OBESITY means a condition in which the Covered Individual's body weight exceeds the normal weight by either 100 pounds or is twice the normal weight of a person of the same height, and conventional weight reduction measures have failed.

NURSE MIDWIFE means a person certified as a Nurse-Midwife to assist with childbirth under the direction and supervision of a licensed Physician.

NON-FORMULARY means a drug that is not a Formulary drug and not a Generic drug.

NON-PPO PROVIDER means a provider that is not part of a PPO.

OPEN ENROLLMENT PERIOD means a period during which an eligible individual may freely enroll in, or a Covered Employee change a coverage option under this Plan.

OUT-OF POCKET-MAXIMUM means the most a Covered Individual has to pay for Covered Expenses in a Calendar Year. After satisfaction of the Out-of-Pocket Maximum, the Plan pays 100% of the costs of Covered Expenses for the remainder of the Calendar Year. The Out-of-Pocket Maximum is also described in Section J.

OUTPATIENT means treatment rendered to a Covered Individual at: an Ambulatory Surgical Center; or at a Hospital or other covered facility, other than as an overnight bed patient.

PARTICIPATING EMPLOYER means an Employer recognized by the 40 Square Health Plan, in accordance with its bylaws, as eligible to participate in this Plan.

PAYMENT PERCENTAGE means the amount payable by the Plan for Covered Expenses after satisfaction of the Deductible amount or Copayment, if applicable. Once the Out-of-Pocket Maximum has been reached, the Plan pays 100% of the Covered Expenses for the remainder of the Calendar Year. The Payment Percentage is shown in the Schedule of Coverage.

PARTICIPATING PHARMACY means a duly licensed pharmacy that has signed a pharmacy services agreement (or similarly named agreement) with MedTrakRx to provide pharmacy services to Covered Individuals in accordance with requirements of such agreement.

PHYSICIAN means a legally licensed doctor of medicine and Surgery, doctor of optometry, psychiatrist, osteopathy, podiatric medicine, surgical chiropody, chiropractic, or doctor of dental Surgery. A Physician shall not include the Covered Individual or any member of his/her Immediate Family.

PLAN means the 40 Square Health Plan, the Plan of benefits reflected in this Plan Document.

PLAN ADMINISTRATOR means the 40 Square Health Plan Trust. The Plan Administrator retains ultimate authority for this Plan Including final appeal determinations. The Plan Administrator is also the Named Fiduciary for purposes of ERISA.

PLAN DOCUMENT means this written document required under the Code and ERISA detailing the provisions of the Plan. This Plan Document also serves as the summary plan description for purposes of ERISA.

PLAN OF HOME HEALTH CARE for purposes of the Home Health Care benefit means a program for continued care and treatment of the Covered Individual established and approved in writing by the Covered Individual's attending Physician within 7 days following termination of a Hospital confinement as a resident Inpatient, and which is for the same or related condition for which the Covered Individual was hospitalized. The attending Physician must certify, and recertify every 90 days, that the proper treatment of the Injury or Sickness would require continued confinement as a resident Inpatient in a Hospital or in a Skilled Nursing Facility in the absence of the services and supplies provided as part of the “Plan of Home Health Care”.

PREFERRED PROVIDER ORGANIZATION (PPO) means a specific group of healthcare providers (a) who have joined together in an arrangement to provide medical services on a more favorable basis in terms of price and utilization than is generally offered to the public on an individual practitioner basis, and (b) that has contracted with the Plan.

PRESCRIPTION DRUG BENEFIT means the inclusions, limitations, and exclusions in coverage of Covered Individuals, Participating Pharmacies, Physicians, and Covered Medications as set forth in the Plan and as may be amended from time to time by the Plan Sponsor.

PREVENTIVE CARE means Preventive Care means the “preventive health services” mandate under Section 2713 of the Public Health Services Act requiring certain health services be provided to adults, women, and children at no cost if provided through a PPO provider or Participating Pharmacy.

PREVENTIVE FORMULARY means a Formulary drug prescribed for preventive purposes that is not considered Preventive Care.

PREVENTIVE GENERIC means a Generic drug prescribed for preventive purposes that is not considered Preventive Care.

PREVENTIVE NON-FORMULARY means a Non-Formulary drug prescribed for preventive purposes that is not considered Preventive Care.

PRIMARY CARE PHYSICIAN means a family practitioner, general practitioner, pediatrician, OB/GYN, internal medicine specialist, or chiropractor.

PPACA means the Patient Protection and Affordable Health Care Act, as amended by the Health Care and Education Reconciliation Act, and any regulatory guidance issued thereunder.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) means a Medical Child Support Order required under ERISA to be recognized by the Plan as further described in Section R.

REHABILITATION FACILITY means a facility accredited by the Joint Commission on the Accreditation of Health Care Organizations or the Commission on the Accreditation of Rehabilitative Facilities as a Rehabilitation Facility for the primary purpose of physical rehabilitation. This facility may also be a ward, floor or other area contained within a Hospital whose primary purpose is physical rehabilitation.

SCHEDULE OF COVERAGE means the schedule appearing at the beginning of the Plan Document, or as later amended, specifying the level of benefits provided by the Plan with respect to a particular coverage option.

SECOND SURGICAL OPINION means a second opinion to evaluate the need for elective Surgery previously recommended by the patient's Physician provided that:

1. The charges that would be made for the recommended Surgery, if performed, must qualify as Covered Expenses;

2. The Physician furnishing the second opinion must not be financially associated with the Physician rendering the first opinion, and must be Board Certified in the appropriate medical Specialty except: a Board Certified specialist is not required if the Physician has been recommended to the patient by a local medical society; and

3. The second opinion must be set forth in writing by the second Physician after the examination of the patient.

SICKNESS means a disorder of the body, disease, condition, Mental/Nervous Disorder(s), Substance Abuse, pregnancy, or complication of pregnancy. All Sicknesses which are due to the same cause or to a related cause or causes will be deemed to be a Sickness.

SKILLED NURSING FACILITY means a place, or a distinct part of a place, which meets all of the following criteria:

1. It is licensed according to state or local laws;

2. Its chief purpose is to provide skilled nursing treatment to a Covered Individual who is recovering from an Injury or Sickness;

3. It includes areas for medical treatment;

4. It provides 24-hour nursing service under the full-time supervision of a Physician or a graduate registered nurse (R.N.);

5. It maintains daily health records for each patient;

6. It has an agreement which provides for the services of a Physician;

7. It has a suitable method for providing drugs and medicines to patients;

8. It has an arrangement with one or more Hospitals for the transfer of patients;

9. It has an effective utilization review plan;

10. Its functions are developed with the advice and review of a skilled group which includes at least one Physician;

11. It is ***NOT*** solely a place for:

    a. Rest, rehabilitation or Custodial Care;

    b. The aged;

    c. Treatment of Substance Abuse; or

    d. Those who are mentally handicapped or who have Mental/Nervous Disorders.

SOUND NATURAL TEETH means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

SPECIAL ENROLLMENT PERIOD means a time period (other than the annual Open Enrollment Period) during which an eligible individual who has experienced a particular event may enroll in a coverage option under the Plan.

SPECIALIST means a Physician other than a Primary Care Physician.

SPECIALTY MEDICATION means a high-cost, complex pharmaceutical that has unique clinical, administration, distribution, or handling requirements, and is not commonly available through traditional retail or mail pharmacies; excluding, however, all Limited Distribution Drugs and Orphan Drugs. For purposes of this definition:

1. "Limited Distribution Drugs" or "LDD" means a drug that is only available through a limited number of specialty pharmacies.

2. "Orphan Drugs" means a drug intended for use in a rare disease or condition as defined by the Orphan Drug Act.

MedTrakRx maintains a list of such medications that are covered under this Plan.

SUBSTANCE ABUSE means the overuse or addiction to alcohol and/or other drugs that is classified as Substance Abuse 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. **NOTE**: Tobacco use screening and cessation interventions are covered as part of the preventive care benefits.

SURGERY means:

1. The performance of generally accepted operative and cutting procedures. This includes related surgical supplies, specialized instrumentations, endoscopic examinations and other invasive procedures.

2. The correction of fractures and dislocations.

3. Injections of medication into joints and bursae for nerve blocks or as an alternative to Surgery, and injections of sclerosing agents and dyes used for radio-opacity.

4. Usual and related pre-operative and post-operative care.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) AND/OR MYOFASCIAL PAIN DYSFUNCTION (MPD) means jaw joint conditions including craniomandibular disorders; and all other conditions of the joint linking the jaw bone, skull; and the complex of muscles, nerves and other tissues related to that joint.

TERMINALLY ILL or TERMINAL ILLNESS means a Covered Individual has an incurable diagnosis and medical prognosis of limited life expectancy, usually 6 months or less.

TRUST means the 40 Square Health Plan Trust, created for the purpose of accepting and holding certain contributions from Participating Employers and disbursing certain Trust assets to pay benefits and administrative expenses associated with the Plan and administrative expenses associated with the Trust. The Trust is a multiple employer trust and a multiple employer welfare arrangement (MEWA) for purposes of ERISA.

TRUSTEE means the Board of Trustees established pursuant to the 40 Square Health Plan Trust, and the individual Trustees that constitute the Board of Trustees.

URGENT CARE CENTER means a facility engaged primarily in providing minor emergency and episodic medical care. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance when the facility is open. The facility must include x-ray and laboratory equipment and life support equipment. For the purpose of this Plan, a facility meeting these requirements will be considered an Urgent Care Center, by whatever name it may be called.

USERRA means Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

USUAL, CUSTOMARY AND REASONABLE FEE means a charge for a given service by a provider to the majority of its clients, but such charge must be one which is within the range of fees charged by the majority of providers of similar training and experience, for that service within a specific, limited geographic or socioeconomic area as determined by the Plan. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise. For purposes of this definition, "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross-section of a level of expenses.

The Usual, Customary and Reasonable Fee for surgical procedures mean Covered Expenses for the services of a Physician for performing an operation.

WEB BASED CARE (ONLINE~~)~~ is care provided by designated participating providers performed without physical face to face interaction, but through electronic (including telephonic) communication allowing evaluation, assessment and the management of health care services that leads to a treatment plan provided by a participating provider who is a licensed physician or who is a qualified licensed health care professional.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

This Section describes eligibility requirements, the enrollment process, when coverage begins, and when coverage ends. **These are all key terms and conditions of the Plan that ultimately impact whether expenses get paid through the Plan.**

NOTE: This Section contains a number of defined terms that only apply with respect to this Section.

Initial Eligibility

Initial Eligibility for the Employee. To be eligible for coverage under the Plan, an Employee must satisfy the definition of Eligible Employee.

Initial Eligibility for the Spouse. To be eligible for coverage under the Plan, the individual must be the Dependent spouse of a Covered Employee (or an Eligible Employee that is enrolling in the Plan to become a Covered Employee.)

Initial Eligibility for Children. To be eligible for coverage under the Plan, the individual must be a Dependent child of Covered Employee (or an Eligible Employee that is enrolling in the Plan to become a Covered Employee.)

Enrollment Process
Enrollment is a required step in order to begin coverage under this Plan. If a person that meets the eligibility requirements does not enroll for coverage at the first opportunity, the next opportunity to enroll will be during the next Open Enrollment unless the Covered Individual experiences a Change in Status or an event that triggers Special Enrollment. Both of these exceptions are described below.

In order to enroll, the Covered Individual must provide the Plan with particular information, enrollment information. Enrollment occurs during the "waiting period," described below. It must be done by the end of the" waiting period." At the conclusion of the "waiting period," the Covered Individual will begin participation in the Plan provided the enrollment process is complete.

Family Coverage. Covered Individuals in the same family must be covered under the same coverage option. Dependents that are eligible for coverage must seek coverage under the same coverage option as the Covered Employee.

If the enrollment process is not complete by the end of the waiting period, the person cannot begin coverage under the Plan. The next opportunity to enroll will be during Open Enrollment unless the Covered Individual experiences a change in status or Special Enrollment before the next Open Enrollment Period. Both of these exceptions are described below.

Waiting Period. The "waiting period" only applies when an Employee first satisfies the eligibility requirements and wants to be covered under the Plan at the first opportunity. The "waiting period" under this Plan is 30 consecutive days of employment with the Participating Employer. It is measured from the first day on which the Employee satisfies the eligibility requirements.

The waiting period shall be waived in any instance where a Covered Individual is merely changing from Dependent Status to Employee status, or vice versa. In these instances, coverage continues without interruption.

NOTE: If an Employee does not enroll for coverage under this Plan when he/she is initially eligible to enroll for coverage, he/she may enroll for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

Effective Date of Coverage. Coverage under the Plan begins for all persons whose enrollment process was timely completed, as of the first day of the calendar month following or coincident with the completion of the "waiting period."

Family Coverage. Covered Individuals in the same family must be covered under the same coverage option. Dependents that are eligible for coverage must seek coverage under the same coverage option as the Covered Employee.

Open Enrollment

Open Enrollment refers to the opportunity for persons to make changes – either enroll for coverage or change coverage (including changing coverage options and stopping coverage) under this Plan. Open Enrollment Period is the time frame designated by the Plan Administrator during the months of November through December, during which eligible persons may make the changes permitted by Open Enrollment ***provided all required information has been timely provided to the Plan***.

As part of the Open Enrollment Period, an eligible person must provide the Plan with particular information. In most cases, the information that needs to be provided relates to becoming covered under the Plan. When a Covered Individual uses the Open Enrollment Period to stop coverage under the Plan (i.e., drop coverage completely), the required information relates to stopping coverage under the Plan.

Persons that have met the eligibility requirements but did not enroll at the first opportunity. If the enrollment process is not complete by the end of the Open Enrollment Period, the person cannot begin coverage under the Plan. The next opportunity to enroll will be the next Open Enrollment Period unless the Covered Individual experiences a Change in Status or Special Enrollment before the next Open Enrollment Period.

Changing Coverage Options. During the Open Enrollment Period, a Covered Individual can change the coverage option under which he/she is covered under the Plan. If the process for changing coverage options is not complete by the end of the Open Enrollment Period, the Covered Individual cannot change coverage options under the Plan. The Covered Individual remains covered under his/her current coverage option. The next opportunity to change coverage options will be the next Open Enrollment unless the Covered Individual experiences a Change in Status or Special Enrollment before the next Open Enrollment Period.

Stopping Coverage under the Plan. During Open Enrollment, a Covered Individual can stop coverage under the Plan – in other words, drop coverage immediately. In order to stop coverage under the Plan, a Covered Individual must provide the Plan with proper written notice. If the process for stopping coverage is not complete by the end of the Open Enrollment Period, the Covered Individual cannot stop coverage under the Plan. The Covered Individual remains covered under the Plan in his/her current coverage option. The next opportunity to stop coverage under the Plan, will be the next Open Enrollment unless the Covered Individual experiences a Change in Status or Special Enrollment before the next Open Enrollment Period.

Effective Date of Change. Upon timely completion of the enrollment process, the coverage or change in coverage (including change in coverage option and stopping coverage) is effective on January 1 of the Plan Year to which the Open Enrollment Period relates. For example, during the Open Enrollment Period ending in December, a Covered Individual changes his/her coverage option under the Plan. Coverage

under the new coverage option begins as of January 1 the first day of the Plan Year to which the Open Enrollment Period relates.

Family Coverage. Covered Individuals in the same family must be covered under the same coverage option. Dependents that are eligible for coverage must seek coverage under the same coverage option as the Covered Employee.

Reinstatement of Coverage
An Employee's coverage that has terminated due to termination of employment, Layoff, reduction to part-time status, or Employer approved Leave of Absence, may be reinstated under the following condition:

1. The Employee returns to full-time active employment within six (6) months of the date such termination or leave commenced; and

2. The Employee re-enrolls for coverage within thirty-one (31) days of the return date to such active employment.

The reinstated coverage will be effective on the date the Employee returns to active employment. "Reinstatement" means that any previous benefit limitations, maximums or waiting periods applied prior to such termination or leave, will be recognized under the reinstated coverage. In other words, coverage will continue as if no time has elapsed between the termination of coverage and reinstatement

Changes During the Plan Year
With the exception of initial eligibility and enrollment described above, enrollment in the Plan is offered once per year – Open Enrollment. That is the only time an eligible person may enroll for coverage (or make a change in coverage) unless a Change in Status occurs or Special Enrollment occurs.

Change in Status. If a Change in Status occurs, a Covered Individual may not have to wait until the next Open Enrollment Period to begin coverage, change coverage, or stop coverage.

Proper Notification. In general, effectuating a change in coverage due to a Change in Status requires you to notify the Plan.

If a Covered Employee has single coverage and wants to change to family coverage because of a change in marital status, he/she must request the family coverage within 31 days of the date of marriage. Provided the request is timely made, coverage change becomes effective as of the date of the marriage.

Should an Employee's marital status change due to divorce or Legal Separation, notification of that change must be given to the Plan within 60 days of the date of that change.

If a Covered Employee has single coverage and wants to change to family coverage to add an eligible Dependent child, he/she must request the change by submitting a new enrollment form within 31 days of acquiring the child as an eligible Dependent. Provided the request is timely made, the child's coverage becomes effective as of the date he/she became an eligible Dependent of the Employee.

If a Covered Employees has family coverage and wants to add an additional eligible Dependent, he/she must request the change by submitting a new enrollment form within 31 days of acquiring the individual as an eligible Dependent. Provided the request is timely made, the individual's coverage becomes effective as of the date he/she became an eligible Dependent of the Covered Employee. Newborns are automatically covered under the Plan if family coverage is already in effect on the date of birth.

