PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

KATHERINE SHAW BETHEA HOSPITAL EMPLOYEE HEALTH BENEFIT PLAN

EFFECTIVE DATE OF THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION:

January 1, 2023

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INTRODUCTION

Katherine Shaw Bethea Hospital (herein referred to as "the Company") has established the Plan for your benefit, on the terms and conditions described in this Plan Document and Summary Plan Description.

This document is both the Plan Document and the "Summary Plan Description", or "SPD" required by ERISA. It has been written for your use and understanding of the broad range of benefits available to you and your Dependents under this Plan. This document is effective as of 12:00 a.m. on January 1, 2023 and is intended to replace all previously distributed materials. Any word or phrase that is capitalized in this document has a special meaning and is defined for you in the "Definitions" section or within the document.

This Plan is a self-funded plan with a Claims Administrator. The Plan Administrator is responsible for all claim decisions. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to the Claims Administrator; however, the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

The benefits of this Plan are only a part of the comprehensive employee benefits program provided for you and are offered as tangible recognition of your contribution to success of KSB Hospital. The Plan is designed to protect you and your Family against catastrophic health care expenses by providing reimbursement for the great majority of Covered Expenses.

This Summary Plan Description is intended to give you, our employee, a general understanding of your benefits in MOST situations; particularly the areas of most interest and concern to you. In order to provide you and your family with an explanation of our benefits plan that is both readable and comprehensive, this booklet is condensed, and not every aspect of our benefits is covered here. If you do not understand the language used in this booklet, contact your Human Resource Department for assistance. During our business hours, you may ask for more specific information on coverage, exclusions, and limitations or ask questions concerning any other area of our benefit plan. We do ask that you please read this booklet thoroughly before bringing your questions in; they may be explained to your satisfaction in this booklet.

The Plan includes a Preferred Provider Organization ("PPO") Network. A current list of PPO providers is available, without charge, through the PPO web site noted on your Plan I.D. card.

Each person covered by this Plan has a free choice of any physician or surgeon, and the physician-patient relationship will be maintained. The patient, together with their 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. 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.

Verification of Benefits

A claim cannot be guaranteed until all necessary information is received and reviewed. Such information includes but is not limited to the diagnosis and codes, the exact treatment and codes, the dates of service, information necessary to confirm Medical Necessity and appropriate treatment patterns, and eligibility. We need to assure that the treatment is covered and not excluded or limited in some way.

Any verification of benefits given to a provider, Plan participant or other party, in writing or orally, in person or by telephone, **is not a guarantee of payment under the Plan**.

Claims Incurred upon this written or oral advice may not be payable and, if determined to be not payable under the Plan, will become your responsibility.

Your Role In Controlling Health Care Costs

Making choices about your health can sometimes be difficult. When you seek health care, take the same approach you use for buying anything else. Ask questions. Make sure you get the most appropriate care for your Condition. Use the following guidelines to help you be a wise health care consumer:

Practice Good Health Habits

Staying healthy is the best way to control your medical costs. Eat a balanced diet, exercise regularly and get enough sleep. Learn how to handle stress. Avoid smoking and excessive use of alcohol.

See Your Doctor Early

Don't let a minor problem become a major one. This makes treatment more difficult and expensive.

Make Sure You Need Surgery

If your Physician recommends Surgery, get a second opinion if you're unsure about the Surgery you face. If you need Surgery, ask about same day Surgery. Many procedures can be performed safely without a Hospital stay. You have these Surgeries as an Outpatient or at a place other than a Hospital and go home the same day.

Use Outpatient Services for X-ray or Laboratory Tests

Outpatient preadmission and diagnostic tests can save costly Room and Board charges.

Compare Prescription Drug Prices

Discuss the use of Generic Drugs with your doctor or pharmacist. Generic Drugs are often less expensive than Brand-Name Drugs for the same quality.

Consider Hospital Stay Alternatives

Home health care, nursing facilities and Hospice care services offer quality care in comfortable surroundings for less cost than staying in the Hospital.

Review Medical Bills Carefully

Make sure you understand all charges and receive itemized bills for all services you receive. Keep your medical records up-to-date.

Talk to Your Doctor

Discuss the need for treatment with your doctor. It's your body. To make wise health care decisions, you must understand the treatment and any risks or complications involved. Ask about treatment costs too. With today's health care costs, your doctor will understand your concerns about your medical expenses.

Be a wise health care consumer. Review your benefits carefully so you can make informed health care decisions. You can help control health care costs while getting the most your health care plan has to offer.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan will be in accordance with the eligibility, effective date, and termination provisions of this Summary Plan Description.

Any change in the coverage available to you or your Dependents due to a change in your classification will become effective automatically on the classification change date.

If provided by Company policy, your coverage will be continued during an approved Leave of Absence, including disability or temporary layoff according to such established written policy. However, your coverage may not continue beyond the periods defined in Company policies and not beyond one year following the leave.

Regardless of the established leave policies mentioned above, the Plan will at all times comply with the Family and Medical Leave Act of 1993 ("FMLA"). During any leave taken under FMLA, your coverage will be maintained under this Plan on the same conditions as coverage would have been provided if you had been continuously employed during the entire leave period.

General Eligibility Provisions

Eligible Employees

Employees eligible for Plan coverage (hereafter referred to as "Eligible Employees") are:

- All regular employees who are regularly scheduled to work a minimum of 20 hours per week; and,
- Physicians per an employment agreement.

You must actually begin work for the Company in order to be eligible. If you are unable to begin work as scheduled, you will not be considered an Eligible Employee until the date you start work.

If you do not meet the eligibility requirements of this Plan when you are initially hired, your eligibility for coverage will be subject to the Measurement and Stability Periods prescribed by the Shared Responsibility for Employers Regarding Health Coverage rules under § 4980H of the Internal Revenue Code, enacted by the Affordable Care Act.

In no event will a leased employee be deemed to be Eligible Employee. An independent contractor will also not be considered an Eligible Employee unless such person is deemed a common law employee by the Internal Revenue Service and meets the eligibility requirements of this Plan.

Eligible Dependents

If you are an Eligible Employee, you may elect to cover your eligible Dependents. An eligible "Dependent" is defined to mean:

1. Your spouse or civil union partner who meets the applicable requirements outlined below, provided they are enrolled for coverage under their employer's group health plan if employed (please refer to the section "Working Spouse/Civil Union Partner Rule" for additional eligibility information):

    a. Spouse means your legal spouse, as evidenced by a valid marriage certificate, who is a resident of the same country as you. Such spouse must have met all requirements of a valid marriage contract of the state in which you were married.

    b. Civil union partner means your partner (same-sex and opposite sex) with whom you have entered into a legal civil union and who is a resident of the same country as you. Such civil union must meet all the requirements of a valid civil union in the State of Illinois or the state in which the civil union was legally established. A copy of your completed civil union registration will be required at enrollment.

    A partner in a legal civil union is entitled to the same benefits provided to a married spouse, in addition to coverage provisions provided under this Plan for a married spouse or a surviving spouse including COBRA. As such, a civil union partner will be a Qualified Beneficiary entitled to

independent COBRA election rights and termination or dissolution of a partnership will be considered a Qualifying Event for the partner and any enrolled Dependent children.

Wherever the term "spouse" is used in this document, an eligible civil union partner is also meant to be included.

The value of any benefits provided by this Plan for your partner may be considered "imputed" income for federal and state income and payroll tax purposes.

Eligibility for coverage for your civil union partner will end on the date the civil union is legally dissolved.

2. Your child, or a child of your spouse/civil union partner, who meets **all** of the following conditions:
   a. Is a natural child, step-child, legally adopted child, or a child who has been placed under your Legal Guardianship or the Legal Guardianship of your spouse or civil union partner; and,
   b. Is less than age 26.

   A Dependent child will continue to be eligible beyond age 26 if the child is mentally or physically handicapped and incapable of self-sustaining employment, unmarried and financially dependent upon you for support and maintenance. The child need not be covered under the Plan on the date the incapacitating handicap occurred. However, such Condition must have begun prior to the child's attainment of age 26 and must be of such severity as to incapacitate the child for an extended period of time. Proof of incapacity acceptable to the Plan Administrator must be submitted upon enrollment or, if later, within 60 days after the date on which the Dependent no longer will be eligible because of age, and at reasonable intervals thereafter.
3. Any child who is placed with you under an interim court order prior to finalization of adoption.
4. Any children as required by a Qualified Medical Child Support Order (QMCSO).

Those situations specifically excluded from the definition of a "Dependent" are:

1. A spouse or civil union partner who is employed and eligible for coverage under his or her employer's group health plan but is not enrolled for such coverage;
2. A spouse from whom you are legally separated by a court order;
3. A former spouse from whom you are legally divorced;
4. A partner in a civil union after the civil union is legally dissolved;
5. Any person on active military duty, unless otherwise required by law;
6. Any person covered under this Plan as an Eligible Employee;
7. Any person who is covered as a Dependent by another employee;
8. A Dependent child's spouse or child (unless the child is placed under your Legal Guardianship or the Legal Guardianship of your spouse or civil union partner.

Working Spouse/Civil Union Partner Rule

If your spouse or civil union partner is employed and enrolled for coverage under their employer's group health plan, you are eligible to enroll your spouse or partner for coverage under this Plan. Benefits will be coordinated as described in the section "Coordination of Benefits Provision".

If your spouse/civil union partner is employed and eligible for coverage under their employer's group health plan but is not enrolled for such coverage, your spouse or partner is not eligible for coverage under this Plan. As part of the enrollment process, you will be required to show that your spouse or partner is enrolled for coverage through their employer if available.

If your spouse or civil union partner is not eligible for coverage due to this Working Spouse/Civil Union Partner Rule, your spouse or partner will become eligible for coverage on the date their employment ends (provided your spouse or partner is not re-employed elsewhere and eligible for coverage under their new employer's group health plan) or they are no longer eligible for coverage through their employer. Coverage must be requested within the 31-day period immediately following your spouse/partner's last day of coverage. Coverage under this Plan will begin on the first day following the last day of coverage under your spouse/partner's employer's plan, provided your enrollment is made on a timely basis.

Exception for New Hires

If you are a new hire and your spouse/civil union partner is not eligible to enroll for coverage under their employer's group health plan due to enrollment restrictions placed on late enrollees, this Plan's Working Spouse/Civil Union Partner Rule may be waived until enrollment under that plan is permitted (for example, until the plan's open enrollment period). In order to obtain this waiver, you will need to submit proof that:

1. Such an enrollment restriction applies to your spouse or civil union partner under their employer's group plan; and,
2. When your spouse or civil union partner would be permitted to enroll for such coverage.

Age Limitation for Eligible Dependent Children

A Dependent child is eligible until the end of the month in which he or she attains age 26 except as otherwise specified for a handicapped child in the section "Eligible Dependents".

Initial Eligibility Date

Your initial eligibility date for Plan coverage is your first date of active work as an Eligible Employee.

If the Company uses a measurement method for your job class and you are classified as an Eligible Employee, your initial eligibility date for Plan coverage will begin on the first day of the Stability Period, in compliance with the regulations relating to Code § 4980H of the Internal Revenue Code.

Written application for coverage, as required by the Plan, must be made within 31 days of your initial eligibility date.

Benefit Plan Options and the Health Reimbursement Credit

The Employee Health Benefit Plan has three benefit plan options – the KSB Plan, the PPO Plan, and the High Deductible Health Plan (the "HDHP"). You will be required to select a plan option when you enroll. The plan option you choose will also apply to your Dependents.

If you complete the current year's Health Plan Year Activity, you may receive a health reimbursement credit to be used during the Calendar Year to reduce your cost for Plan coverage. Any portion of the health reimbursement credit that is not used during the Calendar Year cannot be carried forward to the next Calendar Year.

Note: The HDHP option has been designed to be a "qualified high deductible health plan". An individual who is covered under a qualified HDHP is eligible to establish a Health Savings Account ("HSA"). However, your enrollment under this Plan does not automatically satisfy all IRS regulations for an HSA. For example, if you are covered by any other health plan, you are not eligible to contribute to an HSA unless the other plan is also a qualified HDHP. In addition, you cannot be enrolled in Medicare (Part A or Part B) or claimed as a dependent on another person's tax return to be eligible to contribute to an HSA. Please consult the IRS website (www.irs.gov) for information regarding qualifications for Health Savings Accounts.

Changing Your Coverage Election

This Plan is governed by a special section of the Internal Revenue Code because your contributions may be made on a pre-tax basis. Therefore, changes are permitted on a very limited basis as follows:

- During the annual Open Election/Enrollment Period;
- When an employee takes a leave of absence under the Family Medical Leave Act (FMLA);
- During a Special Enrollment Period (refer to the section "Special Enrollment Periods" for additional information); or,
- When you experience a major life event. The following events qualify as "major life events":
    - Your marriage, divorce, or legal separation;

- Birth or legal adoption of a child, or loss or gain of custody, by court order, of a Dependent;
- The death of your lawful spouse or Dependent child;
- Commencement or termination of spouse's employment with benefits eligibility;
- Termination or commencement of coverage by you, your spouse or Dependent;
- A change in job status from full-time to part-time (or vice versa) by you or your spouse;
- An unpaid leave of absence by you or your spouse;
- A significant change in your spouse's medical coverage, attributable to your spouse's employment such as a significant increase in the out-of-pocket amounts like Deductibles, Copays, or insurance premiums; or,
- You, your spouse or Dependent become entitled to or lose entitlement to Medicare or Medicaid.

Any change in coverage resulting from a change in Family status must be consistent with the major life event. For example, it would be consistent with a major life event to enroll yourself and your Dependent children for coverage following the death of a spouse. However, it would not be consistent to drop your existing coverage. You may be required to provide documentation of the major life event for verification. If you wish to change coverage you need to complete an Eligibility Change form.

Open Election/Enrollment Period

An Open Election/Enrollment Period is held annually. An enrollment or change in coverage made during the Open Election/Enrollment Period will become effective on January 1, provided such request is made by written application as required by the Plan.

Enrollment Rules

Coverage must be requested by written application (and in the manner required by the Plan) within 31 days of your initial eligibility date.

If you do not have eligible Dependents on the date your coverage begins, you must file your written application for Dependent Coverage within 31 days of the date you acquire your Dependent through marriage or civil union, birth, adoption, court order or decree. Once you are enrolled for Dependent Coverage, each newly acquired Dependent must also be enrolled within 31 days of the date they become eligible. However, this enrollment requirement will not apply to a newborn if full Family coverage is in effect prior to the date of a newborn's birth; if you are covered as an employee with only one Dependent, you must enroll your new Dependent within 31 days.

If you are declining enrollment for yourself or your Dependents (including your spouse or civil union partner), you may in the future be able to enroll yourself or your Dependents in this Plan under the Special Enrollment Period rules defined in the following section or during the Open Election/Enrollment Period.

Special Enrollment Periods

This Plan provides Special Enrollment Periods that allow you and/or Dependents to enroll for coverage, even if coverage was previously declined.

Loss of Other Coverage

The Plan will permit you or your Dependent(s) who lose other coverage to enroll under the terms of the Plan, with coverage to be effective on the event date, if the following conditions are met:

1. You and your Dependent(s) are eligible for coverage under the terms of this Plan;
2. You or your Dependent already had other coverage when the Plan was previously offered;
3. If required by the Plan Administrator, you stated in writing at such time that another source of coverage was the reason for declining enrollment; and

4. a. Coverage was not under a COBRA continuation provision and was terminated as a result of:

   (1) A loss of eligibility for the coverage, other than Medicaid or State Child Health Insurance Plan. A "loss of eligibility" includes, but is not limited to, a loss that is a result of Legal Separation, divorce, death, termination of employment, reduction in hours of employment, a child ceasing to qualify as an eligible dependent under the other plan, or the coverage is no longer being made available to a class of similarly situated individuals; or

   (2) Termination of all employer contributions towards such coverage.

   Coverage must be requested not later than 31 days after the loss of other coverage.

   b. The person was covered under COBRA continuation coverage which was exhausted, and the person requested enrollment not later than 31 days after the end of the COBRA coverage.

Acquiring a New Dependent

The Plan will permit a Special Enrollment Period for persons who become a Dependent through marriage, birth, adoption, placement for adoption, or Legal Guardianship. The Dependent Special Enrollment Period will be for 31 days following the actual event.

If you are eligible for enrollment, but not enrolled, you may also enroll at this time. In the case of the birth or adoption of a child, your spouse or civil union partner also may be enrolled as a Dependent, if he or she is otherwise eligible for coverage but not already enrolled. If you enroll a Dependent during the 31-day Dependent Special Enrollment Period, coverage will become effective as of the date of marriage or civil union, birth, adoption, placement for adoption, or Legal Guardianship.

Note: The enrollment requirement does not apply to a newborn if full Family coverage is in effect prior to the date of a newborn's birth.

Medicaid or State Child Health Insurance Plan

The Plan will permit Special Enrollment if you or your Dependent(s) are eligible but not enrolled in the following circumstances:

1. Your coverage or your Dependent's coverage under Medicaid or a State Child Health Insurance Plan (i.e., CHIP) has terminated as a result of loss of eligibility and you request coverage under the Plan within 60 days after the termination; or

2. You or your Dependent become eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e., CHIP), and you request coverage under the Plan within 60 days after eligibility is determined.

If you enroll during the 60-day Special Enrollment Period defined above, coverage will become effective on the first day of the month following the date the Plan receives your request for special enrollment.

Qualified Medical Child Support Orders

The Plan Administrator will enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order or "National Medical Support Notice" ("NMSN") that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an eligible Dependent. Coverage will become effective on the first day of the month following the date the Plan Administrator has determined that such order meets the standards for qualification set forth below or upon the employee's completion of the eligibility Waiting Period, if later. If the employee is not currently enrolled in this Plan, the employee will also be enrolled as of such date.

"Alternate Recipient" means any child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient will be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient will have the same status as a Participant.

"Medical Child Support Order" means any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Person's child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" means a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Person or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Person 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 in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice will be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. a. Identifies either the specific type of coverage or all available group health coverage. If the Company receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Company and the Plan Administrator will assume that all are designated;

   b. Informs the Plan Administrator that, if a group health plan has multiple options and the Covered Person 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
3. 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.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Covered Persons and eligible beneficiaries without regard to this section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator will, as soon as administratively possible:

1. Notify the Covered Person and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator will:

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.

To give effect to this requirement, the Plan Administrator will:

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.

Participant Eligibility

A Participant eligible for coverage under the Plan will include an individual who meets the following conditions:

1. Is employed by the Company on a regular basis, is available to work the number of hours per week outlined in the General Eligibility Provisions, has been in Active Service for the initial eligibility period outlined in the General Eligibility Provisions and has begun work for the Company;
2. Is a Participant who extends coverage under COBRA; or
3. Qualifies under other classifications, as stated in the General Eligibility Provisions.

If you are an Eligible Employee who becomes employed by the Company after the effective date of the Plan, your initial date of eligibility is outlined in the General Eligibility Provisions.

If your Dependent(s) meet the Plan's definition of a Dependent, you will become eligible for Dependent Coverage on the latest of the following:

1. The date you become eligible for Participant Coverage; or
2. The date on which you first acquire a Dependent or the Dependent first becomes eligible for coverage.

If you and your spouse/civil union partner are employed by the Company, either you or your spouse/partner, (but not both) may elect Dependent Coverage. If you choose to enroll for coverage as your spouse/partner's Dependent, you are not eligible to also enroll for Single Coverage. If there are no eligible children, you and your spouse/partner may each elect Single Coverage. If coverage is terminated on one of the individuals, this coverage may be transferred to the remaining spouse/partner's coverage without loss of any benefits or coverage.

The Plan Sponsor may make special eligibility arrangements for new or separating employees when necessary to serve a valid business purpose.

Participant Effective Date

Your Participant Coverage under the Plan will become effective at 12:00 a.m. on the date of your eligibility, provided written application for coverage is made **on or within 31 days of such date.** All Dependent Coverage under the Plan will commence at 12:00 a.m. on the date such coverage is effective.

Participant Termination

Your coverage will automatically terminate at 12:00 midnight upon the earliest of the following dates:

1. Date of termination of your employment;
2. Date on which you cease to be an Eligible Employee as defined by this Plan;
3. Date of expiration of the last period for which you have made a contribution, in the event you fail to make any required contribution for coverage, or you file a written election to discontinue coverage;

   Note: If you elect to make your contribution for coverage on a pre-tax basis under the Company's Section 125 Plan, you will be allowed to discontinue coverage only if permitted in the Section 125 Plan.

4. Date the Plan is terminated, or with respect to any Participant benefits of the Plan, the date of termination of such benefits;
5. Date of your death;
6. If the Company uses a measurement method for your job class and you are classified as an Eligible Employee, the date following the end of the Stability Period, if you failed to qualify during the previous Measurement Period.
7. Immediately after you or your Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information

Upon the termination of coverage, there is no extension of any benefits under this Plan for any reason unless specifically noted in the Plan.

If you are not at work due to layoff, approved personal, non-medical or medical Leave of Absence, your coverage may continue, but not beyond the periods defined in the Company's policies and not beyond one year following the leave.

Participant Reinstatement

If your coverage terminates by reason of termination of employment, layoff, or other change in employment status, coverage may be reinstated if you re-enroll within 31 days of returning to Active Service. The following conditions apply:

1. Employees who return to Active Service within 9 months of the date coverage terminated will be allowed to have their coverage reinstated on:
   - The first day of the month if the employee returns to Active Service on that day; or,
   - The first day of the month following the date the employee returns to Active Service if re-employment commences on or after the second day of the month.
2. Reinstatement is subject to the payment of any required contributions.
3. Any maximum benefit for a Covered Person whose coverage is reinstated will not exceed the total maximum benefit which would have been available had the Covered Person been continuously covered.

If you do not re-enroll for coverage within 31 days of returning to Active Service, you and your Dependents will be considered a Late Enrollee (unless a Special Enrollment event occurs). Late Enrollees are eligible to enroll during the Open Election/Enrollment Period.

If you return to work more than 9 months after the date of original termination, you will be treated as a new employee.

No benefits will be paid for expenses Incurred when coverage was not in force.

Dependent Eligibility

Note: Please refer to the section "Working Spouse/Civil Union Partner Rule" for additional eligibility requirements if your spouse or civil union partner is employed and eligible for health coverage under their employer's group health plan.

A Dependent will be considered eligible for coverage on the date you become eligible for Dependent Coverage, subject to all limitations and requirements of this Plan, and in accordance with the following:

1. Newborn children will be eligible for coverage from the moment of birth for Injury or Illness, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, **provided you properly enroll the child as a Dependent within 31 days of the child's date of birth.** This provision does not apply to nor in any way affect the normal maternity provisions applicable to the mother.

   If full Family coverage (including children) is in effect prior to the date of birth of the newborn, no further enrollment is necessary; however, the Plan Administrator should be notified in a timely manner to ensure your records are kept up to date. If you are covered as an employee with only one Dependent, you must enroll a new Dependent within 31 days.

2. An adopted child will be eligible for coverage on the date the child is legally adopted or placed with you in anticipation of adoption, provided the child is properly enrolled as a Dependent within 31 days.

3. A spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is otherwise eligible and properly enrolled prior to the date of marriage, or within 31 days of the date of marriage.

   A civil union partner will be considered an eligible Dependent from the date your civil union is legally entered into, provided your partner is otherwise eligible and properly enrolled prior to or within 31 days of such date.,

   If your spouse or civil union partner is employed, please refer to the section "Working Spouse/Civil Union Partner Rule" for additional eligibility information.

   If an otherwise eligible spouse or civil union partner is not a resident of the same country as you, your spouse or partner will be considered an eligible Dependent on the date he or she satisfies this residence requirement provided your spouse or partner is properly enrolled within 31 days of such date.

4. If a Dependent is acquired other than at the time of birth, that Dependent will be considered an eligible Dependent from the date of such court order, decree, marriage, or civil union, provided that this new Dependent is properly enrolled prior to or within 31 days of such an event and is otherwise eligible.

5. A Dependent who continues coverage under COBRA.

In order to enroll your eligible spouse and Dependent children, it will be necessary to comply with the Plan's rules and procedures to verify Dependent eligibility status.

Dependent Effective Date

If you file your written request for Dependent Coverage on a form approved by the Plan Administrator, your Dependent(s) will become covered at 12:00 a.m. as follows:

1. If you make such written request within 31 days of your earliest eligibility date, any person who is then your Dependent will become covered on the date your Participant Coverage begins.

2. If you acquire an eligible Dependent after your Participant Coverage begins, your Dependent will become covered on the date the Dependent becomes eligible provided the newly acquired spouse, civil union partner or child is enrolled for coverage within 31 days of such date. However, if full Family coverage is in effect prior to a newborn child's date of birth, the newborn will become covered immediately without specific enrollment required for that child.

If Dependent Coverage under the Plan is requested and you make such written request after the end of the 31-day period specified above or after your previous termination of Dependent Coverage, you may enroll your Dependent during an applicable Special Enrollment Period or during the Open Election/Enrollment Period.

Dependent Termination

Coverage for your Dependent(s) will automatically terminate at 12:00 midnight upon the earliest of the following dates:

1. Date of termination of your coverage under the Plan;
2. Date on which the Dependent ceases to be an eligible Dependent under the Plan;
3. Date you cease to be in a class of Participants eligible for Dependent Coverage;
4. Date of expiration of the last period for which you have made a contribution, in the event you fail to make any required contribution for Dependent Coverage, or you file a written election to discontinue Dependent Coverage;

   Note: If you elect to make your contribution for coverage on a pre-tax basis under the Company's Section 125 Plan, you will be allowed to discontinue coverage only if permitted in the Section 125 Plan.

5. Date the Plan is terminated, or with respect to any Dependent benefit of the Plan, the date of termination of such benefit; or
6. Date the Dependent dies.

Upon the date of termination of coverage, there is no extension of any benefits under this Plan for any reason unless specifically noted in the Plan.

UTILIZATION MANAGEMENT SERVICES (UMS)

Note: The utilization management requirement does not apply to a KSB Hospital admission, or an Outpatient surgical procedure performed at KSB Hospital.