Failure to Timely Request. Any request for coverage after the 31 days will be subject to the Special Enrollment Period provision or the Open Enrollment Period provision

Special Enrollment. If a Special Enrollment event happens, a Covered Individual may not have to wait until the next Open Enrollment Period to begin coverage, change coverage, or stop coverage.

If an Eligible Employee declines coverage for himself/herself or a Covered Employee declines coverage for his/her Dependents (including the Covered Employee's spouse and/or Covered Employee's children) because of "other health coverage," the Eligible Employee will be able to enroll himself/herself and/or his/her Dependents in this Plan at a future date, provided that the Eligible Employee requests coverage within 31 days after loss of eligibility under such "other health coverage." Coverage under this Plan becomes effective on the first day of the calendar month following the Special Enrollment.

This Special Enrollment opportunity ***ONLY*** applies to individuals whose prior other health coverage:

1. Was under COBRA and has been exhausted; or

2. Was not under COBRA and eligibility has been lost due to:

    a. events that are similar to COBRA qualifying events including, but not limited to, loss of eligibility as a result of Legal Separation, divorce, death, termination or reduction in hours of employment or a child aging out under other parent's coverage;

    b. the other coverage is a plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees);

    c. the ***complete*** cessation of the employer contributions for that other coverage (actual termination of other coverage is not required); or

    d. moving out of an HMO's service area.

> **Loss.** Loss of eligibility does **NOT** include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other health coverage).

A Covered Employee must make a request for Special Enrollment within 31 days of the loss of the "other health coverage" and must supply the Plan with "proof of loss" of that other health coverage under the other group health plan.

Additional Special Enrollment rights exist for Eligible Employees and their Dependents (who are eligible for coverage under this Plan but are not enrolled for coverage under this Plan) upon either (1) termination of Medicaid or the State Children's Health Insurance Program (SCHIP) coverage resulting from loss of eligibility; or (2) becoming eligible for premium assistance in this Plan under a Medicaid or SCHIP program. In order to be entitled to this Special Enrollment right, the Eligible Employee must request coverage within 60 days of termination or the date the parent or child is determined to be eligible for assistance.

In addition, if an Eligible Employee, who declined coverage in this Plan for himself/herself or for his/her Dependents, acquires a new Dependent as a result of marriage, birth, adoption, placement for adoption, legal guardianship proceedings, or placement of a foster child, the Eligible Employee will be allowed to enroll for coverage himself/herself and/or his/her Dependent spouse and/or the new Dependent child, provided that the Eligible Employee requests the coverage within 31 days after the marriage, birth, adoption, placement for adoption, legal guardianship proceedings, or placement of a foster child.

EXAMPLES:

1. In the case of marriage, an Eligible Employee who had previously declined coverage could become covered, with or without his/her spouse, under the Special Enrollment Period provision. Coverage becomes effective on the first of the month following the date of enrollment.

2. In the case of birth or adoption, an Eligible Employee and/or his/her spouse, who had previously declined coverage in this Plan could become covered under the Special Enrollment Period provision. Coverage becomes effective on the child's date of birth, adoption or placement for adoption.

NOTE: During a Special Enrollment, the Employee may add a new Dependent under the Employee's current coverage option or the Employee may switch to another option, **if applicable**.

Automatic Termination of Coverage
If certain things happen, coverage under the Plan automatically STOPS. Unless specifically stated otherwise in this Plan Document, coverage under this Plan automatically terminates at midnight on the earliest of the following:

1. The date the Plan is terminated for all Covered Individuals;

2. The date a required contribution, if any, is due but the Covered Individual fails to make the contribution;

3. With regard to a specific benefit, on the date the benefit is terminated or deleted from the Plan;

4. At midnight on the last day of the month that the Covered Individual requests termination of any or all coverage under the Plan, subject to IRS rules regarding cafeteria plans. The request for termination must be in writing and all forms required by the Plan Administrator must be completed;

5. The date the Covered Individual ceases to be eligible for coverage under the Plan, except as specified below;

6. For Employees:

    a. If Covered Employee does not work the required number of hours to be considered an Eligible Employee due to Injury or Sickness, coverage will terminate 120 days after the Employee's last day of full-time active work;

    b. If Covered Employee does not work the required number of hours to be considered an Eligible Employee due to Layoff or Participating Employer approved leave of absence, coverage will terminate 30 days after the Covered Employee's last day of full-time active work;

    c. If a Covered Employee does not work the required number of hours to be considered an Eligible Employee for any reason other than those specifically listed above, (i.e.; voluntary or involuntary termination of employment; or reduction in hours), coverage will terminate on the last day of the month in which the Employee ceases full-time active work;

7. For Dependents:

a. Coverage will terminate at midnight on the last day of the month that coverage terminates for the Covered Employee under whom they are covered;

b. Coverage will terminate at midnight on the last day of the month in which the individual ceases to be eligible because he/she no longer meets the Plan's definition of Dependent;

c. Coverage will terminate on the date as specified in the QMCSO eligibility for Dependent coverage is solely based on this QMCSO.

NOTE: Coverage automatically terminates, without notice, if a Covered Individual:

1. Attempts, through deceit, to obtain benefits that otherwise would not be provided by this Plan; or

2. Attempts to obtain benefits for someone not entitled to benefits under this Plan.

FMLA. Notwithstanding any provision of this Plan, should a Participating Employer be subject to the Family and Medical Leave Act of 1993, this Plan shall operate in conformance with respect to Covered Employees attributable to that Participating Employer.

Continuation Coverage. If coverage terminates, Covered Individuals may have opportunities to continue coverage. Sections E and F.

COBRA CONTINUATION COVERAGE

YOUR CHOICE. COBRA continuation coverage is not required. It is your responsibility to decide whether to elect COBRA or not to elect COBRA.

A Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most group health plans, including this Plan, offer certain Covered Individuals the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This provision is intended to inform Covered Individuals, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. The following paragraphs generally explain COBRA continuation coverage, when it may become available and what a Qualified Beneficiary needs to do to protect his or her right to receive it.

More Information: The Plan Administrator has contracted with a third party to provide assistance with administering its COBRA obligations. All questions, notices, and other communication regarding COBRA should be directed to:

EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
651-695-2500 or 1-800-486-7664

Each person covered under this Plan should read this provision carefully.

The pronoun "you" is used in the following paragraphs regarding COBRA to refer to each Covered Individual who is or may become a Qualified Beneficiary, entitled to COBRA continuation coverage.

WHAT IS COBRA CONTINUATION COVERAGE? COBRA coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a particular event known as a "Qualifying Event". Specific Qualifying Events are listed below in the section entitled "What is a Qualifying Event".

COBRA continuation coverage is the same coverage provided under the Plan to Covered Individuals under the Plan who are not receiving COBRA continuation coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Covered Individuals, including Open Enrollment and Special Enrollment rights.

If a Participating Employer offers more than one coverage option and also offers an Open Enrollment Period (during which time, Covered Individuals are allowed to change to a different coverage option), Qualified Beneficiaries must also be allowed to make these selections during an Open Enrollment Period.

WHO IS A QUALIFIED BENEFICIARY? In general, a Qualified Beneficiary is:

1. Any Covered Individual who, on the day before a Qualifying Event, is covered under this Plan by virtue of being on that day either a Covered Employee, the spouse of a Covered Employee, or a Dependent child of a Covered Employee.

2. A child born to, adopted by, or placed for adoption with a Covered Employee during a period of COBRA continuation coverage is considered a Qualified Beneficiary provided that, if the Covered Employee is a Qualified Beneficiary, the Covered Employee has elected COBRA continuation coverage for himself/herself. The child's COBRA

continuation coverage begins when the child is enrolled in the Plan, including when enrolled through a Special Enrollment or an Open Enrollment.

3. A child who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO), received by the Participating Employer during the Covered Employee's period of employment with the Participating Employer, is entitled to the same rights to elect COBRA as Dependent child of the Covered Employee.

If, however, an individual is denied or not offered coverage under the Plan under circumstances where the denial or failure to offer coverage 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.

For purposes of this section, the term "Covered Employee" includes more than common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his/her performance of services for a Participating Employer (e.g., self-employed individuals, independent contractors, owners or corporate directors).

WHAT IS A QUALIFYING EVENT? A Qualifying Event is the occurrence of an enumerated event (described below) that results in a loss of coverage under the terms of the Plan.

If you are a Covered Employee you will be entitled to elect COBRA if you lose coverage under the Plan because of either of the following Qualifying Events:

1. your hours of employment are reduced; or

2. your employment ends for any reason other than your gross misconduct.

If you are a Covered Individual because you are a covered spouse of a Covered Employee, you will be entitled to elect COBRA if you lose coverage under the Plan because of any of the following Qualifying Events:

1. your spouse (i.e., the Covered Employee) dies;

2. your spouse's (i.e., the Covered Employee) hours of employment are reduced;

3. your spouse's (i.e., the Covered Employee) employment ends for any reason other than his/her gross misconduct;

4. your spouse (i.e., the Covered Employee) becomes entitled to Medicare; or

5. you become divorced or legally separated from your spouse coverage under the Plan. Also, if your spouse (the Covered Employee) reduces or eliminates coverage under the Plan in anticipation of a divorce or Legal Separation, and a divorce or Legal Separation later occurs, then the divorce or Legal Separation may be considered a Qualifying Event even though coverage was reduced or eliminated before the divorce or Legal Separation.

If you are a Covered Individual because you are a covered dependent of a Covered Employee, you will be entitled to elect COBRA if you lose your coverage under the Plan because of any of the following Qualifying Events:

1. the Covered Employee dies;

2. the Covered Employee's hours of employment are reduced;

3. the Covered Employee's employment ends for any reason other than his/her gross misconduct;

4. the Covered Employee becomes entitled to Medicare;

5. the parents (including the Covered Employee) of the Dependent child become divorced or legally separated; or

6. you stop being eligible for coverage under the Plan as a Dependent child.

FMLA Rules. If FMLA applies with respect to the Participating Employer and a Covered Employee takes FMLA leave and does not return to work at the end of that leave, the Covered Employee (and the Covered Employee's Dependents, if any) will be entitled to elect COBRA if they:

1. were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and

2. will lose Plan coverage within 18 months because of the Covered Employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the FMLA leave.)

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).

IMPORTANT: The Employee and Dependents covered under the Plan on the day before the FMLA leave began will be entitled to COBRA continuation coverage upon return from the FMLA leave even if they failed to pay the Covered Employee portion of the contribution for coverage under the Plan during the FMLA leave.

WHEN IS COBRA COVERAGE AVAILABLE? When the Qualifying Event is the end of employment, reduction of hours of employment, or death of the Covered Employee, the Plan will offer COBRA continuation coverage to Qualified Beneficiaries. You need not notify the Plan Sponsor of any of these three Qualifying Events because the Participating Employer notifies the Plan Sponsor. A COBRA election notice, including an Election Form, will automatically be provided.

For the other Qualifying Events (divorce or Legal Separation of the Employee and spouse, or a Dependent child losing eligibility for coverage as a Dependent child), a COBRA Election Form will be sent to you only if you notify the Plan Sponsor in writing within 60 days after the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event.

WHAT IS THE ELECTION PERIOD AND HOW LONG MUST IT LAST? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The Plan conditions availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends on the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his/her right to elect COBRA continuation coverage.

HOW IS COBRA COVERAGE ELECTED? To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and timely submit it to the COBRA Administrator.

Mail, hand-deliver or fax the completed Election Form to:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, MN 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number: (651) 695-1648

The Election Form must be completed in writing and mailed, hand-delivered, or faxed to the individual at the address/fax number specified above. The following are ***not acceptable as COBRA election***s and will not preserve COBRA rights: oral communications regarding COBRA continuation coverage, including in-person or telephone statements about an individual's COBRA continuation coverage; electronic communications, including e-mail messages; and faxed communications (unless they are on a proper Election Form).

If mailed, the Election Form must be postmarked (and if hand-delivered or faxed, the Election Form must be received by the individual at the address/fax number specified above) no later than 60 days after the date of the COBRA election notice provided to you at the time of your Qualifying Event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Each Qualified Beneficiary (including a child who is born to, adopted by or placed for adoption with a COBRA Covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage. Covered Employees and spouses (if the spouse is a Qualified Beneficiary) may elect COBRA on behalf of all of the Qualified Beneficiaries, and parents may elect COBRA on behalf of their children.

Medicare may impact your ability to receive COBRA continuation coverage under this Plan. When you complete the Election Form you must notify the Plan Sponsor if any Qualified Beneficiary has become enrolled under Medicare (Part A, Part B, or both) and, if so, the date of Medicare enrollment. If you become enrolled under Medicare (or first learn that you are enrolled under Medicare) after submitting the Election Form, immediately notify the Plan Sponsor of the date of your Medicare enrollment at the address specified for delivery of the Election Form.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are enrolled under Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a Qualified Beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA, he/she becomes enrolled under Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section entitled "When may a Qualified Beneficiary's COBRA continuation coverage be terminated?".

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

If you reject COBRA before the Election Form due date, you may change your mind as long as you furnish a completed Election Form before the due date.

WHAT ARE THE MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE? The maximum coverage periods are based on the type of Qualifying Event and the status of the Qualified Beneficiary, as shown below:

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

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

    a. 36 months after the date the Covered Employee becomes enrolled in the Medicare program. For example, if a Covered Employee becomes enrolled under Medicare eight months before the date on which his employment terminates, COBRA continuation coverage under this Plan for the spouse and dependent children who lost coverage as a result of his termination can last up to 36 months after the date the Employee became enrolled under Medicare; which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). This COBRA continuation coverage period is available only if the Covered Employee becomes enrolled under Medicare within 18 months **BEFORE** the termination or reduction of hours; or

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

3. In the case of any other Qualifying Event than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

In the case of a Qualified Beneficiary who is a child born to, adopted by or placed for adoption with a COBRA Covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born, adopted or placed for adoption.

UNDER WHAT CIRCUMSTANCE CAN THE MAXIMUM COVERAGE PERIOD BE EXPANDED? If the Qualifying Event that resulted in COBRA continuation coverage was the Covered Employee's termination of employment or reduction in hours, an extension of the maximum coverage period may be available if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the Plan Sponsor of a disability or a second qualifying event in order to extend the period of COBRA continuation coverage. **FAILURE TO PROVIDE NOTICE OF A DISABILITY OR SECOND QUALIFYING EVENT WILL ELIMINATE THE RIGHT TO EXTEND THE PERIOD OF COBRA CONTINUATION COVERAGE.**

1. **Disability extension of COBRA continuation coverage**. If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and you notify the Plan Sponsor in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. This extension is available only for Qualified Beneficiaries who are receiving COBRA continuation coverage because of a Qualifying Event that was the Covered Employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the Covered Employee's termination of employment or reduction of hours (this includes disabilities that began prior to the Covered Employee's termination of employment or reduction of hours). The disability must last at least until the end of the period of COBRA continuation coverage that would be available without the disability extension (generally 18 months, as described above). Each Qualified Beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Plan Sponsor in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

a. the date of the Social Security Administration's disability determination;

b. the date of the Covered Employee's termination of employment or reduction of hours; or

c. the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Covered Employee's termination of employment or reduction of hours.

You must provide the Social Security Administration's determination notice within 18 months after the Covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

2. **Second Qualifying Event extension of COBRA continuation coverage.** An extension of coverage will be available to spouses and Dependent children who are receiving COBRA continuation coverage if a Second Qualifying Event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the Covered Employee's termination of employment or reduction of hours. The maximum amount of COBRA continuation coverage available when a Second Qualifying Event occurs is 36 months. Such Second Qualifying Events may include the death of the Covered Employee, divorce or Legal Separation from the Covered Employee, or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. (This extension is not available under the Plan when a Covered Employee becomes enrolled under Medicare.)

   This extension due to a Second Qualifying Event is available only if you notify the Plan Sponsor in writing of the Second Qualifying Event within 60 days after the later of:

   a. the date of the Second Qualifying Event; or

   b. the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the Second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

WHAT IS THE COST OF COBRA CONTINUATION COVERAGE? The amount a Qualified Beneficiary will be required to pay shall not exceed 102% (or, in the case of an extension of COBRA continuation coverage due to a disability, 150%) of the cost to the Plan for coverage of a similarly situated Covered Individual who is not receiving COBRA continuation coverage (including both Participating Employer and Employee contributions). The amount of your COBRA premiums may change from time to time during your period of COBRA continuation coverage and will most likely increase over time. You will be notified of COBRA premium changes.

WHAT ARE THE COBRA CONTINUATION COVERAGE PAYMENT PROCEDURES? If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA continuation coverage no later than 45 days after the date of your COBRA election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the designated address/fax number, if hand-delivered or faxed.) See the section above entitled "How may COBRA continuation coverage be elected?"

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make the first payment. (For example, your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA continuation coverage on November 15. Your initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of your COBRA election.) You are responsible for making sure that the amount of your first premium payment is correct. You may contact the Plan Sponsor using the contact information provided under the section entitled "How may COBRA continuation coverage be elected?" to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA ***and*** made the first payment for it.

If you do not make your first payment for COBRA continuation coverage in full within 45 days after the date of your election, YOU WILL LOSE ALL COBRA RIGHTS UNDER THE PLAN.

After you make your first payment for COBRA continuation coverage you will be required to make monthly payments for each subsequent month of COBRA continuation coverage. The amount due for each month for each Qualified Beneficiary will be disclosed in the election notice provided to you at the time of your Qualifying Event. Under the Plan, each of these monthly payments for COBRA continuation coverage is due on the first day of the month for that month's COBRA continuation coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA continuation coverage under the Plan will continue for that month without any break. Following your election of COBRA continuation coverage, you will receive a packet of 12 coupons to submit with your monthly COBRA premium. Periodic notices of payments due for these coverage periods will not be sent (that is, a monthly bill will not be sent to you for your COBRA continuation coverage – it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA continuation coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, YOU WILL LOSE ALL RIGHTS TO COBRA CONTINUATION COVERAGE UNDER THE PLAN.