This Plan includes a utilization management requirement for any Inpatient admission or Outpatient surgical procedure other than at KSB Hospital. This means that each proposed Inpatient admission (other than at KSB Hospital) and each proposed Inpatient or Outpatient surgical procedure (performed other than at KSB Hospital) will be reviewed on behalf of the Plan as outlined below. The Plan Administrator has retained the service of a Utilization Manager to perform this utilization management review.

Please refer to your Plan I.D. Card for the name and phone number of the Utilization Manager.

The purpose of utilization management is to assist in the management of the claim. When you have an emergency admission and are released within 24 hours or when you have an emergency visit to an emergency room, there is no reason or requirement to call.

The Utilization Manager must be contacted:

1. When you have to go into the **HOSPITAL OR OTHER FACILITY AS AN INPATIENT**.
2. Upon notification of the need for **SURGERY** on an Inpatient or Outpatient basis, other than for diagnostic and therapeutic endoscopic procedures and minor Surgery performed in a Physician's office during a regular office visit or an Outpatient surgical procedure that is scheduled to be performed at KSB Hospital. It is recommended that the call be made 5 to 7 days prior to the scheduled Surgery.
3. **FOR MATERNITY CASES**, it is recommended that you call the later of four months prior to the medically diagnosed date of delivery or 30 days from the date you first become covered under the Plan. You should also call within 48 hours or by the end of the next business day following the date of confinement.

The Utilization Manager, on behalf of the Plan, will certify:

1. The Medical Necessity of such treatment;
2. The appropriate location for such treatment to be provided; and
3. In the case of an Inpatient admission, a length of stay for each Inpatient confinement. If the Utilization Manager is advised of the need for confinement for a period of time longer than was originally certified, the patient's Physician will be asked to provide additional medical information. If the extended stay is Medically Necessary, an extension to the length of stay will be approved.

The person calling the Utilization Manager will need to provide:

1. Your name, telephone number, individual identification number printed on the Plan I.D. Card and the name of the Plan Sponsor.
2. The name, address, and birthdate of the patient.
3. Names, addresses and telephone numbers of the doctor and the Hospital or other facility.
4. The reason for the Inpatient confinement or Surgery.

In the case of an emergency or Urgent Care need, get treatment.

You are not required to call the Utilization Manager first. You will not be penalized if you do not call before getting emergency or Urgent Care treatment.

However, the Utilization Manager must be contacted:

1. In advance of elective treatment being rendered; or
2. In the case of an Urgent Care need or an emergency, within 48 hours or by the end of the next regular workday following the date of the Urgent Care or emergency admission.

The term "emergency" means an Accident or Illness which requires immediate treatment on an Inpatient basis.

Note: ***If the Utilization Manager is not contacted within the stated time frame following the Urgent Care or emergency Inpatient admission, you will be subject to the penalty outlined below and your claim will be retrospectively reviewed to determine which expenses are eligible for payment under the Plan.***

The Utilization Management Non-Compliance PENALTY of $250:

1. Is in addition to any Deductible under the Plan;
2. Will not be used to satisfy the Out-of-Pocket limit; and
3. Does not apply to maternity cases that do not exceed the requirements of the Newborns' and Mothers' Protection Act of 1996, as amended (that is, 48 hours or less following a vaginal delivery or 96 hours or less following a cesarean section). However, the non-compliance penalty will be applied if the Utilization Manager is not notified of any hospital stay that exceeds the allowed 48- or 96-hour confinement.

CAUTION: Any certification made under these cost management procedures is not to be construed or interpreted as a confirmation of eligibility or that the Inpatient or Outpatient Hospital treatment or Surgery is an eligible medical expense.

The utilization management process is not intended to constitute a medical diagnosis or to interfere with any individual's decision to have a particular course of treatment.

If you do not follow the Plan's utilization management review requirements, or if the Plan determines that a particular treatment is not "Medically Necessary," your level of benefits available under the Plan will be impacted.

Ineligible Expenses

To be eligible for benefits under the Plan, an expense must be Medically Necessary. The addition of utilization review does not change this requirement. If an expense is found to be ineligible, it is not covered under this Plan. Ineligible expenses not reimbursed under the Plan will not be used to satisfy the Plan Deductible or the Out-of-Pocket limit.

If certain Inpatient days are determined by Utilization Manager Physicians to be not Medically Necessary, then the Hospital/facility Room and Board charges for those days will be considered ineligible expenses.

If the treatment received is determined by the Utilization Manager to be not Medically Necessary, then all treatment, services or supplies related to such treatment will be considered to be ineligible expenses.

Right to Appeal a Utilization Management Decision

You have the right to appeal a Utilization Management decision if a requested Inpatient confinement or an extension to the length of stay is denied, whether in whole or in part. Please refer to the "Claim Procedures" section for information on how to file an appeal for a post-service claim.

Since the Plan does not require that you obtain approval of a medical service prior to getting treatment for an Urgent Care or emergency situation, there are no "pre-service Urgent Care claims" under the Plan. All claims are considered to be "post service claims". In an Urgent Care or emergency situation, you should seek treatment and then file the claim as a post service claim.

Second Opinions

The Utilization Manager may require a second opinion before granting pre-certification for certain medical or surgical treatment. Benefits for this expense will be paid as shown in the Schedule of Medical Benefits for the Plan option in which you are enrolled.

Case Management Program

In certain circumstances, typically in the case of a serious illness or injury or with the presence of 3 or more chronic conditions, the Plan may make available to you the services of a case manager. The case manager is a medical or health professional who can be a valuable information resource to you. The case manager will also work with the treating Physician and other providers with the objective of achieving the best and most cost-effective course of treatment or related behavior changes.

If you or your Dependent is selected as a candidate for case management, you will be contacted by a case manager. If you agree to participate, the case manager will then contact the treating Physician.

Participation in this program is encouraged but is strictly voluntary; no Covered Person is obligated to participate, and your benefits will not be adversely affected.

Please contact Professional Benefit Administrators, Inc. (PBA) at (800) 435-5694 if you have questions about how case management works. You should also contact PBA in advance of any major treatment if you are interested in determining if you or a member of your family qualifies for this program.

Specialty Care Benefit

The Plan Administrator has arranged for resources for very specialized care through certain selected facilities, providers, and medical management organizations. This specialized care and/or coordination is designed to offer enhanced outcomes for specific Injuries, Illnesses, and treatment types. The arrangements will allow Covered Persons to receive the best care available at negotiated rates. Any Covered Person who is about to undergo treatment of the types listed below may be a candidate for this specialized care.

These services are freestanding and are separate from any PPO or non-PPO contracts or benefits.

Contact Professional Benefit Administrators, Inc. (PBA) at (800) 435-5694 in order to find out if you qualify for specialized care for any of the following Illnesses or Injuries or in advance of any major or ongoing course of treatment to see if specialty providers may be available to you:

- Cancer treatment
- Renal disease
- Musculoskeletal conditions
- Severe burns
- Premature babies
- Transplants
- Multiple Sclerosis
- Hemophilia

In addition, if the Plan Administrator identifies additional Conditions for which specialty provider services are available, the Covered Person will be given the opportunity to receive care and treatment through the specialty provider and thereby receive full benefits under the Plan.

Pre-approved reasonable and necessary travel and lodging expenses may be covered to and from the site of treatment for the Covered Person and one other individual, or two other individuals in the case of a minor, when specialized care requires travel to the site of treatment.

Please note that each Covered Person has a free choice of any provider, and the Covered Person, together with his provider, 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 specialty care providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any provider.

Do not delay seeking medical care for any Covered Person who has a serious Condition that may jeopardize his life or health because of the requirements of this provision. For Urgent Care, emergency admissions, follow your Physician's instructions carefully, and contact Professional Benefit Administrators, Inc. as soon as possible thereafter.

MEDICAL EXPENSE BENEFITS

All Plan expenses are subject to the following requirements:

1. They must be Medically Necessary, unless otherwise stated; and
2. They must not exceed the Maximum Allowable Charge; and
3. They must be considered Covered Charges by the Plan; and
4. They are subject to the exclusions and limitation provisions.

Comprehensive Major Medical Benefits

Comprehensive Major Medical Benefits are payable for Covered Expenses Incurred for an Injury or Illness while covered by this Plan and are subject to all of the Plan provisions.

Preferred Provider Benefit (PPO)

The Plan includes a Preferred Provider Organization ("PPO") Network. PPO Networks offer health care services and supplies to you at discounted rates which will result in lower costs. A listing of the preferred providers is available without charge through the PPO's website as noted on your Plan I.D. card. Although the Plan provides access to the PPO as an alternative to other providers, the Company in no way recommends or endorses these or any other provider. It is the responsibility of the patient or Family to determine the ability of any provider to render care or treatment.

Benefits will be payable at the PPO level shown in the Schedule of Medical Benefits when charges are Incurred with a "PPO" or "Network" Provider. Charges Incurred with a "Non-PPO" or "Non-Network" Provider will be payable at the PPO benefit level only in the following circumstances unless otherwise specified in the Schedule of Medical Benefits:

- For Emergency Services given in a Hospital or an Independent Freestanding Emergency Department for an Emergency Medical Condition.
- When Hospital ancillary providers (such as anesthesiologists, pathologists, radiologists, assistant surgeons, or emergency room Physicians) render services at KSB or a PPO Hospital.
- For Non-Network claims subject to the No Surprises Act (refer to the following section for additional information).
- For Preventive Care services, as outline in the Schedule of Medical Benefits.

If you are enrolled in the KSB Plan, Covered Expenses Incurred with a Non-PPO provider are covered only in the circumstances outlined above; this exclusion for Non-PPO providers applies regardless of whether you, or a covered Dependent, are referred to a Non-PPO provider by a KSB or PPO provider.

If you or your covered Dependent rely on information received from the Plan, its representative, or a database maintained by the Plan that a particular provider is a Network provider with respect to an item or service, benefits for charges Incurred with that provider for such item or service will be payable at the PPO level if that information proves to be inaccurate.

All PPO benefits payable by the Plan are automatically assigned to the provider of services or supplies unless evidence of previous payment is submitted with the claim. All other benefits payable by the Plan may be assigned at your option. Payments made in accordance with an Assignment of Benefits are made in good faith and release the Plan's obligation to the extent of the payment.

No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act ("NSA"), benefits will be payable at the PPO benefit level and will be calculated on the Plan's Recognized Amount (regardless of the Plan's actual Maximum Allowable Charge). The NSA prohibits providers from pursuing you or your covered Dependent for the difference between the Maximum Allowable Charge and the provider's billed charge for applicable services, unless specifically permitted by the NSA. Any cost-sharing amounts will accrue toward Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

Continuity of Care

Continuity of Care allows a Covered Person to continue receiving benefits at the Plan's Network coverage level for limited period of time if the individual is a Continuing Care Patient receiving a course of treatment from a Network provider and that contractual relationship ends for any reason other than the provider's failure to meet applicable quality standards or for fraud. For purposes of this provision, a "Continuing Care Patient" means an individual who meets any of the following requirements (or as modified by applicable regulations):

1. Is undergoing a course of treatment for a serious and complex Condition from a specific provider;
2. Is undergoing a course of institutional or Inpatient care from a specific provider;
3. Is scheduled to undergo non-elective Surgery from a specific provider, including receipt of postoperative care with respect to the Surgery;
4. Is pregnant and undergoing a course of treatment for the pregnancy from a specific provider; or
5. Is or was determined to be terminally ill and is receiving treatment for such Illness from a specific provider.

If you or your covered Dependent are a Continuing Care Patient who is eligible for Continuity of Care and elect, in writing, to receive continued transitional care, Plan benefits will apply for that health care provider or facility under the same terms and conditions as would be applicable had the termination not occurred, for up to 90 days following approval or the individual ceases to be a Continuing Care Patient, whichever is sooner.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect a Covered Person if the Provider pursues a balance bill.

KSB Plan

Note: All treatment, services, supplies must be received from a KSB or PPO provider to be considered a Covered Expense. Expenses Incurred with a Non-PPO provider are covered only as specified in the section "Preferred Provider Benefit (PPO)".

KSB Plan

Calendar Year Deductible
(Calendar Year Deductibles are combined; Copays do not apply to the Deductible.)

	KSB Providers or PPO Providers When Service Is Not Available from a KSB Provider	***PPO Providers When Service Is Available from a KSB Provider***
Per Covered Person	$1,500	$3,500
Per Family (aggregate)	$2,500	$6,500

The Deductible is the amount of money that you or your Dependent must pay before the Plan provides a benefit reimbursement, unless otherwise noted in this Schedule. The Deductible applies only once for each Covered Person within a Calendar Year. If members of a Family have together, in combination, Incurred Eligible Charges in an amount that satisfied the "Per Family" aggregate shown above, no further Deductible will apply to any member of that Family during the remainder of that Calendar Year.

The annual Deductible is per Calendar Year and only applies to the Calendar Year in which it occurred. There is no Deductible carryover between Calendar Years.

If two or more members of a covered Family unit are Injured in the same Accident, only one Deductible will be applied to Covered Expenses Incurred as a result of that Accident. This will be done only to determine the amount of benefits to be paid for Injuries sustained in that specific Accident.

Coinsurance by Plan

Unless otherwise noted, the Plan will pay the benefit specified below:

KSB Providers and Select Providers*:	100% after satisfying the Deductible
PPO Providers When Service:	
Is *Not* Available from a KSB Provider**:	80% after satisfying the Deductible
Is Available from a KSB Provider:	60% after satisfying the Deductible
Non-PPO Providers:	Not Covered, except as specified in the section "PPO Provider Benefit (PPO)".

* *Charges Incurred with select providers (such as Rockford Radiology Associates or Rockford Anesthesiology RA when performed at KSB, and Physicians Immediate Care in Dixon, IL) will be payable at the KSB benefit level.*

** *If a service is not available from a KSB provider, PPO Providers will be eligible for benefits however, Non-PPO Providers are not covered. Please submit a letter of appeal to the Human Resource Department if the type of service provider is not on the pre-approved list.*

KSB Plan		
Out-of-Pocket Limit *(Out-of-Pocket limits are combined and include the Calendar Year Deductible; Copays do not apply.)*		
	KSB Providers or PPO Providers When Service Is Not Available from a KSB Provider	***PPO Providers When Service Is Available from a KSB Provider***
Per Covered Person	$3,000	$ 5,500
Per Family (aggregate)	$5,500	$10,500

After your Out-of-Pocket expense for your Coinsurance and Deductible equal the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Out-of-Pocket limit for the balance of the Calendar Year.

Note: The Out-of-Pocket limit does not include non-compliance penalties, ineligible charges, charges in excess of the Maximum Allowable Charge, and Copays (including drug card Copays). Copays apply only to the overall maximum out-of-pocket.

KSB Plan Option			
Covered Services	***KSB Providers***	***PPO Providers When Service Is Not Available from a KSB Provider***	***PPO Providers When Service Is Available from a KSB Provider***
Ambulance Services	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
Autism – As outlined in the section "Medical Expense Covered Charges"	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.		
Chiropractic Services Benefits for chiropractic services (including chiropractic x-ray and laboratory services) are limited to a maximum benefit of $1,000 per person per Calendar Year.			
• **Chiropractic Office Visit/ Office Services** Covered Charges include manipulations, adjustments and x-ray and lab services performed in a chiropractor's office.	80% after $20 Copay per visit and KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
• **Chiropractic X-ray and Lab** when performed outside of a chiropractor office.	60% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
Diabetic Education (limited to 8 visits per person per Calendar Year)	100% after Deductible	80% after Deductible	60% after Deductible
Diagnostic X-ray and Lab - Outpatient	100% after Deductible	80% after Deductible	60% after Deductible
Durable Medical Equipment	100% after Deductible	80% after Deductible	60% after Deductible

KSB Plan Option			
Covered Services	***KSB Providers***	***PPO Providers When Service Is Not Available from a KSB Provider***	***PPO Providers When Service Is Available from a KSB Provider***
Emergency Services – Hospital or Independent Freestanding Emergency Department for an Emergency Medical Condition Copay waived if admitted	100% after $250 Copay per visit and Deductible	80% after $250 Copay per visit and KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum	
Urgent Care	100% after $75 Copay per visit and Deductible	80% after $75 Copay per visit and Deductible	60% after $75 Copay per visit and Deductible
Hearing Aid Benefit When Medically Necessary in connection with Injury or Illness (limited to $1,500 per ear every 2 years)	100% after Deductible	80% after Deductible	60% after Deductible
Home Health Care (limited to 90 visits per person per Calendar Year)	100% after Deductible	80% after Deductible	60% after Deductible
Hospice Care	100% after Deductible	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum	
Hospital Services - Inpatient Services	100% after $100 Copay per Inpatient Admission and Deductible	80% after $100 Copay per Inpatient Admission and Deductible	60% after $100 Copay per Inpatient Admission and Deductible
Hospital Services – Outpatient Services	100% after Deductible	80% after Deductible	60% after Deductible
JointStrong® Musculoskeletal Therapy designed to avoid unnecessary Surgery Covered Charges incurred for treatment accessed through the JointStrong® program. Contact JointStrong® at (855) 293-0340 or visit www.jointstrong.com	100%, no Deductible		
Maternity Care	100% after Deductible	80% after Deductible	60% after Deductible
Orthotics (limited to 1 pair per person per Calendar Year)	100% after Deductible	80% after Deductible	60% after Deductible
Physician Office Visit	100% after $20 Copay per visit and Deductible	80% after $20 Copay per visit and Deductible	60% after $20 Copay per visit and Deductible

KSB Plan Option			
Covered Services	***KSB Providers***	***PPO Providers When Service Is Not Available from a KSB Provider***	***PPO Providers When Service Is Available from a KSB Provider***
Physician Services – Other	100% after Deductible	80% after Deductible	60% after Deductible
Pre-Admission Testing	100% after Deductible	80% after Deductible	60% after Deductible
Preventive Services Charges for Preventive Services as outlined in the section "Medical Expense Covered Charges". Preventive Services include, but are not limited to, routine physical exams and screenings, Well Child Care, routine x-ray and lab, mammograms, pap smears, PSA tests, immunizations, and colonoscopies at the age and frequency recommended under federal guidelines required by law or by current American Cancer Society guidelines. The Shingles vaccine will be considered eligible regardless of age. If screening is completed to confirm status of a diagnosed Condition, or if screening to diagnose symptoms, Covered Charges will be covered under regular Plan benefits.			
• **Well Adult Care – Covered Persons Age 19 and Over**	100% no Deductible	90% no Deductible, up to a maximum benefit of $350 per Covered Person per Calendar Year. The maximum includes Routine Well Adult Care benefits paid to Non-PPO providers.	90% no Deductible, up to a maximum benefit of $350 per Covered Person per Calendar Year. The maximum includes Routine Well Adult Care benefits paid to Non-PPO providers.
• **Routine Well Child Care – Covered Dependent less than Age 19**	100% no Deductible	80% after Deductible	80% after Deductible
Preventive Services exception to the exclusion of Non-PPO Providers. *Benefits for charges Incurred with a Non-PPO Provider will be payable as outlined below:* *Well Adult Care: 60%, no Deductible, up to a maximum benefit of $250 per Covered Person per Calendar Year. The maximum includes Routine Well Adult Care benefits paid to PPO providers.* *Well Child Care: 60%, after Deductible.*			
• **Breastfeeding Supplies, including rental of breastfeeding equipment.** The Plan will cover the reasonable cost (not to exceed $250) for the purchase of a manual or standard electric breast pump (non-hospital grade) instead of rental, limited to one pump per pregnancy.	100% no Deductible	100% no Deductible	
Preventive Services exception to the exclusion of Non-PPO Providers. *Benefits for Covered Charges (as outlined above) that are Incurred with a Non-PPO Provider will be payable at 100%, no Deductible.*			

KSB Plan Option			
Covered Services	***KSB Providers***	***PPO Providers When Service Is Not Available from a KSB Provider***	***PPO Providers When Service Is Available from a KSB Provider***
Skilled Nursing Facility (limited to 180 days per person per Calendar Year; 360 days per person per lifetime)	100% after Deductible	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum	
Surgery	100% after Deductible	80% after Deductible	60% after Deductible
Therapy – Occupational, Physical and Speech	100% after Deductible	80% after Deductible	60% after Deductible
Treatment of Mental or Nervous Disorder/ Substance Abuse	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.		
Wig Benefit (initial following chemotherapy or radiation limited to $200 maximum)	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		

Outpatient Prescription Drug Card Benefit

Benefits for prescription drugs covered under the Outpatient Prescription Drug Card Benefit will not be provided under any other section of this Plan. The epiphanyRx Outpatient Prescription Drug Card Network website and telephone number are listed on your Plan I.D. card.

Preventive Services, Short-term Acute Drugs and Maintenance Drugs

You are eligible to purchase covered Outpatient drugs and medicines from the KSB Pharmacy or an epiphanyRx Network Pharmacy. However, a 90-day supply is available only for prescriptions filled through the KSB pharmacy. Your Copay amount for each eligible prescription is as follows; benefits will be provided for the remaining eligible charge:

	KSB Pharmacy		**epiphanyRx Network Pharmacy**
	30-Day Supply	***90-Day Supply***	***30-Day Supply***
Preventive Services (as specified under the Affordable Care Act)	$0	$0	$0
Generic Drugs	$15	$30	$25
Brand-Name Drugs: Preferred	$30	$60	$45
Non-Preferred	$75	$150	$100

Specialty Drugs

Prior authorization must be obtained from epiphanyRx for specialty drugs. Once approval has been obtained, the prescription must be filled through the KSB Pharmacy unless the drug is available only from another pharmacy due to limited distribution of the medication.

Your Copay for each covered prescription is as follows; one specialty drug prescription means up to a 30-consecutive-day supply. Benefits will be provided for the remaining eligible charge.

KSB Pharmacy	$200 per fill
Other Pharmacy *only for limited distribution drugs*	$300 per fill

PPO Plan

PPO Plan		
Calendar Year Deductible *(Calendar Year Deductibles are combined; Copays do not apply to the Deductible.)*		
	KSB or PPO Providers	***Non-PPO Providers***
Per Covered Person	$3,000	$5,000
Per Family (aggregate)	$5,000	$9,000

The Deductible is the amount of money that you or your Dependent must pay before the Plan provides a benefit reimbursement, unless otherwise noted in this Schedule. The Deductible applies only once for each Covered Person within a Calendar Year. If members of a Family have together, in combination, Incurred Eligible Charges in an amount that satisfied the "Per Family" aggregate shown above, no further Deductible will apply to any member of that Family during the remainder of that Calendar Year.

If KSB, PPO, and Non-PPO providers are used during the Calendar Year, your combined total Deductible will not exceed the amount shown for Non-PPO providers. In other words, the amount of Deductible expense a Covered Person will pay for KSB, PPO and Non-PPO providers will be combined, and the total will not exceed the amount shown for Non-PPO providers during a Calendar Year.

The annual Deductible is per Calendar Year and only applies to the Calendar Year in which it occurred. There is no Deductible carryover between Calendar years.

If two or more members of a covered Family unit are Injured in the same Accident, only one Deductible will be applied to Covered Expenses Incurred as a result of that Accident. This will be done only to determine the amount of benefits to be paid for Injuries sustained in that specific Accident.

Coinsurance by Plan

Unless otherwise noted, the Plan will pay the benefit specified below:

KSB Provider*	90% after satisfying the Deductible
PPO Provider:	80% after satisfying the Deductible
Non-PPO Provider:	60% after satisfying the Deductible

* *Charges Incurred with select providers (such as Rockford Radiology Associates or Rockford Anesthesiology RA when performed at KSB, and Physicians Immediate Care in Dixon, IL) will be payable at the KSB benefit level.*

Out-of-Pocket Limit
(Out-of-Pocket limits are combined and include the Calendar Year Deductible; Copays do not apply.)

	KSB or PPO Providers	***Non-PPO Providers***
Per Covered Person	$ 5,500	$ 8,500
Per Family (aggregate)	$10,500	$16,500

If KSB, PPO, and Non-PPO providers are used during the Calendar Year, your combined total Out-of-Pocket limit will not exceed the amount shown for Non-PPO providers.

After your Out-of-Pocket expense for your Coinsurance and Deductible equal the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Out-of-Pocket limit for the balance of the Calendar Year.

Note: The Out-of-Pocket limit does not include non-compliance penalties, ineligible charges, charges in excess of the Maximum Allowable Charge, and Copays (including drug card Copays). Copays for KSB, PPO Providers, and Outpatient drug card Copays apply only to the overall maximum out-of-pocket.