All COBRA premiums must be paid by check or money order. CASH WILL NOT BE ACCEPTED.

Your first payment and all monthly payments for COBRA continuation coverage must be mailed or hand-delivered to:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, MN 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number: (651) 695-1648

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

WHEN MAY A QUALIFIED BENEFICIARY'S COBRA CONTINUATION COVERAGE BE TERMINATED? COBRA continuation coverage is a temporary continuation of coverage. The COBRA continuation coverage periods described above are maximum coverage periods. COBRA continuation coverage can terminate before the end of the maximum coverage period for several reasons, which are described below.

COBRA continuation coverage will automatically terminate before the end of the maximum coverage period if:

1. timely payment is not made to the Plan with respect to the Qualified Beneficiary. **NOTE:** Invalid payments (i.e., checks returned due to insufficient funds) will result in retroactive termination of coverage.

2. the Plan ceases to provide any group health plan (including successor plans) to any Employee.

3. a Qualified Beneficiary becomes covered, after electing COBRA under another group health plan.

4. a Qualified Beneficiary first becomes enrolled under Medicare (Part A, Part B, or both) after electing COBRA.

5. during a disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled.

You must notify the Plan Sponsor in writing within 30 days if, after electing COBRA, a Qualified Beneficiary becomes enrolled under Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied). COBRA continuation coverage will terminate (retroactively, if applicable) as of the date of Medicare enrollment or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the Qualified Beneficiary). The Plan Sponsor will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare enrollment or other group health plan coverage.

If a disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Sponsor of that fact within 30 days after the Social Security Administration's determination. If the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled occurs during a disability extension period, COBRA continuation coverage for all Qualified Beneficiaries will terminate (retroactively, if applicable) as of the first day of the

month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. The Plan Sponsor will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled Qualified Beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Under what circumstances can the maximum coverage period be expanded?")

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Individual not receiving COBRA continuation coverage (such as fraud).

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

DOES A QUALIFIED BENEFICIARY HAVE A DUTY TO KEEP THE PLAN INFORMED OF ADDRESS CHANGES? In order to protect your family's rights, you should keep the Plan Sponsor and the Plan's Claims Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Sponsor and the Plan's Claims Administrator.

YOU MUST GIVE NOTICE OF CERTAIN QUALIFYING EVENTS
If you or your Dependent(s) experience any of the following Qualifying Events, you or your Dependent(s) must notify the Plan Sponsor within 60 calendar days after the later of the date the Qualifying Event occurs or the date coverage would end as a result of the Qualifying Event:

- your divorce or Legal Separation.
- your child no longer qualifies as a Dependent under the Plan.
- the occurrence of a second Qualifying Event as described in "Second Qualifying Event extension of COBRA continuation coverage" (this notice must be received prior to the end of the initial 18-month or 29-month COBRA period). See "Disability extension of COBRA continuation coverage" for additional notice requirements.

Notice must be made in writing and must include: the name of the Plan; name and address of the Covered Employee; covered under the Plan; name and address(es) of the Qualified Beneficiaries affected by the Qualifying Event; the Qualifying Event; the date the Qualifying Event occurred; and supporting documentation (e.g. divorce decree, birth certificate, disability determination, etc.).

IMPORTANT: **Failure to provide timely notification to the Plan Sponsor will eliminate the right to election COBRA continuation coverage.**

QUESTIONS? If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

CONTACTS: You may obtain information about COBRA continuation coverage upon request from:

1. **The Plan Sponsor:**

   40 Square Health Plan
   8011 34th Avenue South, Suite 148
   Bloomington, MN 55425
   Phone number: 1-844-205-9579

2. **COBRA Administrator:**

   COBRA/Eligibility Department
   EBSO, Inc.
   2145 Ford Parkway, Suite 200
   St. Paul, Minnesota 55116-1912
   Phone number: 651-695-2500 or 1-800-486-7664
   Fax number: 651-695-1648

The contact information for the Plan may change from time to time. You will be notified of any such changes.

USERRA CONTINUATION AND REINSTATEMENT PROVISION

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended, requires all employers to offer certain employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health benefits coverage at group rates where the health benefit coverage under a group health plan would otherwise end because of the employee's service in the uniformed services. Notwithstanding any provision of this Plan to the contrary, the Plan shall be operated and maintained in a manner consistent with USERRA, to the extent a Participating Employer is subject to such law and to the extent a Covered Individual is entitled to protections provided by such law.

This Section is intended to inform Covered Individual, in summary fashion, of their rights and obligations under USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe your continuation coverage rights. The Plan Administrator has developed additional policies regarding the provision of continuation coverage under the Plan.

More Information: The Plan Administrator has contracted with a third party to provide assistance with administering its USERRA obligations. All questions, notices, and other communication regarding USERRA should be directed to:

EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, MN 55116-1912
651-695-2500 or 1-800-486-7664

Each person covered under the Plan should read this provision carefully.

Continuation

A Covered Individual who:

1. Is employed by the Participating Employer;

2. Is determined by the Participating Employer to be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);

3. Is absent from his/her position of employment with the Participating Employer by reason of service in the uniformed services; and

4. Would otherwise have his/her coverage under the Plan terminated.

A Covered Individual may elect to continue the coverage under the Plan for the Covered Individual and his/her Covered Dependents had prior to such absence for a period not to exceed the lesser of:

1. The twenty-four (24) month period beginning on the date on which the Covered Individual's absence begins; or

2. The day after the date on which the Covered Individual fails to apply for or return to a position of employment as specified by the Participating Employer.

Service in the Uniformed Services. Service in the uniformed services generally means the voluntary or involuntary performance of duties in the uniformed services. The "uniformed services" include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

Termination of the USERRA Continuation. The continuation coverage under this section may be terminated for any of the following reasons:

- the Participating Employer no longer provides group health coverage to any of its employees;
- the premium for the continuation coverage is not paid on time (including the grace period);
- your failure to return from service or apply for a position of employment as required under USERRA; or
- termination for cause under the generally applicable terms of the Plan

Reinstatement

Upon re-employment, coverage under the Plan will be reinstated for a person who was absent from his/her position of employment with the Participating Employer by reason of service in the uniformed services, as well as for his/her eligible Dependents who were Covered Individuals under the Plan at the time the absence began provided that:

1. The person was a Covered Individual under the Plan until the time his/her absence from employment with the Participating Employer commenced by reason of service in the uniformed services;

2. The person makes application for re-employment within the time limit specified by the Participating Employer; and

3. At the time the person makes application for re-employment, he/she is entitled to benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

In such instances, any exclusion of the Plan or waiting period will not be applied, if that exclusion of the Plan or waiting period would not have been applied had coverage not been terminated as a result of service in the uniformed services. This also applies to any eligible Dependent of the Covered Individual who becomes covered by the Plan as a result of such reinstatement of coverage.

An exclusion or waiting period may be imposed for any Injury or Sickness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

GENERAL LIMITATIONS AND EXCLUSIONS

This Section of the Plan lists the general exclusions and limitations on benefits under this Plan. They apply ***in addition*** to any specific limitations and exclusions reflected in the particular descriptions of Covered Expenses. The items or situations listed should be read together with the description of a Covered Expense and the Schedule of Coverage for the coverage option under which the Covered Individual is covered.

The Plan does not pay expenses for the following, ***UNLESS*** specifically stated as Covered Expenses elsewhere in this Plan Document:

1. **Abortions.** Elective abortions; however, complications of an elective abortion are eligible for benefits.

2. **Absence from Hospital.** Charges made by a Hospital for a period of time when a registered bed patient is absent from the Hospital (e.g., weekend passes).

3. **After the Termination Date.** Charges Incurred after the Covered Individual's termination of coverage under the Plan.

4. **Alternative Care.** Any service or supply not generally accepted in medical practice in the United States as necessary and appropriate for the diagnosis or treatment of the condition of the patient. For example, the following services shall be considered unaccepted charges for the purposes of this Plan, except as specifically described as part of a Covered Expense:

    a. Aroma therapy;

    b. Bioenergetic therapy;

    c. Biofeedback;

    d. Carbon dioxide therapy;

    e. Chelation therapy (unless due to heavy metal poisoning);

    f. Megavitamin therapy;

    g. Nutritional based therapy;

    h. Primal therapy;

    i. Psychodrama;

    j. Rolfing;

    k. Vision perception training.

5. **Athletic/Health Clubs.** Charges for enrollment in an athletic, a health or similar club.

6. **Claim Forms.** Expenses for completion of claim forms or for preparation of medical reports; for missed appointments; or for telephone consultations, except as stated otherwise in Plan.

7. **Cosmetic.** Cosmetic Procedures for beautifying purposes unless reconstructive Surgery is necessitated by an accidental Injury or Sickness, or Surgery is needed to restore normal bodily function due to a birth defect.

8. **Court-Ordered Care.** Charges for health care ordered by the court (i.e. court ordered rehabilitative treatment or services).

9. **Criminal Activities.** Charges Incurred for treatment of an Injury or Sickness sustained while the Covered Individual is participating in an illegal occupation; commission of, or an attempt to commit any crimes (a felony or otherwise); or voluntary participation in a riot, insurrection or civil disobedience.

10. **Custodial Care.** Custodial Care or domiciliary care, rest cures, convalescent care, a place for the aged or a nursing home.

11. **Dental Care.** Dental care (***except*** for any dental procedures specified as a Covered Expenses).

12. **Environmental Change.** Inpatient confinement, when such confinement is primarily for environmental change or rest.

13. **Excess of Maximum Benefit.** Charges in excess of any maximum benefit stated in the Plan.

14. **Excess of Usual, Customary and Reasonable Fee.** Expenses in excess of the Usual, Customary and Reasonable Fee.

15. **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, or occupational, or physical therapy, specifically covered by this Plan.

16. **Experimental.** Charges for services and supplies, which are Experimental/Investigational/Investigative. This exclusion does not apply to covered Routine Patient Costs incurred by a Covered Individual who participates in an Approved Clinical Trial.

17. **Foot Care.** Charges related to the following conditions:

    a. Weak, unstable or flat feet, bunions, unless an open cutting operation is performed;

    b. Treatment of corns, calluses or toenails, unless at least part of the nail matrix is removed. This does **NOT** apply when treatment is Medically Necessary due to diabetes or peripheral vascular disease;

    c. The purchase of arch supports, orthopedic shoes or other devices for support of the feet.

    NOTE: Foot orthotics are generally a Covered Expense.

18. **Genetic Counseling.** Counseling or testing concerning inherited (genetic) disorders when no symptoms are present, ***unless*** specifically described as part of a Covered Expenses. This exclusion does ***not*** apply when services are Medically Necessary as stated by a Physician during the course of a high-risk pregnancy, or BRCA risk

assessment and genetic counseling/testing requirement of the women's preventive care mandate of the ACA.

19. **Government.** Expenses Incurred by a Covered Individual that may be covered or reimbursed by any public program, or by any national, state, provincial, county, or local government or any other political subdivision, instrumentality or agency thereof, except Medicare and Medicaid.

20. **Government Operated Facilities** - Services furnished to the Covered Individual in any veteran's Hospital, military Hospital, institution or facility operated by the United States Government, by any state government, by any agency or instrumentality of such government, or any foreign government agency, for which the Covered Individual has no legal obligation to pay for services rendered or expenses Incurred, ***except*** services Incurred and billed for non-service related conditions or for care or service furnished by a tax supported state Hospital for treatment of Mental/Nervous Disorders.

21. **Hair Loss.** Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

22. **Hair Pieces.** Wigs, except as specifically described as part of a Covered Expense, toupees and hair replacement therapy.

23. **Hearing Aids.** Hearing aids or any related charges, except as specifically described as part of a Covered Expense.

24. **Hospital Employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service.

25. **Hypnotism.** Expenses for hypnotism.

26. **Immediate Family.** Services performed by a person who is a member of the Covered Individual's Immediate Family or who resides in the Covered Individual's home.

27. **Infertility.** Charges related to, or in connection with, fertility testing and studies, sterility testing and studies, consultations, examinations, medications and procedures to restore or enhance fertility including, but not limited to, artificial insemination, in vitro fertilization and embryo transfers.

28. **Inpatient Diagnostic Services, Therapy or Observation.** Charges for Hospital room and board and general nursing care when the Covered Individual is admitted primarily for therapy services, diagnostic study or medical observation provided the necessary care can properly be provided on an Outpatient basis.

29. **Marriage Counseling.** Charges for marriage counseling.

30. **Massage Therapy**. Charges for massage therapy, ***unless*** specifically described as part of a Covered Expense.

31. **No Legal Obligation.** Expenses for which the Covered Individual has no legal obligation to pay or for an expense which would not have been Incurred if the person did not have coverage under this Plan.

32. **Not Medically Necessary.** Expenses, of any kind, that are not in connection with, or are not Medically Necessary for, the treatment of a Sickness or Injury, ***unless*** specifically described as part of a Covered Expense.

33. **Not Recommended.** For any service or supply which is not recommended or approved by a Physician.

34. **Participating Employer Facilities** - Services and supplies provided through a medical department, clinic or other facility provided by or maintained by the Covered Individual's Participating Employer for the exclusive use of that Participating Employer's employees, or a medical clinic or similar facility for which services or supplies are or should be available without charge to the Covered Individual.

35. **Patient Education.** Services or supplies for education or training (this exclusion does **NOT** apply to diabetic self-management education programs); developmental, educational, scholastic or vocational services or training including, but not limited to, treatment for scholastic improvement, vocational training, visual coordination, motor coordination, and special education for the learning disabled.

> **NOTE**: This does ***not*** apply to Medically Necessary therapy as specified as a Covered Expense.

36. **Personal Convenience Items.** Telephone, television, radio, guest trays, personal hygiene or convenience items (other than Hospital admission kits), take-home drugs following discharge from a Hospital, air conditioners, air purifiers, physical exercise equipment, and similar items.

37. **Prescription Drugs.** Unless stated otherwise, medications and vitamins which may be purchased without a Physician's written prescription (over-the-counter medications), and food supplements. Drugs, biologicals and solutions not listed in the latest edition of the United States Pharmacopoeia, the National Formulary or the New and Non-Official drugs. Prescription drugs received on an Outpatient basis are limited to the benefits specifically described under the Prescription Drug Benefit.

38. **Prior to Effective Date.** Charges Incurred prior to a Covered Individual's Effective Date under this Plan.

39. **Reversal of Sterilization.** Charges for reversal of a sterilization procedure.

40. **Safety/Sport Related Items –** Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, diversion therapy, work hardening, or general motivation.

41. **Sexual Dysfunctions.** Charges for therapy, supplies or counseling for sexual dysfunctions or inadequacies, except when organic in nature.

42. **Smoking Cessation.** ***Except*** as specifically described as part of a Covered Expense, charges for services, supplies and for smoking cessation programs, or charges related to the treatment of nicotine addiction, including smoking deterrent patches.

43. **Taxes.** Charges for taxes or surcharges, other than those that a medical facility is legally required to make.

44. **Transsexual Surgery.** Charges Incurred for transsexual Surgery and for any treatment leading to or in connection with sexual transformation.

45. **Travel.** Travel or accommodations for health, whether or not recommended by a Physician. Charges Incurred outside the United States if the Covered Individual traveled to such location for the sole purpose of obtaining medical services, drugs or supplies.

46. **Unlicensed Providers.** Any services rendered by unlicensed/uncertified providers, if a license or certificate is required by law where the services are rendered, or services that are outside the scope of the license of a provider.

47. **Vision.** Expenses for eyeglasses, contact lenses, or for the fitting or examination of such, unless required due to intraocular Surgery or Injury to the eye or specifically described as a part of a Covered Expense. Charges for confinement, treatment, service or materials for Kerato-Refractive Eye Surgery (defined as Surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea including, but not limited to, radial keratotomy and keratomileusis Surgery) or LASIK Surgery.

48. **War/Military Service.** Services or supplies Incurred due to an Injury or Sickness caused by war or an act of war (whether declared or undeclared), nuclear explosion or nuclear accident or major nuclear disaster, or service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared.

49. **Weekend Admission.** Initial Friday, Saturday and Sunday room and board charges Incurred for a Hospital stay which begins on Friday, Saturday or Sunday. This exclusion does not apply to Emergency admissions, pregnancy or scheduled Surgery within the 24-hour period immediately following Hospital admission.

50. **Weight Loss.** ***Except*** as specifically described as part of a Covered Expense, services or supplies rendered for weight reduction by diet control; Surgery to aid in weight reduction or complications of such Surgery; ***including*** when Incurred due to Morbid Obesity.

51. **Worker's Compensation.** Expenses due to a work-related Injury or Sickness sustained while doing anything pertaining to any occupation or employment for remuneration or profit for which all or part of the expense is payable by workers' compensation or similar law.

Notwithstanding the above limitations and exclusions, the Plan will not deny benefits for Covered Expenses for treatment of an Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

INPATIENT ADMISSIONS AND OUTPATIENT SURGERY AUTHORIZATION

NOTE: Obtaining proper authorization does not guarantee payment of expenses by the Plan. Expenses must still be Covered Expenses and all other provisions (e.g., Deductible, Copayment Percentage, Copay, limitations, maximums, etc.) still apply.

Authorization is required for all Inpatient Admissions. For Inpatient Authorization call EBSO Review at 1-800-426-9317 within 2 business days after the Hospital admission. As part of Inpatient Authorization, please be prepared to supply the following basic information:

1. Covered Individual's name and date of birth;
2. Covered Employee's name, address and phone number;
3. Physician's name and phone number;
4. Name of the facility;
5. Reason for the admission;
6. Date the admission starts (or started); and
7. Participating Employer's I.D. Number.