PPO Plan			
Covered Services	***KSB***	***PPO Providers***	***Non-PPO Providers***
Ambulance Services	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
Autism – As outlined in the section "Medical Expense Covered Charges"	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.		
Chiropractic Services Benefits for chiropractic services (including chiropractic x-ray and laboratory services) are limited to a maximum benefit of $1,000 per person per Calendar Year.			
• **Chiropractic Office Visit/ Office Services** Covered Charges include manipulations, adjustments and x-ray and lab services performed in a chiropractor's office.	80% after $20 Copay per visit and KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
• **Chiropractic X-ray and Lab** when performed outside of a chiropractor office.	60% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
Diabetic Education (limited to 8 visits per person per Calendar Year)	90% after Deductible	80% after Deductible	60% after Deductible
Diagnostic X-ray and Lab - Outpatient	90% after Deductible	80% after Deductible	60% after Deductible
Durable Medical Equipment	90% after Deductible	80% after Deductible	60% after Deductible
Emergency Services – Hospital or Independent Freestanding Emergency Department for an Emergency Medical Condition	90% after $250 Copay per visit and KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
Urgent Care	90% after $75 Copay per visit and Deductible	80% after $75 Copay per visit and Deductible	60% after $75 Copay per visit and Deductible
Hearing Aid Benefit When Medically Necessary in connection with Injury or Illness (limited to $1,500 per ear every 2 years)	90% after Deductible	80% after Deductible	60% after Deductible
Home Health Care (limited to 90 visits per person per Calendar Year)	90% after Deductible	80% after Deductible	60% after Deductible

PPO Plan			
Covered Services	***KSB***	***PPO Providers***	***Non-PPO Providers***
Hospice Care	90% after Deductible	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum	
Hospital Services - Inpatient Services	90% after $100 Copay per Inpatient Admission and Deductible	80% after $100 Copay per Inpatient Admission and Deductible	60% after $500 Copay per Inpatient Admission and Deductible
Hospital Services – Outpatient Services	90% after Deductible	80% after Deductible	60% after Deductible
JointStrong® Musculoskeletal Therapy designed to avoid unnecessary Surgery Covered Charges incurred for treatment accessed through the JointStrong® program. Contact JointStrong® at (855) 293-0340 or visit www.jointstrong.com	100%, no Deductible		
Maternity Care	90% after Deductible	80% after Deductible	60% after Deductible
Orthotics (limited to 1 pair per person per Calendar Year)	90% after Deductible	80% after Deductible	60% after Deductible
Physician Office Visit	90% after $20 Copay per visit and Deductible	80% after $20 Copay per visit and Deductible	60% after $20 Copay per visit and Deductible
Physician Services – Other	90% after Deductible	80% after Deductible	60% after Deductible
Pre-Admission Testing	90% after Deductible	80% after Deductible	60% after Deductible

PPO Plan			
Covered Services	***KSB***	***PPO Providers***	***Non-PPO Providers***
Preventive Services Charges for Preventive Services as outlined in the section "Medical Expense Covered Charges". Preventive Services include, but are not limited to, routine physical exams and screenings, Well Child Care, routine x-ray and lab, mammograms, pap smears, PSA tests, immunizations, and colonoscopies at the age and frequency recommended under federal guidelines required by law or by current American Cancer Society guidelines. The Shingles vaccine will be considered eligible regardless of age. If screening is completed to confirm status of a diagnosed Condition, or if screening to diagnose symptoms, Covered Charges will be covered under regular Plan benefits.			
• **Well Adult Care – Covered Persons Age 19 and Over**	100% no Deductible	90% no Deductible, up to a maximum benefit of $350 per Covered Person per Calendar Year. The maximum includes Routine Well Adult Care benefits paid to Non-PPO providers.	60% no Deductible, up to a maximum benefit of $250 per Covered Person per Calendar Year. The maximum includes Routine Well Adult Care benefits paid to PPO providers.
• **Routine Well Child Care – Covered Dependent less than Age 19**	100% no Deductible	80% after Deductible	60% after Deductible
• **Breastfeeding Supplies, including rental of breastfeeding equipment.** The Plan will cover the reasonable cost (not to exceed $250) for the purchase of a manual or standard electric breast pump (non-hospital grade) instead of rental, limited to one pump per pregnancy.	100% no Deductible	100% no Deductible	100% no Deductible
Skilled Nursing Facility (limited to 180 days per person per Calendar Year; 360 days per person per lifetime)	90% after Deductible	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum	
Surgery	90% after Deductible	80% after Deductible	60% after Deductible
Therapy – Occupational, Physical and Speech	90% after Deductible	80% after Deductible	60% after Deductible
Treatment of Mental or Nervous Disorder/ Substance Abuse	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.		
Wig Benefit (initial following chemotherapy or radiation limited to $200 maximum)	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		

Outpatient Prescription Drug Card Benefit

Benefits for prescription drugs covered under the Outpatient Prescription Drug Card Benefit will not be provided under any other section of this Plan. The epiphanyRx Outpatient Prescription Drug Card Network website and telephone number are listed on your Plan I.D. card.

Preventive Services, Short-term Acute Drugs and Maintenance Drugs

You are eligible to purchase covered Outpatient drugs and medicines from the KSB Pharmacy or an epiphanyRx Network Pharmacy. However, a 90-day supply is available only for prescriptions filled through the KSB pharmacy. Your Copay amount for each eligible prescription is as follows; benefits will be provided for the remaining eligible charge:

	KSB Pharmacy		**epiphanyRx Network Pharmacy**
	30-Day Supply	***90-Day Supply***	***30-Day Supply***
Preventive Services (as specified under the Affordable Care Act)	$0	$0	$0
Generic Drugs	$15	$30	$25
Brand-Name Drugs: Preferred	$30	$60	$45
Non-Preferred	$75	$150	$100

Specialty Drugs

Prior authorization must be obtained from epiphanyRx for specialty drugs. Once approval has been obtained, the prescription must be filled through the KSB Pharmacy unless the drug is available only from another pharmacy due to limited distribution of the medication.

Your Copay for each covered prescription is as follows; one specialty drug prescription means up to a 30-consecutive-day supply. Benefits will be provided for the remaining eligible charge.

KSB Pharmacy	$200 per fill
Other Pharmacy *only for limited distribution drugs*	$300 per fill

High Deductible Health Plan (HDHP)

High Deductible Health Plan Option (HDHP)		
Calendar Year Deductible *(Calendar Year Deductibles are combined; Copays do not apply to the Deductible.)*		
	KSB or PPO Providers	***Non-PPO Providers***
If Enrolled for Single Coverage	$4,000	$7,000
If Enrolled for Family Coverage	$7,000	$13,000

The Deductible is the amount of money that must be paid during a Calendar Year before the Plan provides a benefit reimbursement. It applies to all Covered Charges other than Preventive Services. If KSB, PPO, and Non-PPO providers are used during the Calendar Year, your combined total Deductible will not exceed the amount shown for Non-PPO providers. In other words, the amount of Deductible expense a Covered Person will pay for KSB, PPO and Non-PPO providers will be combined, and the total will not exceed the amount shown for Non-PPO providers during a Calendar Year.

If you are enrolled for Single Coverage, the Deductible is the accumulated total of Eligible Charges Incurred by you during a Calendar Year.

If you are enrolled for Family Coverage, the Deductible is the accumulated combined total of Eligible Charges Incurred by all members of your Family during the Calendar Year. The entire Deductible can be satisfied by one family member or a combination of several family members.

Once the Deductible is satisfied, no further Deductible will apply during the remainder of that Calendar Year.

The annual Deductible is per Calendar Year and only applies to the Calendar Year in which it occurred. There is no Deductible carryover between Calendar Years.

Coinsurance by Plan

Unless otherwise noted, the Plan will pay the benefit specified below:

KSB Provider:	90% after satisfying the Deductible
PPO Provider:	80% after satisfying the Deductible
Non-PPO Provider:	60% after satisfying the Deductible

* *Charges Incurred with select providers (such as Rockford Radiology Associates or Rockford Anesthesiology RA when performed at KSB and Physicians Immediate Care in Dixon, IL) will be payable at the KSB benefit level.*

Out-of-Pocket Limit
(Out-of-Pocket limits are combined and include Calendar Year Deductibles and KSB/PPO/Rx Copays.)

	KSB or PPO Providers	***Non-PPO Providers***
If Enrolled for Single Coverage	$ 6,750	$13,000
If Enrolled for Family Coverage	$13,500*	$25,500

* *The Out-of-Pocket limit for KSB/PPO Providers during a Calendar Year is limited to $7,900 per family member.*

If KSB, PPO, and Non-PPO providers are used during the Calendar Year, your combined total Out-of-Pocket limit will not exceed the amount shown for Non-PPO providers.

After your Out-of-Pocket expense for your Coinsurance, Deductible and KSB/PPO/Rx Copays equal the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Out-of-Pocket limit for the balance of the Calendar Year.

If you are enrolled for Family Coverage, the Out-of-Pocket limit is the accumulated combined total of all members of your Family during the Calendar Year.

Note: Non-compliance penalties, ineligible charges, charges in excess of the Maximum Allowable Charge and Non-PPO Provider Copays do not qualify under the Out-of-Pocket limit provision.

High Deductible Health Plan			
Covered Services	***KSB***	***PPO Providers***	***Non-PPO Providers***
Ambulance Services	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
Autism – As outlined in the section "Medical Expense Covered Charges"	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.		
Chiropractic Services Benefits for chiropractic services (including chiropractic x-ray and laboratory services) are limited to a maximum benefit of $1,000 per person per Calendar Year.			
• **Chiropractic Office Visit/ Office Services** Covered Charges include manipulations, adjustments and x-ray and lab services performed in a chiropractor's office.	80% after $20 Copay per visit and KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
• **Chiropractic X-ray and Lab** when performed outside of a chiropractor office.	60% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
Diabetic Education (limited to 8 visits per person per Calendar Year)	90% after Deductible	80% after Deductible	60% after Deductible
Diagnostic X-ray and Lab - Outpatient	90% after Deductible	80% after Deductible	60% after Deductible
Durable Medical Equipment	90% after Deductible	80% after Deductible	60% after Deductible
Emergency Services – Hospital or Independent Freestanding Emergency Department for an Emergency Medical Condition	90% after $250 Copay per visit and KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		
Urgent Care	90% after $75 Copay per visit and Deductible	80% after $75 Copay per visit and Deductible	60% after $75 Copay per visit and Deductible
Hearing Aid Benefit When Medically Necessary in connection with Injury or Illness; limited to $1,500 per ear every 2 years)	90% after Deductible	80% after Deductible	60% after Deductible
Home Health Care (limited to 90 visits per person per Calendar Year)	90% after Deductible	80% after Deductible	60% after Deductible

High Deductible Health Plan			
Covered Services	***KSB***	***PPO Providers***	***Non-PPO Providers***
Hospice Care	90% after Deductible	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum	
Hospital Services - Inpatient Services	90% after $100 Copay per Inpatient Admission and Deductible	80% after $100 Copay per Inpatient Admission and Deductible	60% after $500 Copay per Inpatient Admission and Deductible
Hospital Services – Outpatient Services	90% after Deductible	80% after Deductible	60% after Deductible
JointStrong® Musculoskeletal Therapy designed to avoid unnecessary Surgery Covered Charges incurred for treatment accessed through the JointStrong® program. Contact JointStrong® at (855) 293-0340 or visit www.jointstrong.com	100%, after Deductible		
Maternity Care	90% after Deductible	80% after Deductible	60% after Deductible
Orthotics (limited to 1 pair per person per Calendar Year)	90% after Deductible	80% after Deductible	60% after Deductible
Physician Office Visit	90% after $20 Copay per visit and Deductible	80% after $20 Copay per visit and Deductible	60% after $20 Copay per visit and Deductible
Physician Services – Other	90% after Deductible	80% after Deductible	60% after Deductible
Pre-Admission Testing	90% after Deductible	80% after Deductible	60% after Deductible

High Deductible Health Plan			
Covered Services	***KSB***	***PPO Providers***	***Non-PPO Providers***
Preventive Services Charges for Preventive Services as outlined in this Amendment under the section "Medical Expense Covered Charges". Preventive Services include, but are not limited to, routine physical exams and screenings, Well Child Care, routine x-ray and lab, mammograms, pap smears, PSA tests, immunizations, and colonoscopies at the age and frequency recommended under federal guidelines required by law or by current American Cancer Society guidelines. The Shingles vaccine will be considered eligible regardless of age. If screening is completed to confirm status of a diagnosed Condition, or if screening to diagnose symptoms, Covered Charges will be covered under regular plan benefits.			
• **Routine Well Adult Care – Covered Persons Age 19 and Over**	100% no Deductible	90% no Deductible, up to a maximum benefit of $350 per Covered Person per Calendar Year. The maximum includes Routine Well Adult Care benefits paid to Non-PPO providers.	60% no Deductible, up to a maximum benefit of $250 per Covered Person per Calendar Year. The maximum includes Routine Well Adult Care benefits paid to PPO providers.
• **Routine Well Child Care – Covered Dependent less than Age 19**	100% no Deductible	80% after Deductible	60% after Deductible
• **Breastfeeding Supplies, including rental of breastfeeding equipment.** The Plan will cover the reasonable cost (not to exceed $250) for the purchase of a manual or standard electric breast pump (non-hospital grade) instead of rental, limited to one pump per pregnancy.	100% no Deductible	100% no Deductible	100% no Deductible
Skilled Nursing Facility (limited to 180 days per person per Calendar Year; 360 days per person per lifetime)	90% after Deductible	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum	
Surgery	90% after Deductible	80% after Deductible	60% after Deductible
Therapy – Occupational, Physical and Speech	90% after Deductible	80% after Deductible	60% after Deductible
Treatment of Mental or Nervous Disorder/ Substance Abuse	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit		
Wig Benefit (initial following chemotherapy or radiation limited to $200 maximum)	80% after KSB/PPO Deductible to the KSB/PPO Out-of-Pocket Maximum		

Outpatient Prescription Drug Card Benefit

The epiphanyRx Outpatient Prescription Drug Card Network website and telephone number are listed on your Plan I.D. card.

Your coverage under the HDHP option allows you to **purchase eligible prescription drugs and medicines at a discount from the KSB Pharmacy or epiphanyRx Network Pharmacy until the Calendar Year Deductible is satisfied**. You will be required to pay the full cost of medications (other than Preventive Services) up to the point the Deductible is satisfied. The Calendar Year Deductible does not apply to Preventive Services.

The prescription drug card Network will automatically file your claim with the Claims Administrator.

Preventive Services, Short-term Acute Drugs and Maintenance Drugs

After your Calendar Year Deductible is met, your Copay amount for each eligible prescription is as follows; benefits will be provided for the remaining eligible charge:

HDHP Plan Option *(Copay applies after the Deductible, other than Preventive Services)*			
	KSB Pharmacy		**epiphanyRx Network Pharmacy**
	30-Day Supply	***90-Day Supply***	***30-Day Supply***
Preventive Services (as specified under the Affordable Care Act)	$0	$0	$0
Generic Drugs	$15	$30	$25
Brand-Name Drugs: Preferred	$30	$60	$45
Non-Preferred	$75	$150	$100

Benefits will be provided for the remaining eligible charge. A 90-day supply is available only for prescriptions filled through the KSB pharmacy.

Specialty Drugs

Prior authorization must be obtained from epiphanyRx for specialty drugs.

Once approval has been obtained, the prescription must be filled through the KSB Pharmacy unless the drug is available only from another pharmacy due to limited distribution of the medication.

After your Calendar Year Deductible is met, your Copay for each covered prescription is:

KSB Pharmacy	$200 per fill
Other Pharmacy *only for limited distribution drugs*	$300 per fill

Benefits will be provided for the remaining eligible charge. One specialty drug prescription means up to a 30-consecutive-day supply.

Coinsurance

Upon receipt of written proof of loss (which includes the claim form and information sufficient to enable proper consideration of the claim), the Plan will pay the benefits outlined in the Schedule of Medical Benefits for Eligible Expenses Incurred in each Calendar Year unless otherwise stated in the Plan. All Eligible Expenses Incurred in the benefit period in excess of the Out-of-Pocket limit will be paid at 100%, as outlined on the Schedule of Medical Benefits. The amount payable in no event will exceed any maximum limitation stated in the Schedule of Medical Benefits or in the section entitled “General Exclusions and Limitations.” The Out-of-Pocket limit may not apply to all benefits.

Overall Maximum Out-of-Pocket for KSB and PPO Providers (Includes Drug Copays)

Your overall maximum out-of-pocket expense for KSB, PPO providers and Network pharmacies during the Calendar Year will not exceed **$7,900 per Covered Person and $15,800 per Family (aggregate).** This overall maximum out-of-pocket limit includes your Calendar Year Deductible, your Coinsurance and Copays for charges Incurred with KSB, PPO providers, and Network pharmacies under the Outpatient Prescription Drug Card program. The Plan will pay 100% of Covered Charges Incurred at KSB or with a PPO provider/Network pharmacy for the balance of the Calendar Year after the overall maximum out-of-pocket expense is met.

The following expenses do not qualify under this overall maximum out-of-pocket limit:

- Non-compliance penalties;
- Ineligible charges;
- Charges in excess of the Maximum Allowable Charge; and,
- Your Coinsurance and Copays for charges Incurred with Non-PPO providers.

Allocation and Apportionment of Benefits

The Plan reserves the right to allocate the Deductible amount to any Eligible Charge and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment will be conclusive and binding upon the Covered Person and all assignees.

Medical Expense Covered Charges

To be eligible for benefits under this provision, expenses actually Incurred by a Covered Person must meet the following requirements:

1. They are administered or ordered by a Physician; and
2. They are Medically Necessary, unless otherwise stated; and
3. They are considered Covered Charges under the Plan; and
4. They do not exceed the Maximum Allowable Charge.

Covered Expenses are limited to:

1. **Ambulance.**
   a. Charges for local professional ground ambulance service to the nearest facility where Emergency Medical Care or treatment is rendered, or the Medically Necessary transfer from one facility to another. The “nearest facility” is defined as one that is specialized and equipped to care for the person’s Condition.

   b. Charges for Medically Necessary air ambulance service to the appropriate facility for Emergency Medical Care or treatment if the patient’s Condition is life threatening.

      Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

      If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need such as specialized care that is available at certain Hospitals. To be covered, you must be taken to the nearest facility that can treat you. Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.

2. **Ambulatory Surgical Center.** Charges made by an Ambulatory Surgical Center or minor emergency medical clinic.

3. **Anesthesia.** Charges for the cost and administration of an anesthetic.

4. **Autism Spectrum Disorder**. Charges Incurred for:

   a. The diagnosis of autism spectrum disorder; and,

   b. The following services prescribed by a Physician and rendered by a licensed provider when such treatment is Medically Necessary and result in improved clinical status:

      (1) Psychiatric care;

      (2) Psychological care;

      (3) Habilitative or rehabilitative care (i.e., counseling and treatment programs intended to develop, maintain, and restore the function of an individual);

      (4) Therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas: self-care and feeding; pragmatic, receptive, and expressive language; cognitive functioning; applied behavioral analysis, intervention, and modification; motor planning; and sensory processing.

5. **Blood.** Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood components if replaced by donation; charges for storage of the Covered Person's own blood within 30 days of Surgery.

6. **Cardiac Rehabilitation**. Charges for cardiac rehabilitation program services when ordered by a Physician as part of the treatment program for a Covered Person's Illness. However, Covered Charges do not include Phase III of such programs.

7. **Chemotherapy Services.** Charges for administration of chemotherapy treatment, including drugs and supplies used during the treatment.

8. **Childhood Obesity.** Covered for treatment of childhood obesity limited to the following: 3 Physician visits where obesity and/or co-morbid obesity are indicated including related lab work and 3 nutritional and/or fitness counseling sessions per person per Calendar Year.

9. **Chiropractic.** Charges for chiropractor services, up to the maximum benefit specified under the Schedule of Medical Benefits.

10. **Clinical Trials.** The Plan will not:

    a. Deny any Covered Person the right to participate in a clinical trial for which he or she is eligible according to the trial protocol;

    b. Deny, limit, or impose additional conditions on the coverage of Routine Patient Costs for items and services furnished in connection with participation in the clinical trial; or

    c. Discriminate against any Covered Person who participates in a clinical trial.

    For the purpose of this provision, "Routine Patient Costs" is defined to mean items and services typically provided under the Plan for an individual not enrolled in a clinical trial. However, such items and services do not include:

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

    b. Items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or,

    c. A service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

11. **Diabetic Supplies/Education Programs.** Charges for the following services and supplies provided for a Covered Person with diagnosed gestational, Type I or Type II diabetes:

    a. All Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes. Diabetic supplies will be eligible for medical benefits only if the expense is not covered under the Outpatient Prescription Drug Card Benefit.

    b. Diabetes Outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working

in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Benefits are subject to the limit specified under the Schedule of Medical Benefits.

12. **Diagnostic Tests.** Charges for X-rays, laboratory and pathology tests, neuropsychological testing or similar well established diagnostic tests generally approved by Physicians throughout the United States, for the diagnosis of the Illness or Injury.

13. **Dialysis. – A Specialty Care Benefit.**

    An individual receiving Outpatient dialysis treatment and related services may or may not be eligible for Medicare coverage. Benefits provided under this Plan for treatment received in connection with Outpatient dialysis and related services are subject to the following provisions when services are provided outside of the KSB or PPO Network.

    Although a Covered Person may not be eligible or obligated to apply for Medicare Part A and/or Part B, the Plan will provide benefits as described below regardless of whether or not the Covered Person is eligible or has enrolled for Medicare coverage when services are provided outside of the KSB or PPO Network:

    The Plan will consider Outpatient dialysis treatment and related services at 125% of the then current Medicare allowable expense.

    Charges Incurred with KSB or a PPO provider will not be subject to the above provision. The Plan will provide benefits for charges Incurred with a PPO provider based on the charge negotiated between that provider and the PPO.

    The Plan cannot enroll you in Medicare; it is your decision and your responsibility to enroll in Medicare.

    In order to ensure the correct coordination of claims payments between the Plan and Medicare, members are required to take the following steps:

    a. Notify the Plan Administrator when you are diagnosed with a condition requiring Outpatient dialysis treatment;

    b. Notify the Plan Administrator if or when you begin to receive dialysis treatment;

    c. Give the Plan Administrator a copy of your Medicare card, showing the effective date of the Part A and Part B coverage.

14. **Domestic Violence.** With respect to any Injury which is otherwise covered by the Plan, the Plan will provide benefits for treatment of an Injury for victims of Domestic Violence or if the Injury results from a medical Condition (including both physical and mental health Conditions).

15. **Durable Medical Equipment.** Charges for rental up to the purchase price of a wheelchair to accommodate basic needs, Hospital bed or other Durable Medical Equipment required for therapeutic use, or the purchase of this equipment if economically justified, whichever is less.

    Benefits will also include adjustments or repairs of the equipment to restore useful function or replacement when required because of wear or when the current device has become non-functional due to a change in a patient's status and an improved functional status is expected to be achieved with the replacement.

16. **Gender Dysphoria.** Charges for the treatment of Gender Dysphoria is limited to the following services:

    a. Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses.

    b. Cross-sex hormone therapy:

        (1) Cross-sex hormone therapy administered by a medical provider (for example during an office visit).

        (2) Cross-sex hormone therapy dispensed from a pharmacy.

c. Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting.

d. Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.

e. Surgery for the treatment of Gender Dysphoria, including the surgeries listed below:

(1) Male to Female: Clitoroplasty (creation of clitoris); Labiaplasty (creation of labia); Orchiectomy (removal of testicles); Penectomy (removal of penis); Urethroplasty (reconstruction of female urethra); and Vaginoplasty (creation of vagina).

(2) Female to Male: Bilateral mastectomy or breast reduction; Hysterectomy (removal of uterus); Metoidioplasty (creation of penis, using clitoris); Penile prosthesis; Phalloplasty (creation of penis); Salpingo-oophorectomy (removal of fallopian tubes and ovaries); Scrotoplasty (creation of scrotum); Testicular prosthesis; Urethroplasty (reconstruction of male urethra); Vaginectomy (removal of vagina); and Vulvectomy (removal of vulva).

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements.

The Covered Person must provide documentation of the following for breast surgery: a written psychological assessment from at least one (1) qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:

- The Covered Person has experienced persistent, well-documented Gender Dysphoria.
- The Covered Person has the capacity to make a fully informed decision and to consent to treatment. The Covered Person must be eighteen (18) years of age or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery: a written psychological assessment from at least two (2) qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:

- The Covered Person has experienced persistent, well-documented Gender Dysphoria.
- The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.
- The Covered Person must complete at least twelve (12) months of successful, continuous, full-time, real-life experience in the desired gender.
- The Covered Person must complete twelve (12) months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

The treatment plan must be based on identifiable external sources, including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance.

17. **Genetic Testing.** Charges for genetic testing when required:

a. To diagnose a specific disease process when the Covered Person is symptomatic of the disease and to determine whether treatment will be effective; or,

b. In prenatal testing when the pregnancy is categorized as high-risk, including cases where the mother is age 35 and over, or if the mother or father are at high risk as carriers for a hereditary genetic disease/disorder that may be passed on to the fetus.

18. **Hearing Aids.** Charges for hearing aids that are Medically Necessary in conjunction with an Illness or Injury, subject to the maximum specified under the Schedule of Medical Benefits. Covered Charges do not include hearing aids for hearing loss due to the normal aging process.

19. **Home Health Care.** Charges made by a Home Health Care Agency for Medically Necessary care, up to the maximum specified under the Schedule of Medical Benefits. Such expenses may include, but are not limited to:

    a. Part-time or intermittent nursing care by a Nurse.

    b. Home health aides.

    c. Medical supplies, drugs or other Medically Necessary services prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

    TRANSPORTATION SERVICE, DOMESTIC SERVICE, CUSTODIAL CARE AND NON-MEDICAL SUPPLIES ARE NOT COVERED.

20. **Hospice Care.** Charges made by a Hospice care program for services, supplies and treatment which are ordered by a Physician for the care of a terminally ill person. Charges include emotional support services and bereavement counseling for the patient's immediate family members covered by the Plan for up to 6 months following the patient's death.

21. **Hospital.** Charges made by a Hospital for:

    a. **Room and Board.** Daily Room and Board and general nursing services, or confinement in an intensive care unit, not to exceed the applicable maximum limits shown:

Hospital Room and Board Charges	Average Semi-Private
Private Room Charges	Average Semi-Private
Intensive Care Units	Full Maximum Allowable Charge
Medically Necessary Isolation Room	Full Maximum Allowable Charge
Single Bed/Private Room Only Charges	Full Maximum Allowable Charge
Birthing Room	Full Maximum Allowable Charge

    b. **Hospital Miscellaneous Expenses.** Hospital Miscellaneous Expenses, and incremental nursing charges, furnished by the Hospital during an Inpatient confinement.

    c. **Outpatient Treatments.** Medically Necessary services and supplies for Outpatient Hospital treatments.

22. **Marital or Family Counseling.** Charges for marital or family counseling. Professional services are limited to only those providers listed as covered Physicians or Mental Health/Substance Abuse Providers under the "Definitions" section.

23. **Mastectomy.** Charges for reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce symmetrical appearance; and coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient. Such coverage may be subject to the annual Deductibles and Coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan.

24. **Medical Supplies.** Charges for dressings, sutures, casts, splints, trusses, crutches, braces, cervical collar, colostomy bags or supplies, ileostomy supplies, catheters, or other Medically Necessary medical supplies. Charges for blood pressure kits and blood testing kits are eligible only if the Condition is severe enough to require self-home testing as prescribed by a Physician. Covered Charges do not include dental braces (fixed or removable appliances that move or reposition teeth) or corrective shoes unless required due to the use of a Medically Necessary brace.