Authorization is required for the following Outpatient Surgeries:

- Biopsies (excluding skin)
- Vascular Access Devices for the Infusion of Chemotherapy (e.g. PICC and Central Lines)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Creation and Revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for Dialysis
- Oophorectomy, unilateral and bilateral
- Back Surgeries and hardware related to surgery
- Osteochondral Allograft, knee
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Sleep apnea related surgeries, limited to:
    - Radiofrequency ablation (Coblation, Somnoplasty)
    - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Potentially Cosmetic Procedures, including but not limited to:
    - Abdominoplasty
    - Blepharoplasty
    - Cervicoplasty (neck lift)
    - Facial skin lesions (Photo therapy, laser therapy - excluding MOHS)

- Hernia repair, abdominal and incisional (only when associated with a cosmetic procedure)
- IDET (thermal intradiscal procedures)
- Liposuction/lipectomy
- Mammoplasty, augmentation and reduction (including removal of implant)
- Mastectomy (including gynecomastia and prophylactic)
- Morbid obesity procedures
- Orthognathic procedures (e.g. Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Otoplasty
- Panniculectomy
- Rhinoplasty
- Rhytidectomy
- Scar revisions
- Septoplasty
- Varicose vein surgery/sclerotherapy

For Outpatient Surgery Authorization, call EBSO Review at 1-800-426-9317 within 2 business two days after the Outpatient Surgery. As part of the Outpatient Surgery Authorization, please be prepared to supply the following basic information:

1. Covered Individual's name and date of birth;
2. Covered Employee's name, address and phone number;
3. Physician's name and phone number;
4. Name of facility;
5. Reason for the procedure;
6. Date of the procedure; and
7. Participating Employer's I.D. Number.

APPLICABLE PENALTY: The penalty for non-compliance with this provision is described in the Schedule of Coverage for the coverage option under which the Covered Individual is covered.

NOTE: Amounts paid as a penalty are not Covered Services under this Plan. No cost sharing provisions apply (e.g., Deductible, Copay, Copayment Percentage, or Out-of-Pocket Maximum).

Imposition of the penalty is treated as a denied claim for Medical Benefits.

CLAIMS AUDIT/MEDICAL RECORD REVIEW

In accordance with the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to conduct a bill review and/or claim audit for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

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

COMPREHENSIVE MAJOR MEDICAL BENEFITS

IMPORTANT: Unless specifically stated otherwise, the Covered Expenses described below are subject to the

- Deductible
- Copayment Percentages
- Copay
- Maximum payment amounts shown in the Schedule of Coverage for the coverage option under which the Covered Individual is covered
- Usual Customary and Reasonable fee limitation
- General exclusions and limitations
- All other provisions of the Plan

All expenses must be Covered Expenses, Incurred as the result of an Injury or Sickness, and recommended by a Physician as Medically Necessary, unless specifically stated otherwise.

Obstetrics and Gynecology. You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals specializing in obstetrics or gynecology, contact your PPO. The website and telephone number are listed on the back of your ID card.

COVERED EXPENSES

Schedule of Coverage. The descriptions of Covered Expenses in this Section should be read together with the Schedule of Coverage for the coverage option under which the Covered Individual is covered, and other provisions of this Plan.

1. **Acupuncture.** Charges for or in connection with acupuncture or acupressure treatments, including those services which are performed in-lieu of anesthesia administered in conjunction with a covered Surgery.

2. **Allergy Testing, Injections and Serum.** Allergy testing, injections and serum when rendered by a Physician or Health Care Professional.

3. **Ambulance Services.** Emergency transportation by local professional ground or air ambulance service:

   a. From the Covered Individual's home, scene of accident or medical Emergency to a Hospital; or

   b. Between Hospitals and/or Skilled Nursing Facility.

   Transportation is limited to the nearest facility equipped to treat the condition.

4. **Anesthetics.** Anesthetics and their administration when rendered in connection with an eligible surgical procedure and when administered by an anesthetist, anesthesiologist, Physician or by a registered nurse (under supervision of a Physician).

5. **Birthing Centers.** Charges made by a Birthing Center are covered on the same basis as if the charges had been made by a general Hospital.

6. **Blood Services.** Blood services, including whole blood, blood components, and blood processing administration. The Plan does not pay for the whole blood or blood components when donated or otherwise replaced by or on behalf of the patient.

7. **Chiropractic Care.** Includes x-rays, manipulations and supportive care. Supportive care means treatment, which is Medically Necessary to prevent the Covered Individual's condition from significantly deteriorating. Maintenance care is routine and is not Medically Necessary for the treatment of a condition. Maintenance care is ***NOT*** covered by the Plan.

8. **Circumcisions.** Circumcisions (including routine circumcisions) and the related charges for all male Covered Individuals.

9. **Clinical Trial Routine Patient Costs** incurred by a Qualified Individual (defined below) who participates in an Approved Clinical Trial (defined below). If a Covered Individual is covered under a PPO option, as shown on the Schedule of Coverage, a Qualified Individual who wishes to participate in an Approved Clinical Trial must use a PPO provider if a PPO provider is participating in the trial and the PPO provider accepts the Qualified Individual as a participant in the trial. However, if a Covered Individual is covered under a PPO option, and the Approved Clinical Trial is either conducted outside the state in which the Qualified Individual resides by a Non-PPO provider or there is no PPO provider conducting the Approved Clinical Trial and accepting the Qualified Individual in the individual's state of residence, then Routine Patient Costs (defined below) will be covered as if provided by a PPO provider.

   For the purpose of this category of Covered Expenses, the following definitions apply:

   Approved Clinical Trial means a phase I, phase II, phase III, or phase IV Clinical Trial that is (1) conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition (defined below) and (2) is one of the following:

   a. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
      i. The National Institutes of Health.
      ii. The Centers for Disease Control and Prevention.
      iii. The Agency for Health Care Research and Quality.
      iv. The Centers for Medicare & Medicaid Services.
      v. A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses i) through iv) above or the Department of Defense or the Department of Veterans Affairs.
      vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
      vii. Any of the following in clauses a. – c. below if the following conditions are met: The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
         a) The Department of Veterans Affairs
         b) The Department of Defense

c) The Department of Energy; or

b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

c. The study or investigation is a drug trial that is exempt from the investigational new drug application requirements.

Life-threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualified Individual means a Covered Individual who meets the following conditions:

a. The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening diseases or conditions.

b. Either:
   i. The referring health care provider has concluded that the Covered Individual's participation in the Clinical Trial would be appropriate based upon the Covered Individual meeting the conditions described in paragraph a. above; or
   ii. The Covered Individual provides medical and scientific information establishing that participation in such trial would be appropriate based upon the Covered Individual meeting the conditions described in paragraph a. above.

Routine Patient Costs means all items and services that are typically covered by the Plan for a Qualified Individual who is not enrolled in an Approved Clinical Trial. Routine Patient Costs do not include:

a. The investigational item, device, or service, itself;

b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

10. **Dental Services.** Expenses related to dental services for:

a. Treatment to sound natural teeth required due to an accidental Injury, other than those caused by chewing food or similar substances. Treatment includes replacement of such teeth or setting a jaw fractured or dislocated in an accidental Injury.

b. Exposure or extraction of impacted teeth.

c. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

d. Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

e. Excision of benign bony growths of the jaw and hard palate.

f. External incision and drainage of cellulitis.

g. Incision of sensory sinuses, salivary glands or ducts.

h. Reduction of dislocations and excision of temporomandibular joints.

i. Apicoectomy – excision of apex of tooth root.

j. Gingivectomy or mucogingival osseous Surgery – excision of loose gum tissue to eliminate infection.

k. Alveoplasty – the leveling of structures supporting teeth for the purpose of fitting dentures.

l. Frenectomy.

m. Root canal therapy if performed in conjunction with an apicoectomy.

n. Orthognathic Surgery, ***LIMITED*** to one Surgery per lifetime of the Covered Individual.

o. Functional osteotomies.

p. Hospital services, supplies and any related services rendered on an Outpatient basis when the procedure or the Covered Individual's condition requires a Hospital setting.

11. **Diabetic Education.** Diabetic education and training for self-management programs for Covered Individuals with diabetes.

12. **Dialysis services.** Charges for kidney dialysis, wherever performed. Charges for supplies and rental of dialysis equipment for home dialysis. This does ***NOT*** include charges for set-up or for furniture.

13. **Hearing Aids.** Coverage includes only external hearing aids for Covered Individuals 18-year-old and younger who have hearing loss that is not correctible by other Covered Services. Limited to one hearing aid for each ear every three years.

14. **Home Health Care Services/Home Health Care Agency.** Charges made by a Home Health Care Agency for services rendered to a Covered Individual due to an Injury or Sickness. Eligible Home Health Care Services begin on the day of initial treatment by a Home Health Care Agency. No amount will be payable for Home Health Care Services unless the following conditions are met:

    a. Continued confinement in a Hospital or Skilled Nursing Facility would have been required if Home Health Care had not been available;

    b. The care at home is Medically Necessary and is not primarily for Custodial Care;

    c. The treatment at home is for the same illness or related condition that made the Hospital and Skilled Nursing Facility confinement necessary;

d. A Physician must have given a written order for Home Health Care Services.

Eligible “Home Health Covered Services” shall consist of:

a. Part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN);

b. Part-time or intermittent services of a home health aide;

c. Physical, occupational or speech therapy;

d. Dietary guidance; and

e. Medical supplies, medical appliances, medical equipment, drugs and/or medications prescribed by the attending Physician. These services may be provided on an Outpatient basis by a Home Health Care Agency, by a Hospital or other facility under an arrangement with a Home Health Care Agency.

Services not covered under this benefit include, but are not limited to, dietitian services, homemaker services, maintenance therapy, dialysis treatment, purchase or rental of dialysis equipment, food or home delivered meals.

Benefits are subject to the limitations set forth in the Schedule of Coverage for the option under which the Covered Individual is covered. A Home Health Care “visit” shall consist of four hours of service provided through the Home Health Care Agency.

15. **Home Infusion Therapy Services.** Charges by a Home Health Care Agency, home infusion company, or infusion suite for Home Infusion Therapy Services for the following:

a. Intravenous chemotherapy;

b. Intravenous antibiotic therapy;

c. Intravenous steroidal therapy;

d. Intravenous pain management;

e. Intravenous hydration therapy;

f. Intravenous antiretroviral and antifungal therapy;

g. Intravenous inotropic therapy;

h. Total parenteral nutrition;

i. Intravenous gamma globulin.

“Home Infusion Therapy Services” mean treatment or service required for the administration of intravenous drugs or solutions, which:

a. Is required as a result of a Sickness or Injury;

b. Prevents, delays, or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility Confinement;

c. Is documented in a written plan of care; and

d. Is prescribed by the attending Physician.

The Home Infusion Therapy Services must be rendered in accordance with a prescribed written plan of care. The written plan of care must be set up prior to the initiation of the Home Infusion Therapy Services and be prescribed by the attending Physician.

Covered charges are limited to drugs; intravenous solutions; Durable Medical Equipment; pharmacy compounding and dispensing services; fees associated with drawing blood for the purpose of monitoring response to therapy; ancillary medical supplies; nursing services for intravenous restarts and dressing changes; and nursing services required due to an Emergency.

"Home Infusion Therapy Services" do not include charges for:

a. Services or supplies for any nursing visits, care or services associated with Home Infusion Therapy Services other than those identified in this Section; or

b. Services or supplies for other services required to administer therapy in the home setting, but which do not involve direct patient contact, including, but not limited to, delivery charges and record keeping.

16. **Hospice Care.** Charges made for hospice care when performed as part of a hospice program are included as Covered Expenses. For purposes of this category of Covered Expenses, "hospice care" is care rendered to a Terminally Ill Covered Individual by or under arrangements with a Hospice Agency.

Covered charges by a hospice facility, Hospital, convalescent facility or Hospice Agency include:

a. Room and board and services/supplies furnished to a Covered Individual while an Inpatient for pain control and other acute and chronic symptom management; and

b. The following services and supplies furnished to a Covered Individual while not confined as an Inpatient.

i. Part-time or intermittent nursing care by a registered nurse (RN), licensed practical nurse (LPN) or home health aide for up to 8 hours in any day.

ii. Medical social services provided to the hospice patient and his/her Immediate Family:

a) Assessment of the Covered Individual's social, emotional and medical needs, and the home and family situation.

b) Identification of the community resources which are available.

c) Assisting the Covered Individual in obtaining those resources needed to meet his/her assessed needs.

d) Psychological and dietary counseling.

e) Consultation or case management services by a Physician.

f) Physical and occupational therapy.

g) Medical supplies, drugs, and medicines prescribed by a Physician.

h) Bereavement counseling provided by a licensed social worker or a licensed pastoral counselor. Benefits are subject to the limitations set forth in the Schedule of Coverage for the option under which the Covered Individual is covered.

i) Respite care, which is care furnished during a period of time when the Covered Individual's family or usual caretaker cannot, or will not, attend to the Covered Individual's needs.

Covered charges do not included charges made for:

a. Funeral arrangements.

b. Financial or legal counseling which includes estate planning or the drafting of a will.

c. Homemaker or caretaker services which are not solely related to care of the Covered Individual, including sitter or companion services for either the Covered Individual who is ill or other members of the family, transportation, housecleaning and maintenance of the house.

d. Pastoral counseling.

17. **Inpatient Hospital Services.** Hospital charges for Hospital Miscellaneous Expenses, wards, semi-private rooms, Intensive Care Units, nursery rooms for newborn sick and well babies, and private rooms, (provided such confinement is Medically Necessary for the Covered Individual's condition or provided the Hospital ***ONLY*** has private rooms). If private room confinement is not Medically Necessary for the Covered Individual's condition, the Plan considers as a Covered Expense an amount equal to the Hospital's semi-private room rate. If the Hospital only has private rooms, the Plan considers as a Covered Expense an amount equal to the Hospital's least expensive room rate.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a 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). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

NOTE: When the delivery is outside of the Hospital, the minimum period of Hospital stay begins when the mother or newborn is admitted. The attending Physician will determine

whether an admission is in connection with childbirth, and thereby eligible for the minimum length of stay.

18. **Maternity Care.** Maternity Care including Outpatient facility services and Physician medical and surgical services (including office visits) for normal pregnancy, miscarriage, and complications of pregnancy.

This benefit is available to all Covered Individuals. Additional benefits may be covered under Preventive Care benefits and are available to all Covered Individuals.

NOTE: Charges Incurred for maternity Inpatient admissions are payable under the Inpatient Hospital Services category of Covered Expenses.

This category of Covered Expenses includes the services of a certified Nurse-Midwife for care performed under the direction and supervision of a licensed Physician. The supervising Physician shall be identified and the cost of supervision is a reimbursable expense. Total fees cannot exceed the fee the Physician would have charged had the Physician provided the entire service.

19. **Medical Supplies. "**Medical supplies" include:

a. Supplies customarily provided by prescription and Medically Necessary for the treatment of a Sickness or Injury including, but not limited to, needles, syringes, surgical dressings, casts, splints, trusses, colostomy bags, catheters, and other similar items which serve only a medical purpose, unless covered under the Prescription Drug Benefit. Items usually stocked in the home for general use, such as adhesive bandages, petroleum jelly and thermometers are not Covered Expenses.

b. Oxygen and other gases including rental of equipment for their administration.

c. The purchase, fitting, adjustments and repairs of prosthetic devices and supplies that:

i. Replace all or part of a missing body part and its adjoining tissues;

ii. Aid in the function of a malfunctioning body part.

Repair or replacement of the above will be covered only if it is shown that the repair or replacement is due to a change in the Covered Individual's physical condition or it is less costly to buy a replacement than to repair the existing prosthesis.

d. **Orthopedic braces and/or crutches**.

e. **Orthotics,** including foot orthotics.

f. **Durable Medical Equipment**. Rental (not to exceed the purchase price) or purchase (at the Plan's option) of Durable Medical Equipment. Covered Expenses for Durable Medical Equipment which are prescribed by a Physician will be covered while the Covered Individual is receiving medical care. Covered Expenses are limited to the least expensive item, which is adequate for the Covered Individual's needs. Repairs of purchased equipment are covered when

needed to restore proper function. Replacements are covered only when an item cannot be repaired to a serviceable condition.

g. Medically Necessary **supplies used with covered medical equipment**.

h. **Mechanical medical devices** placed in a body cavity to replace an internal organ or to aid the function of a body part including, but not limited to, pacemakers, artificial larynx, artificial hips and artificial knees.

i. The **first purchase of glasses or contacts** for aphakia, keratoconus or **following cataract Surgery**.

j. **Diabetic supplies** (i.e., insulin, insulin syringes/needles, test tape and chemstrips), including **insulin infusion pumps**, only to the extent that these items are not covered under the Prescription Drug Benefit.

20. **Mental/Nervous Disorders and/or Substance Abuse.** Charges for the treatment of Mental/Nervous Disorders and/or Substance Abuse when recommended by or under the clinical supervision of a licensed Physician or a licensed psychologist. Such treatment must be recognized as appropriate in accordance with broadly accepted standards of medical practice.

Eligible Inpatient Services: Room & board and miscellaneous charges. Medical services including individual and group psychotherapy, psychological testing, family counseling, and convulsive therapy.

Day Hospitalization is payable under this Plan.

Eligible Outpatient Services: Medical services including individual and group psychotherapy, psychological testing, family counseling, and charges by an approved treatment facility.