25. **Mental or Nervous Disorder/Substance Abuse.** Charges for services rendered for Psychiatric Care and/or Substance Abuse Treatment. Treatment may be rendered as an Inpatient, Outpatient

or through an Intensive Outpatient Plan. Covered Charges include treatment provided at a Residential Treatment Facility. When treatment is provided on an Inpatient basis, the confinement is subject to utilization management review. Please refer to the section "Utilization Management Service" for Plan requirements. Coverage does not include treatment that is considered custodial. Professional services are limited to only those providers listed as covered Physicians or Mental Health/Substance Abuse Providers under the "Definitions" section.

26. **Multiple Surgical Procedures**. Subject to other Plan provisions, charges for multiple surgical procedures will be eligible as follows:

    a. For related operations or procedures performed through the same incision or in the same operative field, Covered Expenses will include the surgical allowance for the highest paying procedure, plus 50% of the surgical allowance for each additional procedure.

    b. When two or more unrelated operations or procedures are performed at the same operative session, Covered Expenses will include the surgical allowance for the highest paying procedure, plus 50% of the surgical allowance for each additional procedure.

27. **Nursing.** Charges for the services of a Nurse, acting within the scope of his or her license.

28. **Obesity.** (Pre-authorization is strongly recommended.) Charges for surgical treatment of morbid obesity when the below listed criteria is met, provided the surgical procedure is performed at a Bariatric Center of Excellence that is an accredited Metabolic and Bariatric Surgery Center and is Medically Necessary and not Experimental or Investigational:

    Criteria

    In order for morbid obesity Surgery or related expenses to be a Covered Expense, the Covered Person must satisfy all of the following requirements:

    a. The Covered Person must have completed adult growth (i.e., 18 years of age or documentation of completion of bone growth).

    b. The Covered Person must have one of the following:

        (1) A body mass index ("BMI") of 40 or greater; or,

        (2) A BMI of 35 or greater and a serious condition related to obesity such as Type II diabetes, life threatening cardiac or pulmonary conditions (i.e., coronary artery disease, severe sleep apnea not responding to CPAP) or debilitating joint disease in weight bearing joints.

    c. The Covered Person must supply documentation to support consistent participation in a previous Physician-supervised weight loss attempt within the 2-year period prior to the proposed surgery date for a duration of 6 consecutive months. This includes a complete history and physical, weight loss record, diet(s), nutritional counseling/programs, exercise programs/regime, and progress notes. "Consistent participation" means the Covered Person has attended least one appointment per month with a Nutritionist and other members of the bariatric team throughout the course of the program.

    d. The Covered Person must have no medical contraindications to Surgery (e.g., significant heart, lung, liver, or kidney disease; or a history of cancer other than skin cancer).

    e. The Covered Person must have no untreated physiological Condition that may contribute to the morbidly obese Condition (i.e., hypothyroidism).

    f. Current substance abuse has not been identified.

    g. The Covered Person has received clearance for Surgery following a psychological evaluation to assess motivation and the ability to consent to Surgery and the ability to comply with postoperative instructions and lifestyle.

    Repeat bariatric Surgery is covered only when Medically Necessary to correct complications (i.e., obstruction, stricture, erosion, or band slippage) from a prior Medically Necessary Surgery.

29. **Organ and Tissue Transplants.** Charges for the replacement of organs or tissues to the extent that they are Medically Necessary and are NOT Experimental or Investigational.

It is IMPORTANT that you contact the Utilization Manager as soon as you are told that you or a covered Dependent is a candidate for a covered organ transplant. The Utilization Manager will work with you and your Physicians to make sure that the most appropriate treatment program is developed.

a. **Mandatory Second Opinion.** A second opinion (record review or physical exam) **must** be obtained prior to undergoing any transplant procedure. This mandatory second opinion must be by a Physician qualified to render such a service either through experience, specialized training, education, or such similar criteria, and who is not affiliated in any way with the Physician who will be performing the actual Surgery.

b. **Donor Expenses.** Eligible Expenses Incurred by the donor will be considered for benefits only if the recipient is covered by this Plan. Charges for the donor are considered as part of the recipient's claim and not the donor.

c. **Other Charges.**

(1) **Acquisition, Storage and Transportation.** Charges for the cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and the Hospital's charge for storage or transportation of the organ.

(2) **Transportation - Recipient.** Transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the case of a minor, two other individuals, and all reasonable and necessary lodging expenses Incurred, up to a maximum of $10,000. Benefits for this expense will be payable at 100%, subject to the Plan Deductible if enrolled in the HDHP.

30. **Orthognathic.** Charges are eligible only when such treatment is Medically Necessary.

31. **Orthotics.** Limited to one (1) pair per Calendar Year – includes orthotics that are specially molded and custom-made when prescribed by a Physician. Covered orthotics are special shoe inserts for arch or foot supports that are prescribed following an open surgical procedure on the bones, tendons, etc., of the foot or may be prescribed to avoid an open surgical procedure.

32. **Oxygen.** Charges for oxygen and rental of equipment for its use.

33. **Physician.** Charges for services of a Physician for treatment of an Illness or Injury including, but not limited to, office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care and consultations, including telephone and online consultations.

34. **Pregnancy.** Charges for treatment of pregnancy for you or your covered Dependent.

a. **Maternity Stays.** Coverage for a Hospital stay following a normal vaginal delivery will be 48 hours for both the mother (if a Covered Person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Coverage for a Hospital stay in connection with childbirth following a Cesarean section will be 96 hours for both the mother (if a Covered Person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician.

b. **Birthing Center.** Charges made by a Birthing Center when such facility is used in lieu of childbirth in a Hospital.

c. **Pre-natal Care.** Obstetrical care services rendered by a Physician, including pre-natal standard tests and two routine ultrasounds.

d. **Newborn Care.** Newborn Well Baby Care for Hospital nursery charges, in-Hospital doctor visits and circumcision. Newborn Covered Expenses will also include neo-natal intensive care Room and Board and necessary ancillary expenses for treatment of an Illness. However, newborn charges will be considered eligible only if the newborn is an eligible Dependent and has been properly enrolled as required by the Plan.

35. **Prescription Drugs.** Charges for drugs requiring the written prescription of a Physician, to the extent that the drugs are not covered under the Outpatient Prescription Drug Card Benefit; such

drugs must be FDA approved for the treatment of the Illness or Injury. Purchase is limited to a 90-day supply.

36. **Preventive Care Services.** Charges Incurred for Preventive Care services including, but not limited to, routine physical exams and screenings, Well Child Care, routine x-ray and lab, mammograms, pap smears, PSA tests, immunizations, and colonoscopies, at the age and frequency recommended under federal guidelines or by current American Cancer Society guidelines.

    Federal guidelines fall under four broad categories as shown below:

    a. Evidence-based items or services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:

        (1) Breast cancer;
        (2) Cervical cancer;
        (3) Colorectal cancer;
        (4) High Blood Pressure;
        (5) Type 2 Diabetes Mellitus;
        (6) Cholesterol;
        (7) Child and Adult Obesity.

    b. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

    c. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

    d. With respect to women, additional preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

        (1) FDA approved women's contraceptives and counseling, including sterilization procedures. Prescription drugs will be covered under the Outpatient Prescription Drug Card benefit unless a Physician is required to administer an injection or insert a device.

        (2) Breastfeeding support, supplies, and counseling.

        (3) Gestational diabetes screening.

        (4) Human papillomavirus (HPV) DNA testing.

        (5) Counseling for sexually transmitted infections.

        (6) Counseling and screening for human immune-deficiency virus.

        (7) Screening and counseling for interpersonal and domestic violence.

        (8) Breast cancer genetic test counseling (BRCA) for women at high risk.

    Additional information about Preventive Care services required under the Affordable Care Act (ACA) is available at the following government websites:

    https://www.healthcare.gov/coverage/preventive-care-benefits/;
    https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

    https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;

    https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;

    https://www.hrsa.gov/womensguidelines/.

    Any exclusion contained in the Plan for an exam, screening, service, supply, drug, or device that is considered a required *Preventive Care service* does not apply.

37. **Prosthetics.** Charges for placement of the original prosthetic devices, special appliances, and surgical implants (not to include dental or penile implants) required as a result of an Illness or Injury. Benefits will also include adjustments, repairs and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or when the current device

has become non-functional due to a change in a patient's status and an improved functional status is expected to be achieved with the replacement.

38. **Radiation Therapy.** Charges for treatment by x-ray, radium, external radiation, or radioactive isotopes, including the fee for materials.

39. **Respiratory/Inhalation Therapy.** Charges for respiratory and inhalation therapy.

40. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility for services and supplies furnished by the facility in connection with convalescence from the Illness or Injury. These expenses include:

    a. **Room and Board.** Room and Board, including general nursing services. If private room accommodations are used, the Room and Board charge allowed will not exceed the facility's average semi-private rate. However, this limitation will not apply if the facility offers only private rooms.

    b. **Other Services.** Medical services customarily provided by the facility, with the exception of private duty or special nursing services and Physician's fees.

41. **Sterilization.** Charges for elective sterilization for you or your covered spouse. Sterilizations for women are covered under the Preventive Care services benefit as required under the Affordable Care Act (ACA).

42. **Surgical Assistants.**

    a. **Assistant Surgeons.** Charges for services by a licensed Physician who actively assists the operating surgeon in the performance of surgical procedures when the Condition of the patient and complexity of the Surgery warrant such assistance. Covered Charges will be limited to 20% of the contract rate or Maximum Allowable Charge, as applicable, for the total procedure.

    b. **Certified Surgical Assistants.** Covered Charges include these services when rendered by a licensed/certified surgical assistant; such charges will be limited to 15% of the contract rate or Maximum Allowable Charge, as applicable, for the total procedure.

    c. **Physician Assistants.** Benefits are also provided for these services when rendered by a licensed physician assistant; Covered Charges will be limited to 15% of the contract rate or Maximum Allowable Charge, as applicable, for the total procedure.

43. **Therapy: Physical - Occupational – Speech**

    a. **Physical Therapy.** Treatment or services rendered by a licensed or qualified physical therapist in a home setting, facility, or institution whose primary purpose is to provide medical care for an Illness or Injury which is designed and adapted to promote the restoration of a useful physical function. Physical therapy does not include educational training or services designed and adapted to develop a physical function.

    b. **Occupational Therapy.** Treatment or services rendered by a licensed or qualified occupational therapist to treat the physically or emotionally ill in a home setting, facility, or institution whose primary purpose is to provide constructive therapeutic goal-oriented activity to achieve optimum function. Occupational therapy includes, but is not limited to, various forms of exercise with or without equipment, designed and adapted to improve function as it relates to bed mobility, wheelchair transfers and balance activities. Therapy employing similar modalities with emphasis on activities of daily living, such as grooming, bathing and hygiene are not included. Occupational therapy does not include educational training or services designed and adapted to develop a physical function, or services designed to develop work, play or leisure time task performance skills.

    c. **Speech Therapy.** Fees of a Physician or qualified speech therapist for:

        (1) Restorative or rehabilitory speech therapy for loss of previously normal speech patterns due to an Illness or Injury.

        (2) Speech therapy for delayed or defective external speech due to a congenital defect, disease, trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote a useful physical function. This includes therapies

designed to coordinate the movements of the larynx, mouth, lips, chest, and abdominal muscles. Speech therapy does not include educational training or services designed and adapted to develop an individual's vocabulary. Therapy also does not include services designed to develop the ability to connect thoughts to words or the mental processes that form this connection.

Covered Expenses do not include therapy services (i.e., physical therapy, occupational therapy, or speech therapy) determined to be for maintenance treatment. Maintenance treatment is considered to be therapy rendered after the patient has reached his or her optimal level of functioning, or when no measurable improvement is shown from continuous ongoing care.

44. **Wig**. Charges associated with the initial purchase of a wig following chemotherapy or radiation therapy. Charges are limited as outlined in the Schedule of Medical Benefits.

OUTPATIENT PRESCRIPTION DRUG CARD BENEFIT

A list of “Network Pharmacies” can be obtained directly from the prescription drug card Network listed on your Plan I.D. card.

When you are being treated for an Illness or Accident, your Physician may prescribe certain drugs or medicine as part of your treatment. Your coverage includes benefits for drugs, and this section explains which drugs are covered and the benefits that are available for them. Benefits will be provided only if such drugs are Medically Necessary.

Covered Services

Outpatient drugs for which benefits are available under this section are:

1. Drugs that require, by Federal law, a written prescription which are Medically Necessary for the care and treatment of an Illness or Injury;
2. Injectable insulin, including syringes and needles purchased by prescription, and diabetic supplies;
3. Any drug or device that is considered a Preventive Care service as defined by the Affordable Care Act, provided the Covered Person has a valid prescription for such drug or device. Covered Charges include, but are not limited to:
    a. FDA approved women’s contraceptives that a Covered Person self-administers. Prescription contraceptives that require a Physician to administer an injection or insert a device are covered under the medical portion of this Plan;
    b. FDA approved tobacco cessation drugs, including over-the-counter nicotine replacement products;
    c. Immunizations/vaccines administered at a pharmacy (such as flu and shingles vaccines).