21. **Eligible Organ/Tissue Transplant services. For purposes of this category of Covered Expenses,** "organ/tissue transplant service" means any of the following services, which are Medically Necessary, and rendered to a Covered Individual as such services relate to an Eligible Organ/Tissue Transplant:

a. Organ/tissue procurement (including typing and acquisition);

b. Medical supplies/services and room and board in a Hospital or in an alternate treatment setting approved by the Plan; and

c. Drugs and Physician charges.

Donor Expenses:

If a transplant operation is determined to be an Eligible Organ/Tissue Transplant, expenses Incurred by a **donor** will be treated as Covered Expenses under this Plan as follows:

a. if the donor is not a Covered Individual, but donates to a Covered Individual, this Plan will be secondary to any other plan under which the donor is entitled to benefits for these expenses.

b. if the donor is covered by this Plan, but the recipient is not covered by this Plan, the recipient's plan will be primary for the donor's expenses and this Plan will be secondary. ***THE RECIPIENT IS NOT ENTITLED TO BENEFITS UNDER THIS PLAN UNLESS HE/SHE IS A COVERED INDIVIDUAL.***

c. if both the donor and the recipient are covered by this Plan, all Covered Expenses Incurred by both the donor and the recipient will be paid as part of the recipient's claim.

If any organ or tissue is sold, rather than donated, to a recipient, no benefits are payable for the purchase price of such organ or tissue. However, the costs related to the evaluation and procurement of the organ or tissue are Covered Expenses for the recipient.

22. **Outpatient Facility Services.** Services and supplies received in connection with treatment rendered in the Outpatient department of a Hospital, Urgent Care Center, emergency room, emergency care clinic or Ambulatory Surgical Center.

23. **Physicians' Services.** The following services and supplies when performed by a Physician or any other properly licensed/certified Health Care Professional, while acting within the scope of his/her license/certificate, are considered Covered Expenses:

a. Charges for visits made by a Physician to a Covered Individual while confined as an **Inpatient in a covered medical facility**. Consultations when requested by the attending Physician, limited to one consultation per day per specialist. This includes routine pediatric examinations of a newborn sick or well baby.

b. Charges made by a Physician, for **Hospital Outpatient services, office visits or home visits for diagnosis and treatment of a specific Injury or Sickness**, including voluntary second or third surgical opinions; immunizations and injections of medication (including the medication) related to a covered Injury or Sickness. Charges made by a Physician for Web Based Care (Online - e-visits and telephone consultations.

c. **Surgical Services.** Charges for Surgery when performed in a Hospital, Outpatient department of a Hospital, Ambulatory Surgical Center, Physician's office or clinic.

For documented multiple surgical procedures the Plan shall cover the greater surgical procedure at 100% of the Usual, Customary and Reasonable Fee and 50% of the Usual, Customary and Reasonable Fee for each lesser procedure during the same operative session.

NOTE: Charges for the treatment of separate and distinct fractures and surgeries that require the skills of two or more surgeons who have different specialties and when each performs a separate operation are covered at 100% of the Usual, Customary and Reasonable Fee.

Covered Expenses include Hospital pre-operative and post-operative care. Covered Expenses for specific surgical services include the following:

i. **Cosmetic Procedures** required as a result of an accidental Injury.

ii. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a **Mastectomy**. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, the Covered Individual is being provided this notice to inform him or her about these provisions. The law mandates that individuals receiving benefits for a **Medically Necessary Mastectomy** will also receive coverage for:

(a) Reconstruction of the breast on which the Mastectomy has been performed.
(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance.
(c) Prostheses and physical complications from all stages of Mastectomy, including lymphedemas.

in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with the Covered Individual and his or her attending Physician.

iii. **Functional repair** or restoration of any body part when Medically Necessary to achieve normal body function.

iv. **Assistant surgeon** charges.

v. **Abortion procedures** for a Covered Individual when the pregnancy is considered a life threatening complication of a non-psychiatric, medical condition.

vi. **Voluntary sterilizations**, including all related charges, for all Covered Individuals.

For purposes of this category of Covered Expenses, the word "visit" means a personal interview between the Covered Individual and a Physician.

24. **Preventive Care Services.** Covered Expenses include expenses for Preventive Care. Covered Expenses for Preventive Care include routine physical exams (including the related office visit) and the following services:

a. PSA tests, annual diabetic eye exam, hearing screenings, vision screenings which are limited to screening tests (i.e., Snellen eye chart) and Ocular Photo screenings.
b. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

c. Immunizations that have in effect a recommendation for the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Individual involved;
d. With respect to Covered Individuals who are infants, children, and adolescents, evidence –informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
e. With respect to Covered Individuals who are women,
    i. Well women visits: one per year for an adult woman to obtain the recommended preventive services that are age appropriate and developmentally appropriate, including preconception and prenatal care. This also includes women's preventive services (i.e., mammograms, pap smears, USPSTF A & B rated services; immunizations);
    ii. Screening for gestational diabetes: one screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be high risk for diabetes;
    iii. Human papillomavirus DNA testing: one screening for women 30 years and older and no more frequently than once every 3 years;
    iv. Counseling for sexually transmitted infections: one counseling session per year;
    v. Counseling and screening for human immune-deficiency virus: one counseling and screening per year;
    vi. Breastfeeding support, supplies and counseling in conjunction with each birth: coverage includes comprehensive lactation support and counseling during pregnancy and/or in the postpartum period. Also includes the costs of rental of breastfeeding equipment;
    vii. Domestic violence screening and counseling: one screening and counseling for interpersonal and domestic violence per year; and
    viii. FDA-approved prescription contraceptive drugs and devices, unless covered under the Prescription Drug Benefit, contraceptive counseling, sterilization procedures, and patient education and counseling. This benefit includes the related office visits. Abortifacient drugs are not covered.

    More than one visit may be needed to obtain all the recommended preventive screening services, depending on a woman's health status, health needs and other risk factors. Additional well-woman visits will be covered if the doctor determines they are necessary to help establish what preventive screening services are appropriate and to set up a plan to help the woman get the care she will need to be healthy.

For preventive screening services, Deductible, Copayment and/or Copayment Percentage cost-sharing requirements may apply to the office visit if (a) the preventive screening service is billed separately from the office visit, or (b) the primary purpose of the office visit is other than the delivery of preventive screening services and the preventive screening service is not billed separately from the office visit.

For preventive screening services, cost-sharing requirements will not be applied to the office visit if (a) the preventive screening service is not billed separately from the office visit, and (b) the primary purpose of the office visit is the delivery of the preventive screening service.

With respect to a recommendation or guideline for recommended preventive screening services or items that does not specify a frequency, method, treatment or setting for the

provision of that service, the Plan may use reasonable medical management to determine any coverage limitations. The Plan may rely on established techniques and the relevant evidence base to determine the frequency, method, treatment, or setting for which a recommended preventive screening service will be covered without cost-sharing requirements to the extent not specified in a recommendation or guideline.

25. **Private Duty Nursing Services.** Charges for services of a nurse, excluding relatives or members of the Covered Individual's Immediate Family, when ordered by the attending Physician, as follows:

    a. In a Hospital, services of a registered nurse (RN), services of a licensed practical nurse (LPN) or licensed vocational nurse (LVN), provided such services cannot be obtained by the regular nursing staff of the Hospital; and

    b. Other than in a Hospital, services of a registered professional nurse (RN). Services of a LVN or LPN are covered if it can be shown that a RN was not available. Outpatient private duty nursing on a 24-hour-shift basis is not covered.

26. **Rehabilitation Facility.** Treatment in a Rehabilitation Facility when the treatment cannot be safely provided on an Outpatient basis. Charges made by an Inpatient Rehabilitation Facility are Covered Expenses on the same basis as if the charges had been made by a general Hospital.

27. **Skilled Nursing Facility.** Charges by a Skilled Nursing Facility for confinement as an alternative to Hospital confinement. Covered Expenses available in a Hospital are available in a Skilled Nursing Facility when prescribed by the attending Physician and the confinement is due to an Injury or Sickness.

    Benefits are available only as long as necessary for the proper care and treatment of the Covered Individual. The Plan may require written certification by the attending Physician as to the continuing need for skilled nursing care.

    Covered Individuals are eligible for benefits under this provision while recovering from a Sickness or Injury requiring services of an intensity less than those available in an acute general Hospital but greater than those available at the Covered Individual's home.

    Benefits are subject to limitations set forth in the Schedule of Coverage for the coverage option under which the Covered Individual is covered.

28. **Surcharges.** Charges for state-imposed surcharges.

    NOTE: If the Plan contains an exclusion for sales tax or other tax, the exclusion shall not be applicable to any surcharges.

29. **Temporomandibular Joint Dysfunction (TMJ)/Myofascial Pain Dysfunction (MPD).** Services and supplies for, or related to, the treatment of Temporomandibular Joint Dysfunction (TMJ)/Myofascial Pain Dysfunction (MPD).

30. **Therapies and/or Treatments.** Fees of a Hospital, Physician or Health Care Professional for services used to promote recovery from a Sickness or Injury for the following therapies and/or treatments:

    a. **Cardiac Rehabilitation.** Charges for clinically supervised exercise designed to strengthen the heart and improve cardiovascular functioning for those who

cannot engage in unsupervised exercise without a clear risk to their health. This benefit will be payable if the following conditions are met:

i. The Covered Individual has had an acute myocardial infarction, coronary bypass Surgery, stable angina pectoris, angioplasty, cardiac valve Surgery, or other major Surgery; and

ii. The Covered Individual starts his cardiac rehabilitation program as soon as possible after the cardiac event.

Custodial Care is ineligible.

b. **Chemotherapy**. The treatment of malignant disease by chemical or biological antineoplastic agents.

c. **Occupational Therapy**. The treatment of a physically disabled Covered Individual by means of constructive activities designed and adapted to promote the restoration of the Covered Individual's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the Covered Individual's particular occupational role.

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational or vocational therapies (such as hobbies, arts and crafts).

d. **Physical Therapy**. The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles, and devices. Such therapy is performed to relieve pain, restore maximum function and to prevent disability following Sickness, Injury or loss of a body part.

e. **Radiation Therapy**. The treatment of disease by x-ray, radium, radon, roentgen or radioactive isotope.

f. **Respiratory or Inhalation Therapy**. The treatment of a condition by the administration of medicines, water vapors, gases or anesthetics by inhalation.

g. **Speech Therapy**. Expenses for speech therapy for restorative or rehabilitative speech therapy for speech loss or impairment due to an Injury or Sickness other than a functional nervous disorder, or due to Surgery performed as the result of an Injury or Sickness. If the speech loss is due to a congenital anomaly, Surgery to correct the anomaly must have been performed prior to the therapy.

31. **Vision Exam.** Charges for Routine vision exam, ***LIMITED*** as shown on the Schedule of Coverage.

32. **Wigs.** Charges for the purchase of a wig or hairpiece for hair loss purposes, provided such hair loss is the result of Alopecia Areata. This does not include the repair or replacement of a wig or hairpiece or maintenance charges (i.e., cleaning and styling).

33. **X-Rays or Laboratory Tests.** X-rays or laboratory tests recommended by a Physician or surgeon for diagnosis of a Sickness or Injury. This includes charges for pre-admission testing.

COST SHARING REQUIREMENTS

Cost sharing amounts (e.g., Deductible, Copayment Percentage, Copay, Out-of-Pocket Maximums) are used to determine the portion of the cost of a Covered Expense – both Medical Benefits and Prescription Drug Benefits - that is the Covered Individual's responsibility for payment and the portion of the cost of a Covered Expense that is the Plan's responsibility for payment.

DEDUCTIBLE PROVISIONS & COPAYMENT PERCENTAGES

A Deductible refers to the amount of Covered Expenses that must be paid by the Covered Individual (or Covered Individuals for family coverage) each Calendar Year before the Plan begins to pay the particular Covered Expenses. Once the applicable Deductible has been met, the Plan pays a portion of Covered Expenses that are subject to the Deductible. The applicable Deductibles and Plan payments are shown in the Schedules of Coverage.

Copayment Percentage. The Copayment Percentage is the portion of the Covered Expenses for which the Covered Individual is responsible following satisfaction of the applicable Deductible. It is not the portion paid by the Plan.

Not all Covered Services are subject to the Deductible. For example, services for Preventive Care are not subject to a Deductible if they are provided by a PPO provider. Covered Services that are not subject to a Deductible are shown in the Schedules of Coverage.

The Deductible amount can only be satisfied by Covered Expenses. The Deductibles are shown in the Schedules of Coverage. The Deductible applies to all Covered Expenses ***UNLESS*** specifically stated otherwise. For example, certain Copays for Prescription Drug Benefits are NOT counted towards satisfaction of the Deductible. Be sure to check the Schedule of Coverage under which the Covered Individual is covered.

Once a family has collectively satisfied the family Deductible amount as shown in the Schedule of Coverage for the option under which the Covered Individuals are covered during a Calendar Year, no further Deductibles will be applied to Covered Expenses for other members of the family that are Covered Individuals for the remainder of the Calendar Year.

The PPO Deductible will ***NOT*** be used to satisfy the Non-PPO Deductible, and vice versa. Covered Expenses provided by PPO providers are subject to, and count towards satisfaction of, the PPO Deductible. Similarly, Covered Expenses provided by Non-PPO providers are subject to, and count towards satisfaction of, the Non-PPO Deductible.

NOTE: Claims may not be received or processed in the same order that a Covered Individual has received service. The Deductible and Copayment Percentage will be applied to Covered Services in the sequence that claims are submitted and processed for payment.

COPAY

Copay refers to the amount, typically a set dollar amount, the Covered Individual must pay for a particular type of Covered Expense regardless of whether the applicable Deductible has been met. For example, the Schedule of Coverage for the $1,500 Deductible Plan shows a Physician's office visit requires a $40 Copay after which the Plan pays 100%. Note also that the Deductible is waived. Copays are not counted for purposes of satisfying applicable Deductibles. Covered Services that are subject to a Copay are shown in the Schedules of Coverage. Copays are different than the Copay Percentage described above.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the maximum amount of Covered Expenses that are payable by the Covered Individual (or Covered Individuals for family coverage), during a Calendar Year. It is comprised of the Deductible amount, Copayment Percentage and Copays. The Out-of-Pocket Maximums are shown in the Schedule of Coverage or the option under which the Covered Individuals are covered. Once the applicable Out-of-Pocket Maximum has been satisfied, the Plan pays 100% of Covered Expenses for the remainder of the Calendar Year.

The family Out-of-Pocket Maximum is the amount contributed toward the Out-of-Pocket Maximum by two or more family members; provided, the amount contributed toward the family Out-of-Pocket Maximum by any one family member cannot be more than the individual Out-of-Pocket Maximum.

The PPO Out-of-Pocket Maximum will ***NOT*** be used to satisfy the Non-PPO Out-of-Pocket Maximum, and vice versa. PPO and Non-PPO Covered Expenses are not combined. Covered Expenses provided by PPO providers subject to the PPO Deductible and Copayment Percentages and Copays attributable to Covered Expenses provided by PPO providers are considered together for purposes of determining when the PPO Out-of-Pocket Maximum has been satisfied. Similarly, Covered Expenses (for Medical Benefits) provided by Non-PPO providers subject to the Non-PPO Deductible and Copayment Percentages and Copays attributable to Covered Expenses provided by Non-PPO providers are considered together for purposes of determining when the Non-PPO Out-of-Pocket Maximum has been satisfied.

The Out-of-Pocket Maximum does ***NOT*** count:

1. Charges Incurred for services and supplies which are not Covered Expenses under the Plan.

2. Charges in excess of the Usual, Customary and Reasonable Fee.

3. Charges Incurred in excess of any maximum benefit listed in the Plan.

4. Any penalty payable by the Covered Individual for non-compliance with the with Plan authorization requirements (e.g., Inpatient Authorization) provision.

PPO LEVEL OF MEDICAL BENEFITS COVERAGE

As shown in the Schedules of Coverage, the Plan pays at the PPO level for Covered Services (for Medical Benefits) provided by PPO providers, and at the Non-PPO level for Covered Services (for Medical Benefits) provided by Non-PPO providers. In general, the PPO level pays a larger portion of the Covered Services (for Medical Benefits). The Plan includes a PPO to offer health care services through specific Physicians, Hospitals and various other providers of services. In order to receive benefits at the PPO level, a Covered Individual must receive treatment from a PPO provider.

Check Providers. PPO providers change from time to time. You should check the status of a provider before receiving services. The Plan has contracted with the PreferredOne Network for providers within Minnesota and with the MultiPlan Network for providers outside of Minnesota. This means you have access to providers in the PreferredOne Network and the MultiPlan Network. A current listing of Minnesota PPO Providers is available upon request at no charge at www.preferredone.com or by calling 1-800-451-9597. If you, or a covered family member, need providers outside of Minnesota, visit www.multiplan.com or call 1-888-342-7427.

The Plan will pay for Covered Expenses rendered by PPO providers based upon the approved amount of the charge by the PPO. Benefits are subject to the percentages listed in the Schedule of Coverage for the option under which the Covered Individual is covered.

Responsibility for use of Preferred Providers

It is the Covered Individual's responsibility to use PPO providers if the Covered Individual wants to receive the PPO higher level of benefits provided under this Plan.

The following are the only additional circumstances in which the Covered Individual will receive the PPO higher level of benefits as specified in the Schedule of Coverage for the option under which the Covered Individual is covered:

1. If a PPO provider is not available within a 50-mile radius of the Covered Individual's home; or

2. If the PPO network verifies that there was not a PPO provider who could have performed the services;

3. If ancillary services and supplies (such as, but not limited to, anesthesia, radiology, pathology, physical therapy, etc.) are rendered at a PPO Hospital/facility regardless of whether the Physician or Health Care Professional providing the services is a PPO provider, provided however that the attending Physician is a PPO provider; or

4. If the Covered Individual is in an Emergency situation.

In these situations, the Plan pays Covered Expenses as if a PPO provider had provided the services.

PRESCRIPTION DRUG BENEFIT

Each Schedule of Coverage includes a Prescription Drug Benefit.

IMPORTANT: Unless specifically stated otherwise, the Covered Expenses described below are subject to the

- Deductible
- Copayment Percentages
- Copay
- Maximum payment amounts shown in the Schedule of Coverage for the coverage option under which the Covered Individual is covered
- Usual Customary and Reasonable fee limitation
- General exclusions and limitations
- All other provisions of the Plan

All expenses must be Covered Expenses, Incurred as the result of an Injury or Sickness, and recommended by a Physician as Medically Necessary, unless specifically stated otherwise.

THE PRESCRIPTION DRUG BENEFIT PORTION OF THIS COVERAGE OPTION IS ADMINISTERED BY: MedTrakRx 1-800-771-4648

Schedule of Coverage. The descriptions of Covered Expenses in this Section should be read together with the Schedule of Coverage for the coverage option under which the Covered Individual is covered, and other provisions of this Plan.

A number of factors impact the amount a Covered Individual must pay for a particular medication, including the coverage option, the type of drug, the pharmacy, whether the cost applies towards the satisfaction of the Deductible or Out-of-Pocket Maximum, etc. It is the Covered Individual's responsibility to determine the specifics related to a particular prescription medication.

Working with the Prescriber. The Covered Individual should work with his/her provider in securing the best price for appropriate medications. For example, if the medication is a dry product (e.g., pills) and the Covered Individual will need 90 days or more of the medication, it may be more cost effective (e.g., cost per pill) for the Covered Individual to have the prescription filled through a Performance 90 pharmacy or a mail service pharmacy.

Generic/Formulary/Non-Formulary Medications

The type of medication impacts the cost to the Covered Individual. The different costs are reflected in the Schedule of Coverage for the coverage option under which the Covered Individual is covered.

Generic. Generic medications are less expensive versions of Brand drugs. In most cases, they are as safe and effective as the Brand drug.

Generic Incentive. If a Formulary brand or Non-Formulary brand is dispensed ***at the Covered Individual's request*** when a Generic equivalent is available, the Covered Individual pays the difference in cost between the Generic and the Formulary or Non-Formulary plus the applicable Copay. The difference in cost does not apply towards satisfaction of the Deductible or the Out-of-Pocket Maximum. If a Formulary brand or Non-Formulary brand is dispensed ***at the provider's request*** when a Generic equivalent is available, the Covered Individual only pays the applicable Copay.

Formulary/Non-Formulary. With respect to medications that are not Generic, this Plan uses a "formulary approach." The Formulary is a list of preferred medications. When a Formulary medication is

prescribed, the cost to the Covered Individual is less than the cost of a Non-Formulary Medication. A Non-Formulary medication is a medication that is not Generic and not on the Formulary.

Accessing the Formulary. MedTrakRx Select Formulary is available at www.medtrakrx.com and clicking My Plan Information, Forms and Downloads. A copy of the Formulary is also available upon request at no charge by calling 1-800-771-4648.

Participating Pharmacies
In order to be a Covered Expense for purposes of this Plan, a prescription must be filled by a Participating Pharmacy. The amount of the Copay or Copayment Percentage, depends in part upon the type of pharmacy that fills the prescription.

Retail Pharmacies. MedTrakRx has a network of retail pharmacies at which a Covered Individual may fill a prescription at the costs listed in the Schedule of Coverage for the coverage option under which he/she is covered. A list of those pharmacies is available at www.medtrakrx.com and clicking Pharmacy locator or by calling 1-800-771-4648.

Performance 90 Pharmacies. MedTrakRx has a network of pharmacies at which a Covered Individual may fill a prescription for a 90 day supply of medication (e.g., maintenance drugs) at the costs listed in the Schedule of Coverage for the coverage option under which he/she is covered. A list of Performance 90 pharmacies is available at www.medtrakrx.com and clicking on the Pharmacy Locator or by calling 1-800-771-4648.

Mail Service. Prescriptions for 90 day supplies of medications can be filled through EnvisionMail, a mail order pharmacy located at 7835 Freedom Ave. NW, North Canton, OH 44720 . In order to submit a prescription to be filled, a special enrollment form must accompany the prescription from the provider. It is the Covered Individual's responsibility to submit these items to EnvisionMail. The special enrollment form is available at www.medtrakrx.com and clicking on the "My Plan Information" tab . A copy of the enrollment form is also available upon request at no charge by calling 1-800-771-4648.

Preventive Medications.
Depending upon the coverage option under which the Covered Individual is covered, there may categories of medications that are "preventive." Preventive Medications are subject to a separate Copay structure.

Specialty Medications.
Specialty Medications are high-cost, complex pharmaceuticals that have unique clinical, administration, distribution, or handling requirements, and are not commonly available through traditional retail or mail pharmacies. A list of Specialty medications covered under this Plan is available at www.medtrakrx.com and clicking on the "My Plan Information" tab or by calling 1-800-771-4648.

Exclusions.
Most prescriptions are Covered Expenses under the Plan. However, in addition to the Exclusions described in Section G of this Plan Document, the following items are NOT Covered Expenses regardless of whether there is a prescription:
The prescription drug benefits will not cover any costs or expenses of any kind related to the any of the following:

- Unless otherwise noted, medications and other items available over-the-counter that do not require a written prescription from your authorized prescriber (except (i) insulin, insulin needles and insulin syringes, and (ii) OTC allergy, ophthalmologic, smoking cessation, and ulcer medications which have been preapproved by the Plan Sponsor)
- Any drug that is equivalent to an over-the-counter medication
- Anabolic steroids, anti-wrinkle agents, dietary supplements, blood or blood plasma, irrigational solutions and supplies

- Medications for cosmetic purposes
- Contraceptive devices other than those requiring a written prescription
- Drugs and/or devices that are intended to induce an abortion
- Compounded medications with ingredients that do not require a prescription
- Prescription vitamins (except Prenatal Vitamins and Vitamins D & K which requires prior authorization)
- Prescription drugs that are not of Medical Necessity unless otherwise specified
- Diagnostic testing supplies
- A drug or medicine that can legally be purchased without a written prescription (except injectable insulin or specified OTC medications)
- Devices of any type, even such devices that may require a prescription (including—but not limited to—therapeutic devices, artificial appliances, braces, support garments, or similar devices)
- Any medication with no approved FDA indications
- Any experimental, investigational, or new drug, unless specifically approved by the Plan Sponsor
- Any charge to administer or inject any drug
- Any drug that is consumed or administered at the place where it is dispensed
- Any drug to be taken, in whole or in part, while hospital-confined (including being confined in any institution that has a facility for dispensing drugs and medicines on its premises)
- Any portion of a prescription or refill which does not comply with the applicable limitations (including limitations related to patient age, day supply, or quantity)
- Any drug requiring certain administration for effectiveness for which the Plan Sponsor requires a contract related to such drug administration and the applicable patient either refuses to enter into, or fails to comply with, the contract
- Any drug requiring prior authorization to ensure the condition being treated has reached a certain stage, if such condition has not yet met the stage predetermined by the Plan Sponsor for coverage under the prescription drug benefits
- Any drug which may be properly received without charge under local, state or federal programs
- Any drug available in prescription strength without a prescription
- Any limited distribution drugs
- Any drug designated as an “orphan drug”, unless specifically approved by the Plan Sponsor
- Upon a reasonable determination by MedTrakRx, any misuse of these prescription drug benefits, including—but not limited to—the purchasing of prescriptions for use by anyone other than the applicable individual
- Compound Program
- Specific Therapy Classes for Specialty Drugs

COORDINATION OF BENEFITS

NOTE: This Coordination of Benefits Section includes many of its own defined terms for use just in this Section.

Excess Insurance

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

The Plan's benefits will be excess to, whenever possible, any of the following:

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

When a Covered Individual under this Plan, also has other coverage responsible for payment, this Section M (and Section N where the other coverage is government program) determines which coverage pays first such that total benefits available will not exceed 100% of the Allowable Expense for the services. When This Plan pays second, it will pay, with respect to each claim submitted for payment, 100% of Allowable Expenses less whatever payments were actually made by the Plan (or Plans) that paid first.

For purposes of this Section, the following terms are defined as follows:

An "Allowable Expense" means any health care service or expense, including coinsurance, copays or copayment and without reduction for any deductible, that is covered in full or in part by any Plan(s) covering the person. Allowable Expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under This Plan.

"Claim Determination Period" means the time during any one benefit year when a person is covered and incurs charges for services or supplies covered under This Plan and one other Plan.

As each claim is submitted, each Plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred during the Claim Determination Period. However, that determination is subject to adjustment as later Allowable Expenses are incurred during the same Claim Determination Period.

"Plan" means any plan providing health benefits or health services including, but not limited to:

1. Group, blanket or franchise insurance coverage;

2. Group practices and other group pre-payment coverage;

3. Any coverage under labor-management trusteed plans, union welfare plans, Participating Employer organization plans, or employee benefit organization plans; and

4. Any coverage under governmental programs, such as Medicare, Tricare/CHAMPUS, and any coverage required or provided by any statute, such as no-fault auto insurance.

"Plan" shall not include:

1. School accident type coverage;

2. Hospital indemnity coverage; or

3. Individual insurance coverage.

“This Plan” means the 40 Square Health Plan.

EFFECT ON BENEFITS

Plans determine the sequence in which they pay benefits, or which Plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC). Any Plan that does not use these same rules always pays its benefit first.

When two Plans cover the same person, the following order of benefit determination rules establish which Plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until the order of benefits is established. The rules are as follows:

Rule 1: Non-Dependent/Dependent

A. The Plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the Plan that covers the same person as a dependent pays second;

B. There is one exception to this rule. If the individual is a Medicare beneficiary, then, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

1. Secondary to the Plan covering the individual as a dependent; and

2. Primary to the Plan covering the individual as other than a dependent (e.g., a retired employee),

then the order of benefits is reversed so that the Plan covering the individual as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Rule 2: Dependent Child Covered Under More Than One Plan.

A. The Plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose birthday falls later in the calendar year pays second, if:

1. the parents are married or living together;

2. the parents are not separated (whether or not they ever have been married); or

3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

B. If both parents have the same birthday, the Plan that has covered one of the parents for a longer period of time pays first; and the Plan that covered the other parent for the shorter period of time pays second.

C. The word “birthday” refers only to the month and day in a calendar year, not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the Plan of that parent has actual knowledge of the terms of that court decree, that Plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s spouse does, the Plan of the spouse of the parent with financial responsibility pays first. This rule applies to plan years commencing after the Plan is given notice of the court decree.

E. If the parents are divorced, separated or not living together (whether or not they have ever been married), and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the Plans of the parents and their spouses (if any) is:

1. The Plan of the custodial parent pays first;

2. The Plan of the spouse of the custodial parent pays second; and

3. The Plan of the non-custodial parents pays third; and

4. The Plan of the spouse of the non-custodial parent pays last.

If the dependent child is covered under a Plan of an individual other than the parents, the order of benefits is determined as if those individuals were the parents of the child. The custody rule is applicable to anyone who has legal custody of the dependent child.

Rule 3: Active/Laid-off or Retired Employee

A. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off or retired, is primary. The Plan covering that same person as a retired or laid-off employee is secondary. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.

B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

C. This rule does not apply if Rule #1 described above can be used to determine the order of benefits

This rule is applicable only in the rare situations when the same individual is covered under two plans, one as an active employee and the other as a retired or laid-off employee. This rule does not apply to an individual covered under his or her own Plan as either an active, retired, or laid-off employee and also as a dependent under another Plan. In those situations, Rule #1 should be applied.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal (e.g. COBRA) or state law is also covered under another Plan, the Plan that covers the person as

an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the Plan providing continuation coverage to that same person pays second.

B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

This rule is applicable only in the rare situations when an individual is covered under both COBRA and non-COBRA Plans as other than a dependent, or as a dependent of an individual who is covered under both plans as a non-dependent. In the majority of continuation coverage situations, two employee spouses are involved (one on COBRA and one on the basis as active employment). In this scenario, Rule #1 is applicable.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the Plan that covered the person for the longer period of time pays first; and the Plan that covered the person for the shorter period of time pays second.

Rule 6: None of the Above Rules Apply

If the preceding rules do not apply, the allowable expenses shall be shared equally between the Plans.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this Section of This Plan or any other Plan, the Plan may without the consent of or notice to any persons release to, or obtain from, any insurance company or other organization or person any information with respect to any person which it deems to be necessary for such purposes. Any person claiming benefits under This Plan shall furnish to the Plan information as may be necessary to implement this Section.

FACILITY OF PAYMENT

Whenever payments which should have been made under This Plan in accordance with this Section have been made under any other Plan, This Plan shall have the right, exercisable alone and at its sole discretion, to pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this Section and amounts so paid shall be deemed to be benefits paid under This Plan and to the extent of such payments for covered services, This Plan shall be fully discharged from liability.

Right of Recovery

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

GOVERNMENT PROGRAMS

MEDICARE SECONDARY PAYER PROVISION

This Plan follows the Medicare Secondary Payer requirements under Federal law. The applicability of these requirements depends in part upon the size of the particular Participating Employer. It is entirely possible that some Participating Employers will be subject to the requirements while other Participating Employers will not be subject to the requirements.

If the Participating Employer has **less** than 20 Employees (as defined in 42 U.S.C. §1395y(b)(1)(A)(ii)), Medicare coverage is primary (and this Plan will be secondary) for active Covered Employees age 65 or older and their Dependents age 65 or older. This Plan will reduce payment by the amount paid or payable by Medicare.

If the Participating Employer had 20 or **more** Employees (as defined in 42 U.S.C. § 1395y(b)(1)(A)(ii)), Federal law requires that Medicare coverage be secondary to this Plan. The Covered Individual has the option of rejecting this Plan thereby retaining Medicare as his/her primary coverage. If the Covered Individual chooses Medicare as primary, the Participating Employer cannot provide any supplemental coverage. If the Covered Individual rejects coverage under this Plan, that choice must be made in writing and provided to the Participating Employer.

Federal law also mandates which coverage pays primary and which pays secondary in the case of Covered Individuals who are covered under Medicare due to disability (as defined in 42 U.S.C. § 1395y(b)(1)(B)) or end stage renal disease (as defined in 42 U.S.C. § 1395y(b)(1)(C)).

NOTE: This Plan will determine the primary and secondary payment of claims based on the current rules and regulations set forth by Medicare.

CARE PROVIDED BY THE UNITED STATES GOVERNMENT

This Plan follows coordination with government programs as required under Federal law. The Plan shall pay for care rendered by the Veterans Administration for non-service connected disabilities, on the same basis as these services are otherwise covered by the Plan. The Plan shall pay for care rendered by the United States to military retirees and dependents who are covered by this Plan on an Inpatient basis through a facility of the uniformed services, on the same basis as these services are otherwise covered under the Plan.

GENERAL PROVISIONS

The Plan And The Plan Document
The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator and/or the Trustees, identified in Section A.

Discretion
The Plan will be administered in accordance with its terms. The Plan Administrator, Named Fiduciary and/or any other person acting as a fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate the Plan, to make factual findings, to construe the terms of the Plan, and to determine all questions arising in connection with the administration, interpretation, and application of the Plan, including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on the Plan, Covered Individuals, Claimants, and all interested parties.

Plan Administrator
The Plan Administrator as used in this Plan shall be the person responsible for the day to day functions and management of the Plan. The Plan Administrator is 40 Square Health Plan Trust.

The construction and interpretation of the Plan are vested with the Plan Administrator, in its absolute discretion, including, without limitation, the determination of benefits, eligibility and interpretation of Plan provisions. The Plan Administrator will endeavor to act, whether by general rules or by particular decisions, so as to treat all persons in similar circumstances without discrimination. Subject to the Plan's Claim/Appeal Procedures, all such decisions by the Plan Administrator, determinations and interpretations shall be final, conclusive and binding upon all persons having an interest in the Plan.

Named Fiduciary
The Named Fiduciary is the Plan Administrator and has the authority to control and manage the operation and administration of the program. In addition to any powers and responsibilities that may be described in the Plan, the Named Fiduciary and Plan Administrator have the powers and responsibilities described under Section 404 of ERISA. A Covered Individual shall not receive Plan benefits under this Plan unless the Plan Administrator determines that the person is entitled to such benefits.

Other Fiduciaries
In addition to the persons designated above as fiduciaries of the Plan, any person who functions as a fiduciary, as described under Section 3(21)(A) of ERISA, shall also be looked to and held responsible as a fiduciary for purposes of applicable law including ERISA.

Nondiscrimination Under Code
As a self-insured group health plan, this Plan is subject to the nondiscrimination requirements regarding eligibility and benefits under Section 105(h) of the Code and the regulations thereunder. The consequences of failure are the particular Participating Employer's responsibility.

The Plan Is Not An Employment Contract
The Plan shall not be deemed to constitute a contract between a Participating Employer and any Employee or be a consideration for, or an inducement or condition of, the employment of a person. Nothing in the Plan shall be deemed to give any person the right to be retained in the service of the Participating Employer or to interfere with the right of the Participating Employer to discharge any person at any time; provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Participating Employer with the bargaining representative of any persons.

Exchange of Information
To the extent permitted under applicable law, the Plan shall promptly provide to appropriate Federal, state and local law enforcement authorities and to other appropriate health plans:

1. Information indicating a potential violation of civil, criminal, or administrative laws relating to fraud and abuse with respect to health plans.

2. Information requested by Federal, state, or local law enforcement agencies which the agency states is relevant to an investigation, audit, evaluation, or inspection under the Federal Fraud and Abuse Control Program.

3. Information which would assist in the identification of potential violations or assist in the identification of areas requiring investigation, audit, evaluation, or inspection. Such information may include:

    a. Surveys; Quality assurance reviews;

    b. Provider and patient profiles;

    c. Utilization review, and

    d. Other similar analyses.

Case Management Situations
Where the medical condition of the Covered Individual is expected to be or is serious in nature, the Plan may arrange for a third party (familiar with medical protocols and treatment for the medical condition) to provide case management services, including review and recommendations. In limited circumstances, the Plan Administrator may consider and authorize payment for care, services, supplies, reimbursement of expenses, or payments that would not normally be covered under the Plan or would be covered at a lesser level under the Plan. To the fullest extent permitted under applicable law, such action by the Plan Administrator shall not be considered precedent setting.

Free Choice of Physician
Each Covered Individual has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. The Covered Individual, together with his/her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

Nondiscrimination of Providers
To the extent an item or service is a Covered Expense under the Plan, and consistent with the Plan's reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan is prohibited from discriminating against a provider based on the provider's license or certification, as long as the provider is acting within the scope of the provider's license or certification under applicable state law.

Worker's Compensation Notice
The Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by worker's compensation insurance.

Erroneous Payment Refund Provision
Covered Expenses are occasionally paid erroneously by the Plan (i.e., paid more than once; incorrectly paid under the Plan's terms, conditions, limitations or exclusions; or conditionally paid pending further review). A Covered Individual or health care service provider receiving such an overpayment or erroneous payment shall, upon discovery or notice thereof, return such payment to the Plan within 30 days of discovery or demand. Neither the Plan nor the Plan Administrator shall have any obligation to make any other payment of the bill prior to refund by the health care provider or repayment by the Covered Individual. A health care provider may not apply an erroneous or duplicate payment to another bill balance or any other Covered Individual. The Plan Administrator shall have the exclusive right to choose who will repay the Plan for an overpayment or erroneous payment (i.e., including, but not limited to, the Covered Individual, health care service provider or another health benefit plan). If the Plan elects to seek refund from the Employee or Dependent, recovery of the overpaid amount shall, at the Plan Administrator's option, be reimbursed in a lump-sum, time payments or deducted from future claims presented for processing.

Conformity With Applicable Law
This Plan shall be deemed to automatically be amended to conform to the minimum standards required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the Plan and the terms of this Plan Document. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare benefit plans, as well as any other applicable law.

Clerical Error
Clerical errors, such as inaccurate transcription of premiums, Effective Dates, termination dates, or such as erroneous mailings, shall not change the rights or obligations of any person under the Plan and shall not operate to grant additional benefits to Covered Individuals or any other person.

Fraud
The following actions by any Covered Individual, or a Covered Individual's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for that Covered Individual:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Individual in the Plan;

2. Attempting to file a claim for a Covered Individual for services which were not rendered or drugs or other items that were not provided;

3. Providing false or misleading information in connection with enrollment in the Plan; or

4. Providing any false or misleading information to the Plan.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Covered Individual whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further

processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer.

The Participating Employers shall fund the Trust in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other applicable laws and regulations. The Trust shall be funded on a lawful and sound basis; but, to the extent permitted by governing law.

Entire Plan
The Plan Document including any amendments, Exhibits, and appendices thereto, and documents incorporated by reference, together constitute the Plan.

Plan Modification and Amendment
The Managing Body of 40 Square Health Plan shall be empowered to amend this Plan or any benefit under this Plan at any time by a written instrument. An increase or decrease in Plan benefits will become effective as of the date specified in the Plan or in an applicable amendment.

The Plan shall provide a summary of any material reductions in covered services or benefits as required under applicable law, including ERISA.

Plan Termination
The Managing Body of 40 Square may terminate the Plan at any time by written instrument. Upon termination, the rights of the Covered Individuals to benefits are limited to claims Incurred and due up to the date of termination. Any termination of the Plan shall be promptly communicated to Covered Individuals.

Assignment
The Plan Administrator may revoke an Assignment of Benefits at its discretion and treat the Covered Individual as the sole beneficiary; this is specifically intended to apply to Providers or any other entity in receipt of an Assignment of Benefits. Benefits for medical expenses covered under this Plan may be assigned by a Covered Individual to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Covered Individual, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Individual, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

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

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

NOTE: With respect to any assignment to a provider, that provider is subject to the same terms and conditions under the Plan as the Claimant.

Covered Individual Disability or Incapacity
If, in the Plan Administrator's opinion, a person entitled to receive any payment of a benefit or installment under the Plan is under a legal disability or is incapacitated in any way so as to be unable to manage their financial affairs, the Plan Administrator may direct that payment be applied for the benefit of such person in such manner as the Plan Administrator considers advisable. Any such payment of a benefit, or installment, in accordance with the provisions of this Section, shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

Direct Payment
All Covered Expenses payable under this Plan shall be paid to the provider; unless the Claimant furnishes proof of payment of the Covered Expenses at the time the claim is filed with the Claims Administrator, in which case payment shall be made to the Claimant. The Plan is discharged from liability to the extent of such amounts paid to a Claimant for Covered Expenses.

Physical Examination
Unless otherwise prohibited or limited under applicable law, the Plan, at its own expense, shall have the right and opportunity to examine any Claimant, whose Injury or Sickness is the basis of a claim, as often as it may reasonably require while a claim is pending.

SUBROGATION/RIGHT OF REIMBURSEMENT

Cooperation is Required. This Section describes responsibilities of Covered Individuals. Cooperation with the Plan is a ***condition to receiving benefits under this Plan.***

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Individuals, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Individual(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").

Covered Individual(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. The Plan shall have an equitable lien on any funds received by the Covered Individual(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 Covered Individual(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Individual(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Individual shall be a trustee over those Plan assets.

In the event a Covered Individual(s) settles, recovers, or is reimbursed by any Coverage, the Covered Individual(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Individual(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Individual(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Individual(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

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 Covered Individual(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Individual(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 Covered Individual(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Individual(s) fails to so pursue said rights and/or action.

If a Covered Individual(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Individual(s) may have against any

Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Individual is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Individual is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

If the Covered Individual(s) fails to file a claim or pursue damages against:

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

the Covered Individual(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Individual's/Covered Individuals' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Individual(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

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Individual(s) is fully compensated by his or 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 and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Individual are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Individual's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Individual is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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 Covered Individual(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.

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 Covered Individual(s).

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

Covered Individual is a Trustee Over Plan Assets

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

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Covered Individual is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Individual obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) (Incurred) prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the

benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

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.
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 Covered Individual(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Individual(s), such that the death of the Covered Individual(s), or filing of bankruptcy by the Covered Individual(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 Covered Individual(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 Covered Individual(s) and all others that benefit from such payment.

Obligations

It is the Covered Individual's/Covered Individuals' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. 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.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Individual may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Covered Individual is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Individual obtains a settlement

to include the Plan or its authorized representative as a payee on the settlement draft.

11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Individual over settlement funds is resolved.

If the Covered Individual(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Individual(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 Covered Individual(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Individual's/Covered Individuals' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Covered Individual and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Individual'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 Covered Individual(s) in an amount equivalent to any outstanding amounts owed by the Covered Individual to the Plan. This provision applies even if the Covered Individual has disbursed settlement funds.

Minor Status

In the event the Covered Individual(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.

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 with respect to this provision. 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.

CLAIM/APPEAL PROCEDURES

The procedures outlined below must be followed by Covered Individuals as Claimants to obtain payment of Covered Expenses (Medical Benefits and Prescription Drug Benefits) under this Plan.

All claims and questions regarding for Covered Expenses claims should be directed to the appropriate Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to an appropriate Claims Administrator; provided, however, that the Claims Administrator is not a Named Fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion. The Plan Administrator has retained the services of an independent third party administrator, EBSO, Inc. ("Claims Administrator") to provide technical services, with respect to the Plan other than Prescription Drug Benefits, including the processing of claims for Medical Benefits. The Plan Administrator has retained the services of an independent third party administrator, MedTrakRx ("Claims Administrator") with respect to Prescription Drug Benefits.

IMPORTANT. It is important to submit a claim in accordance with the claim/appeal procedures that apply to the particular type of claim. Claims for Medical Benefits must be submitted to, EBSO, Inc., the Claims Administrator responsible for the Medical Benefits. Claims for Prescription Drug Benefits must be submitted to, MedTrakRx, the Claims Administrator responsible or the Prescription Drug Benefits.

Each Covered Individual claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator, in its sole discretion may require, written proof that the expenses were Incurred and that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

MEDICAL BENEFITS

Under the Medical Benefits portion of the Plan, there are four types of claims: Pre-service, Urgent, Pre-service Non-urgent, Concurrent Care and Post-service. The rules for each of these types of claims differ.

Definitions

Words which are capitalized in this document are either defined below or in Section C of this Plan Document.

Pre-service Claims:

A "Pre-service Claim" arises when there is a claim for a benefit under the Plan and the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical/dental care.

A "Pre-service Urgent Care Claim" arises when there is any claim for medical/dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Claimant's medical/dental condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. "Pre-service Claims" that are not "Pre-service Urgent Care Claims" are "Pre-service Non-Urgent Claims."

Life Threatening: It is important to remember that, if a Claimant needs medical/dental care for a condition which could seriously jeopardize his/her life, there is no need to contact the Plan for prior approval. The Claimant should obtain such care without delay.

Further, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims:

A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims:

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

Appointment of Authorized Representative

A Claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. To appoint an Authorized Representative, the Claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. In the event a Claimant designates an authorized representative, all future communications from the Plan will be with the Authorized Representative, rather than the Claimant, unless the Claimant specifically directs the Plan Administrator, in writing, to the contrary.

Assignment of Benefits. An assignment of benefits by the Claimant to a provider **does not** constitute appointment of the provider as an Authorized Representative.

When Health Claims Must Be Filed

Health claims must be filed with the Claims Administrator within six months of the date charges for the service were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered filed when the request for approval of treatment or services is made and received by the utilization review Organization in accordance with the Plan's utilization review requirements.

However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA, Form UB92 or Form ADA:

1. The date of service;

2. The date the Injury or Sickness began;

3. The name, address, telephone number and tax identification number of the provider of the services or supplies;

4. The place where the services were rendered;

5. The diagnosis and procedure codes;

6. The amount of charges;

7. The name of the Plan and Plan ID #;

8. The name and home address of the Employee;

9. The Employee's social security number;

10. The name and home address of the patient; and

11. The patient's social security number.

Upon receipt of this information, the claim will be deemed filed with the Plan. The utilization review organization will determine if enough information has been submitted to enable proper consideration of the Pre-service Claim or Pre-service Urgent Claim (a Clean Claim). The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the Post-service Claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (or by the utilization review organization within 48 hours in the case of Pre-service Urgent Care Claims) from receipt by the Claimant of the request for additional information. **Failure to do so may result in claims being delayed, denied, or reduced.**

NOTE: The Plan does not consider inquiries about benefits, eligibility or the circumstances under which benefits might be paid, to be "claims." An inquiry does not become a claim unless the proper claim procedure is followed. Further, questions concerning eligibility for benefits, such as calls from providers of medical/dental services, are NOT ever considered claims.

Timing of Claim Decisions

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the Claimant to provide the information.

Pre-service Non-urgent Care Claims:

If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

Concurrent Claims:

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, the Claimant will be notified 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.

Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, the claim will be determined as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims:

If the Claimant has provided all of the information needed to process the claim (a Clean Claim), the claim will be determined in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, in which case the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the Plan provisions.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or, if permitted, electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;

2. Specific reason(s) for a denial;

3. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;

5. A 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 Claimant's claim for benefits;

6. The identity of any medical, dental or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request);

8. In the case of denials based upon a medical/dental judgment (such as whether the treatment is Medically/Dentally Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical/dental circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request; and

9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

Requested copies will be provided to the Claimant within a reasonable period of time, not to exceed 30 days from the date the Plan receives the written request for copies.

Appeal of Adverse Benefit Determinations – Internal Review

A. Procedures for Review of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review relevant documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. If the Claimant does not appeal on time, he/she will lose the right to file suit in court and will have failed to exhaust the Plan's internal administrative appeal procedures, which is generally a prerequisite to bringing suit;

2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. For a review that is independent from the initial Adverse Benefit Determination and is conducted by an appropriate Named Fiduciary of the Plan who is not the same individual who decided the Claimant's initial Adverse Benefit Determination and who is not also that individual's subordinate;

4. For a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;

5. That, if an Adverse Benefit Determination is based in whole or in part upon a medical/dental judgment, the Plan fiduciary shall consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is not the same person as the health care professional consulted in connection with the initial Adverse Benefit Determination;

6. For the identity of medical/dental/vocational experts consulted in connection with the appeal, even if the Plan did not rely upon their advice; and

7. In an Urgent Care Claim, for an expedited review process pursuant to which:

    a. A request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and
    b. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

B. Requirements for Appeal

The Claimant must file the appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an initial Adverse Benefit Determination. For Pre-service Urgent Care Claims, if the Claimant chooses to orally appeal, Claimant may telephone: Appeal Dept. EBSO, Inc. at 800-558-7798. To file an appeal in writing, the Claimant's appeal must be addressed as follows and mailed and/or faxed to the following number: *Attention: Appeal Dept. c/o EBSO, Inc. 215 Stanford Parkway, Findlay, OH 45840. Fax (419) 423-5834.*

It shall be the responsibility of the Claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Participant;

2. The name of the Claimant;

3. The Participant's social security number;

4. The Claimant's social security number;

5. The group name and identification number;

6. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal may result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal**;

7. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

8. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

C. Notification of Benefit Determination on Review

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Concurrent Claims: Within a reasonable period of time based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods: The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

D. Manner and Content of Notification of Adverse Benefit Determination on Review.

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

1. The specific reason or reasons for the denial;

2. Reference to the specific portion(s) of the Plan Document on which the denial is based;

3. The identity of any medical, dental or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

4. A 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 Claimant's claim for benefits;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

6. If the Adverse Benefit Determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided free of charge upon request;

7. A description of any available External Review process and how to initiate an External Review;

8. A statement of the Claimant's right to bring an action under section 502(a) of ERISA, following an Adverse Benefit Determination on final review; and

9. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or the Plan Administrator."

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied and the Plan's internal review procedures have been exhausted.

Appeal of Adverse Benefit Determinations – External Review

A. Overview

If the claim is denied, the Claimant may be eligible to have his/her claim reviewed by an Independent Review Organization (IRO) pursuant to a process called "External Review." Generally, External Review is available only after the claim denial has been upheld after the final level of appeal under the Plan. The Claimant may, however, in limited circumstances have the right to have the claim reviewed by an IRO prior to exhausting the Plan's appeal process. See **Expedited External Review** for further details.

B. Request for Review

External Review is available only for medical claims that involve medical judgment (including, for example, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination as to whether a treatment is Experimental/Investigational/Investigative) and for rescissions of coverage (i.e. retroactive cancellations of coverage because of the Covered Individual's fraud or intentional misrepresentation of a material fact regarding eligibility for coverage).

Federal government agency guidance may further limit or broaden the scope of External Review. The Plan will provide an External Review process in accordance with applicable guidance.

A request for External Review must be filed in accordance with the instructions contained in the Claimant's appeal denial notice and must be received not later than four months after the date he/she receives the appeal denial notice. If there is no corresponding date four months after the date of the appeal denial notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

C. Preliminary Review

Within five business days after receiving the Claimant's External Review request, the Plan Administrator will complete a preliminary review to determine whether Claimant's request is complete and eligible for External Review. That preliminary review will determine: whether the Claimant was covered under the Plan at the time the item or service was requested or provided; whether the final denial of Claimant's appeal related to the Claimant's failure to meet the Plan's eligibility requirements; whether the Claimant exhausted the Plan's internal appeal process (or are not required to exhaust the process); and whether the Claimant has provided all the information and forms required to process an External Review.

Within one business day after the completion of the preliminary review, the Plan Administrator will notify the Claimant of one of the following:

1. That his/her request is complete, but she/he is not eligible for External Review. This notice will state the reasons for the ineligibility and provide contact information for the Employee Benefits Security Administration.

2. That his/her request is incomplete, but may still be eligible for External Review. This notice will describe the information or materials needed to complete the request. The Claimant will be permitted to provide the required information by the later of: (a) the last day of the four month filing period or (b) 48-hours after receipt of the notice.

3. The request is complete and eligible for External Review.

D. Referral to IRO

If the Claimant's request for External Review is complete and eligible, the Plan Administrator will assign a qualified IRO to conduct the External Review and within five business days after making the assignment will provide the IRO with the documents and information the Plan Administrator considered in making its final appeal denial.

The Claimant will have at least 10 days to submit additional information to the IRO. If the Claimant submits additional information, the IRO will send that information to the Plan and the Plan may reconsider its determination. If the Plan decides, on reconsideration, to reverse its benefits denial and provide coverage or payment, then the External Review can be terminated.

If the Plan does not reverse its determination, the IRO will review all of the information and documents timely received. In reaching a decision the IRO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeal process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate will consider the following in reaching a decision: the Claimant's medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the Plan Administrator, the Claimant's treating provider; the terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan; appropriate practice guidelines; any applicable clinical review criteria developed and used by the Plan; and the opinion of the IRO's clinical reviewer(s).

The IRO must provide written notice to the Claimant and the Plan Administrator of the final External Review decision within 45 days after the IRO receives the request for External Review. If the IRO reverses the Plan's determination, the Plan must immediately provide coverage or payment for the claim, even if the Plan intends to seek judicial review.

E. Expedited External Review

Under the following circumstances, the Claimant may be eligible to file for an expedited External Review:

1. If the Claimant receives a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Plan Administrator would seriously jeopardize the Claimant's life or health, or that would jeopardize the Claimant's ability to regain maximum function, and the Claimant has filed a request for an expedited internal appeal; or

2. If the Claimant receives a final appeal denial from the Plan Administrator and: he/she has a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize his/her life or health, or would jeopardize his/her ability to regain maximum function; or if the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant has received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited External Review, the Plan Administrator will complete a preliminary review of the Claimant's request in order to determine his/her eligibility for expedited External Review. Immediately after completion of the preliminary review, the Plan Administrator will issue the Claimant a written notification of his/her eligibility for expedited External Review. If the Claimant's request is complete but not eligible for External Review, the notice will include the reasons for ineligibility. If the Claimant's request is incomplete, the notice will describe the information or materials needed to make the request complete and the Claimant will have an opportunity to complete the request.

Upon a determination that a request is eligible for expedited External Review, the Plan Administrator will assign an IRO for review and transmit all necessary documents and information to the IRO. The IRO must provide notice, to the Claimant and the Plan Administrator of the final External Review decision as expeditiously as possible, but in no event later than 72 hours after the IRO receives the request for the expedited External Review.

All claim review procedures described in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after exhaustion of the Plan's claim review procedures.

PRESCRIPTION DRUG BENEFITS

Under the Prescription Drug Benefits portion of the Plan, there is one type of claim: Post-service. The rules for this type of claim are described below.

Definitions

Words which are capitalized in this document are either defined below or in Section C of this Plan Document.

Appeals Process:

A "Post-service Claim" is a claim for a benefit under the Plan after the medication has been provided.

NOTE: The Plan does not consider inquiries about benefits, eligibility or the circumstances under which benefits might be paid, to be "claims." An inquiry does not become a claim unless the proper claim procedure is followed. Further, questions concerning eligibility for benefits, such as calls from providers of medical/dental services, are NOT ever considered claims.

1. Appealing a Denied Claim

If a claim for benefits is denied, you may call MedTrak toll free at (800)771-4648 to resolve your issue over the phone. If MedTrak is unable to resolve your issue, you have the right to file a formal appeal as described below. If you wish to appeal a denied request for benefits or a rescission of coverage, you or your authorized representative must submit your appeal in writing as described below within 180 days of receiving the Adverse Benefit Determination.

This written request should include:

1. the participant's name and ID number as shown on the prescription benefits card;
2. the provider's name;
3. the date of service;
4. the reason you disagree with the denial or coverage decision; and
5. any documentation or other written information to support your appeal.

You or your authorized representative may send a written appeal to: MedTrak Services, Clinical Care Center, 7101 College Blvd, Suite 1000, Overland Park, KS 66210; or fax your request to: (866)552-8939. For denied urgent claims for benefits, your provider may submit a written appeal as described above or call MedTrak toll free at (800)771-4648 to request an appeal.

Note: You may designate an authorized representative who has the authority to represent you in all matters concerning your claim or appeal of a claim determination. If you have an authorized representative, any references to "you" or "participant" herein will also refer to the authorized representative.

2. Internal Appeal

MedTrak will conduct a full and fair review of your appeal. The appeal may be reviewed by two pharmacists who did not make the initial benefit determination. If MedTrak upholds the denial, you will receive a written explanation of the facts and basis for the denial and a description of additional appeal procedures, if applicable. If MedTrak overturns the denial and approves the Claim, you will receive notification and Benefits will be paid, as appropriate.

If your urgent care claim was denied, you may request an expedited external review at the same time that you request an expedited internal appeal to MedTrak. Immediately upon receipt of your request for an expedited external review, MedTrak will determine whether the request meets the reviewability requirements for an external review. Immediately upon completing this review, MedTrak will (i) submit the request to an independent review organization for external review; (ii) notify you or your provider that the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) notify you and/or your provider that the request is complete, but not eligible for review.

3. Reconsideration – Failure to Meet Coverage Criteria

MedTrak applies a review process to certain drugs to define the conditions ("Coverage Criteria") under which such drugs will be covered under your pharmacy benefits. These Coverage Criteria are developed by the MedTrak Clinical Care Center and are subject to review and revision from time to time. In the event such Coverage Criteria are not met, the benefit or claim is not a covered benefit, and therefore not eligible for the other appeal rights provided herein. However, you or your provider may request that MedTrak reconsider the application of the Coverage Criteria. Upon receipt of such request, two pharmacists not involved in the initial review will reconsider the Coverage Criteria denial and provide notice to you of the outcome of such reconsideration.

4. External Review

If you are not satisfied with the determination made during the internal review, or if MedTrak fails to respond to your appeal within the applicable time, you may be entitled to request an immediate external review of the determination made by MedTrak. If one of the above applies, you may request a free external review of an Adverse Benefit Determination if (i) the determination involves a question of medical judgment; (ii) coverage was terminated retroactively; or (iii) if it is otherwise required by applicable law. You may also have the right to pursue external review in the event that MedTrak has failed to comply with

the internal claims and appeals process, except if such failure is related to minor violations that did not cause, and are not likely to cause, you harm.

You may request (i) a standard external review by sending a written request to the address set out in the determination letter or (ii) an expedited external review, in urgent situations as detailed below, by calling MedTrak toll free at (800)771-4648 or by sending a written request to the address set out in the determination letter. A request must be made within 120 days from the date of the final internal determination from MedTrak. An external review request should include (i) a specific request for an external review; (ii) the participant's name, address, and insurance ID number; (iii) your authorized representative's name and address, when applicable; (iv) the service that was denied, the date of service, the provider's name; and (iv) any new, relevant information that was not provided during the internal appeal. An external review will be performed by an Independent Review Organization (IRO). MedTrak has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available, a standard external review and an expedited external review.

5. Standard External Review

Within the applicable time frame, MedTrak will review the external review request to determine whether (i) the applicable member was covered under the Plan at the time the prescription drug product or service at issue in the request was provided or requested; (ii) the applicable internal appeals have been exhausted; and (iii) all the information and forms required to process the request have been provided. Following review, MedTrak will forward the information to the appropriate IRO, which is determined by rotating review assignments among the IROs. MedTrak will provide the assigned IRO with the documents and information considered in making the determination. The documents include (a) all relevant medical records; (b) all other documents relied upon by MedTrak; (c) all other information or evidence that you or your provider submitted regarding the claim; and (d) all other information or evidence that you or your provider wish to submit regarding the claim, including, as explained below, any information or evidence that was not previously provided. If your claim involves an issue of medical judgment or rescission that is subject to external review, you may submit in writing to the IRO within ten (10) business days following the date you receive notice from the IRO, any additional information that you want the IRO to consider when conducting the external review. In reaching a decision, the IRO will review the claim without regard to any decisions or conclusions reached by MedTrak. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless the IRO requests additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and MedTrak, including the basis for its determination. Upon receipt of a Final External Review Decision reversing the determination by MedTrak, MedTrak will notify you within 48 hours of receiving the IRO's decision. The Plan will immediately provide coverage or payment of the Benefits at issue in accordance with the terms and conditions of the Plan. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the prescription drug product or service and you will have exhausted your appeal rights. All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

6. Expedited External Review

An expedited external review is similar to a standard external review, except with certain shorter time periods, and the timeframe for you or your provider to submit additional information to the IRO is eliminated. In some instances, you may file an expedited external review before completing the internal appeals process. You may make a written or verbal request for an expedited external review if you receive either (i) an Adverse Benefit Determination of a claim or appeal if the Adverse Benefit Determination involves a medical condition for which, in the opinion of your prescriber, the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function and you have filed a request for an expedited internal appeal; or (ii) a final appeal decision, if the determination, in the opinion of your prescriber, involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or prescription drug product or service for which the participant received emergency services, but has not been discharged from a facility. Immediately upon receipt of the request, MedTrak

will determine whether the participant (i) was covered under the Plan at the time the prescription drug product or service that is at issue in the request was provided; and (ii) has provided all the information and forms required so that MedTrak may process the request. After completing the review, MedTrak will immediately assign an IRO in the same manner MedTrak utilizes to assign standard external reviews to IROs. The IRO will determine if the matter contains an issue involving medical judgment and, upon a determination that a request is eligible for expedited external review. MedTrak will provide all necessary documents and information considered in making the determination to the assigned IRO. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review. In reaching a decision, the IRO will review the claim without regard to any decisions or conclusions reached by MedTrak. The IRO will provide notice of the Final External Review Decision for an expedited external review as expeditiously as the participant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the IRO's notice of the Final External Review Decision is not in writing, within 48 hours of providing such notice, the assigned IRO will provide written confirmation of the decision to you and to MedTrak. All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

7. Time Frames

The following list provides the required timing for the corresponding actions. The timing is based on when the request is received, unless otherwise noted below.

a. **Urgent Care Claims**
   i. If your Request is complete, MedTrak must notify you and your provider of the benefit determination within 72 hours.
   ii. If your request is incomplete, MedTrak must notify you that it is incomplete within 24 hours.
      1. You must then provide the completed request to MedTrak within 48 hours after receiving the notice requiring additional information.
      2. MedTrak must notify you and your provider of the benefit determination within 48 hours after receiving the additional information.
   iii. If MedTrak denies your request for benefits, you must appeal an Adverse Benefit Determination no later than 180 days after receiving such determination.
   iv. MedTrak must notify you of the internal appeal decision within 72 hours of receiving the appeal.

b. **Post-Service Claims** – a claim submitted after receiving the benefit
   i. If your claim is incomplete, MedTrak must notify you within 30 days.
   ii. You must then provide completed claim information to MedTrak within 45 days.
   iii. MedTrak must notify you of the benefit determination 30 days of a completed claim filing or upon the receipt of all additional required information if your initial claim was incomplete.
   iv. You must appeal an Adverse Benefit Determination no later than 180 days after receiving such determination.
   v. MedTrak must notify you of the internal appeal decision within 15 days of receiving such appeal.

c. **External Review**
   i. You must submit a request for external review to MedTrak within 120 days after receiving the internal appeal determination.
   ii. For an expedited external review, the IRO will provide notice of its determination within 72 hours.
   iii. For a standard external review, MedTrak will complete a preliminary review to ensure the request meets requirements for an external review within 5 business days.

iv. You may submit in writing to the IRO any additional information that you want the IRO to consider within 10 business days.

For a standard external review, the IRO will provide written notice of its determination within 45 days. **All claim review procedures described in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after exhaustion of the Plan's claim review procedures.**

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

NOTE: This Section reflects the requirements of a particular Federal law. It contains a number of defined terms that only apply with respect to this Section.

For purposes of this Section:

1. "Medical Child Support Order" or "Order" means a judgment, decree, or order (including an approval of a property settlement) that is made pursuant to applicable State law and provides for the support or health benefit coverage of a child of a participant (including someone eligible or who will be eligible) under a group health plan and relates to benefits under that group health plan.

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

3. "National Medical Child Support Notice" (NMSN) is a standardized medical child support order authorized under the Child Support Performance and Incentive Act of 1998, that is used by State child support enforcement agencies to enforce medical child support obligations.

A Medical Child Support Order creates, or recognizes the existence of, an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits to which a Dependent child ***may be*** entitled under this Plan. The Plan is required to recognize ***Qualified*** Medical Child Support Orders ("QMCSOs). The Plan Administrator determines whether a Medical Child Support Order is a QMCSO and, therefore, must be followed by the Plan.

IMPORTANT: Not all Medical Child Support Orders are "qualified." For example, if the Medical Child Support Order requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Covered Individuals, it is not "qualified". ***Only if the Plan Administrator determines an order is "qualified," will the Plan provide the coverage described in it.***

In order for the Plan Administrator to determine a Medical Child Support Order to be "qualified," a QMCSO, the Medical Child Support Order must clearly specify the following:

1. The name and last known mailing address of the Covered Individual and the name and mailing address of each such Alternate Recipient covered by the Order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner by which the type of coverage is to be determined;

3. The period of coverage to which the Order pertains (including an end date); and

4. The name of this Plan.

Once having determined a QMCSO exists, the Plan Administrator shall enroll Alternate Recipient (e.g., child) and coverage under the Plan shall begin as of the first day of the calendar month following determination that the Medical Child Support Order is a QMCSO. If the Alternate Recipient is already a Covered Individual, there is no need to enroll but coverage under the Plan will be subject to the terms of the QMCSO.

Review Process

The Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

A Covered Employee and/or an Alternate Recipient may request at any time a copy of QMCSO procedures from the Plan Administrator without charge.

Upon receiving a Medical Child Support Order (Order) (other than an NMSN described separately below), the Plan Administrator shall, as soon as administratively possible:

1. Notify the Covered Employee and each Alternate Recipient covered by the Medical Child Support Order (at the address included in that Order) in writing of (a) the receipt of such Order, and (b) the Plan's procedures for determining whether the order qualifies as a QMCSO; and

2. Administratively determine whether if the Medical Child Support Order is a QMCSO and notify the Covered Employee and each affected Alternate Recipient of such determination.

National Medical Support Notice. A special process applies when the Plan receives a NMSN. Upon receiving a National Medical Support Notice (Notice), the Plan Administrator shall:

1. Notify the state agency issuing the Notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

    a. Whether the child is covered under the Plan; and

    b. Either the Effective Date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

A National Medical Support Notice (NMSN) shall be a QMCSO if it:

1. Contains the information set forth below;

    a. Name of an issuing state agency;

    b. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Individual) or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipient(s);

    c. Identity of an underlying child support order;

2. Identifies either the specific type of coverage or all available group health coverage. If the Participating Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Participating Employer and the Plan Administrator will assume that all are designated;

3. Informs the Plan Administrator that, if a group health plan has multiple options and the Covered Individual is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

More Information: All questions, notices, and other communication, or a copy of the QMCSO procedures, please direct the Plan Administrator:

40 Square Health Plan
Attn: Executive Director
8011 34th Avenue South, Suite 148
Bloomington, MN 55425
Email: info@40Square.coop
Phone: 1-844-205-9579

Disclosure Of Administrative Protected Health Information (including Electronic Protected Health Information) To The Plan Sponsor For Plan Administrative Functions

Privacy Notice. You should have been provided a copy of the Plan's Notice of Privacy Practices. This Notice describes (1) the uses and disclosures of his/her Protected Health Information that may be made by or on behalf of the Plan, (2) the individual's rights, and (3) the Plan's legal duties with respect to the individual's Protected Health Information. If you need a copy, please contact the Plan Administrator by calling 844-205-95790

NOTE: This Section reflects requirements under a particular Federal law. Any terms not otherwise defined shall have the meanings set forth in the Privacy Standards or Security Standards. It contains a number of defined terms that only apply with respect to this Section.

For purposes of this Section, the following terms are defined as follows:

"Protected Health Information" means health information as defined in 45 CFR § 160.103.

"Electronic Protected Health Information" means Protected Health Information in electronic format as defined 45 CFR § 160.103.

"Plan Administrative Functions" means the functions necessary for Plan operation as defined in 45 CFR § 164.504(a).

"Privacy Standards" means the Standards of Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164 at Subparts A and E.

"Security Incident" means a situation defined in 45 CFR § 164.304.

"Security Measures" means steps taken by the Plan to fulfill the requirements under the Security Standards.

"Security Standards" means the Security Standards and Implementation Specifications at 45 CFR Part 160 and Part 164, Subpart C.

"Summary Health Information" means health information as defined in 45 CFR § 164.504(a).

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Protected Health Information (including Electronic Protected Health Information) for Plan Administrative Functions, the Plan Sponsor agrees to:

1. Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Protected Health Information (including Electronic Protected Health Information) that it creates, receives, maintains, or transmits on behalf of the Plan in accordance with the Privacy Standards, Security Standards, and other regulatory agency guidance;

2. 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;

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Protected Health Information (including Electronic Protected Health Information) created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic Protected Health Information; and

4. Report to the Plan any Security Incident of which it becomes aware.

Privacy Standards

1. 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.

2. Disclosure of Protected Health Information to the Plan Sponsor for Plan Administrative Functions.

   In order that the Plan Sponsor may receive and use Protected Health Information for Plan Administrative Functions, the Plan Sponsor agrees to:

   a. Not use or further disclose Protected Health Information other than as permitted or required by the Plan Document or as "required by law "(as defined in the Privacy Standards);

   b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information;

   c. Not use or disclose Protected Health Information 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;

   d. Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

   e. Make available Protected Health Information in accordance with 45 CFR § 164.524;

   f. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;

   g. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

   h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of 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;

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

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is established as follows:

i. The following persons under control of the Plan Sponsor, shall be given access to the Protected Health Information to be disclosed:

Executive Director

Director of Benefits and Distribution
Benefits Specialist

ii. The access to and use of Protected Health Information by the individuals described in subsection (i) above shall be restricted to the Plan Administrative Functions that the Plan Sponsor performs for the Plan.

iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of Protected Health Information, the Plan Sponsor 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.

The Plan shall disclose Protected Health Information 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.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor.

Pursuant to 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.

4. Disclosure of Protected Health Information to Obtain Stop-loss or Excess Loss Coverage.

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Claims Administrator, to disclose Protected Health Information 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 Plan benefits paid from the Trust. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of Protected Health Information.

With respect to all other uses and disclosures of Protected Health Information, the Plan shall comply with the Privacy Standards.

IN WITNESS WHEREOF, the Employer has caused this instrument to be executed by its duly authorized officer on the date written below.

Date: April 10, 2019

40 Square Health Plan

By: Robby B. Giesecke

Its: Board Chair