Benefits for these drugs will then be provided when you have been given a written prescription for them by your Physician and you purchase the drugs from the KSB Pharmacy or a Participating Pharmacy. However, certain drugs may be subject to Step Therapy or Clinical Prior Authorization requirements.

Not all drugs are covered by this Plan. Please contact the prescription drug card vendor listed on your Plan I.D. card if you have any questions concerning which drugs or devices qualify for benefits under this Plan or if you have any questions concerning Step Therapy or Prior Authorization requirements.

Benefits will not be provided for refills if the prescription is more than one year old.

Preventive Care Services

Covered Charges include any drug or device that is considered a Preventive Care service under the Affordable Care Act (“ACA”), provided the Covered Person has a valid prescription for such drug or device and it is purchased from the KSB Pharmacy or a Network Pharmacy. Preventive Care services may include some items that are available “over-the-counter” (provided the item is purchased with a valid prescription).

Benefits for Preventive Care services will be payable in keeping with the requirements of ACA. Any exclusion contained in the Plan for a drug or device that is considered a required Preventive Care service does not apply.

Mandatory Generic Substitutions

This Plan has a mandatory Generic Drug requirement. This means that if there is an approved Generic match for a Brand-Name Drug, you will be required to pay the difference between the cost of the Generic Drug and Brand-Name Drug (in addition to the higher Brand-Name Copay) if the Brand-Name Drug is dispensed. If your Physician does not want a Generic substitute, he must indicate this on the prescription. In this case, you will only pay the higher Brand-Name Drug Copay.

Benefit Payment for Prescription Drugs

Please refer to the plan option in which you are enrolled for information on benefits available to you under this program.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses Incurred by all Covered Persons:

1. **Alternative Therapies.** Charges for alternative therapies including but not limited to aromatherapy, light therapy, rolfing, homeopathy, hydrogen peroxide, magnetic, naturopathic, acupuncture or chelation therapy (except for the extraction of heavy metal poisoning) or any other treatments that are not conventional or the treatment of choice by mainstream medicine.

2. **Behavior Modification.** Charges for milieu therapy; any confinement in an institution primarily to change or control one's environment; services or treatment of behavioral problems, learning disabilities, developmental delays, or dysfunctional relationships, unless otherwise specified.

3. **Biofeedback**. Charges for biofeedback, except when Medically Necessary for treatment of an Illness or Injury.

4. **Close Relative.** Charges for services rendered by a Physician, Nurse, licensed therapist, or other covered provider, if such Physician, Nurse, licensed therapist, or other covered provider is a Close Relative of the Covered Person or resides in the same household as the Covered Person.

5. **Complications.** Charges for services or supplies that result from complications arising from a non-covered Illness or Injury, or from a non-covered procedure, unless otherwise specified.

6. **Cosmetic.** Charges Incurred in connection with, including any complications resulting from, the care, treatment or Surgery performed for a Cosmetic Procedure. This exclusion will not apply, as allowed by applicable law, when:

   a. Such treatment is rendered to correct a Condition resulting from an Accidental Injury;

   b. When reconstructive Surgery is performed for the treatment of a disease, but only if the disease is considered a covered Condition under the Plan; or

   c. When rendered to correct a Medically Necessary congenital abnormality other than for psychological reasons.

7. **Counseling.** Charges for counseling for social maladjustment, pastoral issues, financial issues, behavioral issues, or lack of discipline or other antisocial action, except when specifically required to treat a Mental or Nervous Disorder.

8. **Custodial.** Charges Incurred for services or supplies which constitute personal comfort or beautification items, television, or telephone use; in connection with Custodial Care, education, or training; or actually Incurred by other persons.

9. **Effective Date.** Charges Incurred prior to the effective date of coverage under the Plan, or after coverage is terminated, unless otherwise stated in the Plan.

10. **Elective Abortions.** Charges for services, supplies, care, or treatment in connection with an elective abortion, including fetal reduction surgery. However, this exclusion does not apply if the life of the mother is endangered by the continued pregnancy, or when termination of pregnancy is suggested by a Physician when the baby/fetus has a serious medical condition/anomaly, or when pregnancy is the result of incest or rape. This exclusion also does not apply to charges Incurred for treatment of complications arising during the course of an elective abortion.

11. **Equipment.** Charges related to:

    a. Personal comfort or convenience items including, but not limited to, air conditioners, humidifiers and purifiers, exercise therapy equipment, ramps, elevators, TDD/TTY communication devices and personal safety alert systems. This exclusion also applies to expenses Incurred for the modification of homes, vehicles, or personal property to accommodate patient convenience.

    b. Purchase or rental of luxury medical equipment when standard equipment is appropriate for the patient's Condition (for example, motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).

12. **Excess.** Charges, or a portion of a charge, that exceed Plan limits including but not limited to the Maximum Allowable Charge. This includes charges that are not deemed to be Medically Necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms set forth by and within this document.

13. **Exercise Programs**. Charges Incurred for participation in exercise programs, including Phase III cardiac rehabilitation programs.

14. **Experimental.** No benefits will be paid for Experimental, Investigational, or educational treatment. In addition, no benefits will be paid for any treatment, services, or supplies that are provided primarily for research. This exclusion will not apply to health care services, items, and drugs that are typically provided in health care and would be covered under this Plan if the Covered Person were not enrolled in a clinical trial, including health care services, items, and drugs provided to a patient during the course of treatment in a cancer clinical trial for a Condition or any of its complications that are consistent with the usual and customary standard of care, including the type and frequency of any diagnostic modality.

15. **Feet.** Charges resulting from the treatment of weak, unstable, or flat feet, bunions (unless an open cutting procedure is performed), corns, calluses, toenails (unless part of the nailbed or nail root is removed), orthopedic shoes, modative inlays or inserts.

16. **Felonious Act.** Charges resulting from or occurring during the commission of a Felonious Act as defined by this Plan (see "Definitions") or aggravated assault by the Covered Person; or while the Covered Person is engaged in an illegal occupation. An occurrence of driving under the influence of a drug or alcohol is not considered a "Felonious Act" under this Plan. This exclusion applies if it is established that the Covered Person is initially charged or cited with commission of such Felonious Act, regardless of whether a conviction results or whether charges are later dropped or reduced.

17. **Fertility.**

    a. Charges related to, or in connection with, surrogate parenting, donor eggs, donor sperm and host uterus.

    b. Charges related to, or in connection with, fertility studies, sterility studies, procedures to restore or enhance fertility (including fertility drugs), artificial insemination, in-vitro fertilization, gamete intra-fallopian transfer (G.I.F.T. Program) or similar programs or infertility medication or testing.

18. **Food Supplements.** Charges related to food supplement or augmentation, in any form (unless Medically Necessary to sustain life in a critically ill person).

19. **Gender Dysphoria.** Charges for the following cosmetic procedures for the treatment of Gender Dysphoria:

    a. Abdominoplasty;

    b. Blepharoplasty;

    c. Breast enlargement, including augmentation mammoplasty and breast implants;

    d. Body contouring, such as lipoplasty;

    e. Brow lift;

    f. Calf implants;

    g. Cheek, chin, and nose implants;

    h. Injection of fillers or neurotoxins;

    i. Face lift, forehead lift, or neck tightening;

    j. Facial bone remodeling for facial feminizations;

    k. Hair removal;

    l. Hair transplantation;

    m. Lip augmentation;

n. Lip reduction;

o. Liposuction;

p. Mastopexy;

q. Pectoral implants for chest masculinization;

r. Rhinoplasty;

s. Skin resurfacing;

t. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple);

u. Voice modification surgery; and

v. Voice lessons and voice therapy.

20. **Government.** Charges Incurred while confined in a Hospital owned or operated by the United States Government or any agency thereof; or charges for service, treatment or supplies furnished by the United States Government or any agency thereof; unless applicable law requires the Plan to pay.

21. **Hearing Aids.** Charges Incurred in connection with hearing aids or such similar aid devices in excess of the maximum benefit specified under the Schedule of Medical Benefits.

22. **HMO.** Services rendered to an employee who is covered under a Company-sponsored HMO or similar organization.

23. **Legally Obligated.** Charges Incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay, that would be covered by a grant; or for which a charge would not ordinarily be made in the absence of this coverage. Not to be affected by this exclusion is the Plan's liability as outlined in the section entitled "Coordination of Benefits" in connection with another plan that is an HMO.

24. **Maximum Allowable Charge.** Charges in excess of the Maximum Allowable Charge.

25. **Medically Necessary.** Charges Incurred in connection with services and supplies which are:

    a. Not Medically Necessary for the treatment of an Injury or Illness; or

    b. Not recommended and approved by a Physician unless specifically shown as a Covered Expense elsewhere in the Plan.

    The fact that a Physician or other provider may prescribe, order, recommend or approve a service or supply, does not, in and of itself, make such service or supply Medically Necessary.

    Charges for services, supplies or treatment not recognized by the Food and Drug Administration, National Institute of Health or the Centers for Medicare and Medicaid Services (CMS) as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the Food and Drug Administration, National Institute of Health or CMS as having no medical value.

    Non-Medically Necessary Hospital Inpatient admissions, extended stays to Inpatient admissions, Hospital Miscellaneous Expenses, diagnostic tests, exams, x-rays or other treatment.

26. **Motor Vehicle.** Charges Incurred as a result of a motor vehicle Accident while the Covered Person was insured or eligible for health benefits or benefits under a valid "no-fault" automobile policy or medical pay benefit, but only to the extent of coverage under the "no-fault" automobile policy or medical pay benefit, unless required by law.

27. **Not Covered.** Charges for services or supplies that are not specifically covered under this Plan.

28. **Obesity.** Charges for treatment of obesity including but not limited to suction lipectomy, weight reduction, dietary consultations, and surgical treatment of obesity or complications thereof, unless otherwise stated in the "Medical Expense Covered Charges" section or as otherwise required by ACA for a Preventive Care service. X-ray and laboratory tests performed to determine the cause of obesity are covered.

29. **Occupation/Occupational.** Any payment for occupational Accidents or Illnesses to the extent the Covered Person is covered or is required to be covered under Worker's Compensation or similar occupational disability benefits or law.

30. **Period of Coverage.** Charges Incurred prior to or after any period of coverage under this Plan, except as specifically provided herein.

31. **Physician.** Charges for Physician's fees for any treatment which is not rendered by or in the physical presence of a Physician, including standby Physician/surgeon, except as otherwise specified.

    Charges for failure to keep a scheduled visit, for completion of a claim form or for preparation of report(s) to other Physicians, or late payment fees assessed by the Physician.

32. **Prohibited by Law.** Charges that are to the extent that payment under this Plan is prohibited by law.

33. **School.** Charges for services rendered or billed for by a school or half-way house or a member of its staff.

34. **Sexual Dysfunction.** Charges for any treatment of a sexual dysfunction, including but not limited to sexual counseling or therapy, and hormonal therapy, except if the dysfunction is due to organic disease or gender dysphoria. Any implants are excluded regardless of the cause.

35. **Smoking.** Charges for services, supplies, or treatment rendered for the purpose of nicotine addiction, except as otherwise required by ACA for a Preventive Service.

36. **Sterilization.** Charges resulting from or in connection with the reversal of sterilization procedures.

37. **Teeth.** Charges Incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes will not be eligible for medical benefits; however, medical benefits will be payable for charges Incurred:

    a. Removal of complete bony impacted teeth (no allowance for other extractions) on an Outpatient basis unless Hospital confinement is Medically Necessary. Charges for extraction of partially impacted teeth are covered under the Katherine Shaw Bethea Hospital ("KSB") Employee Dental Plan. The KSB Employee Health Benefit Plan does not coordinate benefits with the KSB Employee Dental Plan;

    b. For the removal of tumors in the oral cavity;

    c. For treatment required because of Accidental Injury to sound natural teeth (but not from chewing, excluding dental implants unless dentally necessary), and not for repair or replacement of a denture. Such expenses must be Incurred within 12 months of the date of the Accident (unless otherwise required by applicable law); and,

    d. For charges by a Hospital (Inpatient or Outpatient care) or Outpatient facility (including anesthesia) when treatment at the facility is Medically Necessary for the dental treatment.

    Dentist and oral surgeon's charges for treatment of a dental Condition are not eligible under the medical benefits portion of the Plan unless stated above or under the section entitled "Medical Expense Covered Charges."

    Charges for appliances, medical or surgical treatment for correction of malocclusion or protrusion or recession of the mandible; maxillary hyperplasia, or maxillary hypoplasia unless otherwise stated under the section "Medical Expense Covered Charges". (Malocclusion occurs when teeth do not fit together properly, which is also referred to as a "bite problem;" mandible protrusion or recession; "underbite," or which the chin is excessively large; "overbite," or when the chin is abnormally small; maxillary hyperplasia, or "overbite" due to excess growth of upper jaw; maxillary hypoplasia, or undergrowth of upper jaw).

38. **Testing.** Charges for any examination or procedure performed for screening, surveys, research, or an examination rendered in connection with a physical examination ordered or required for the

use of a third party, educational testing, or training, including Intelligence Quotient testing, or court-ordered evaluations or programs (unless deemed Medically Necessary).

39. **Travel.** Charges Incurred outside the United States if the Covered Person traveled to such a location for the purpose of obtaining medical services, drugs, or supplies. The exclusion does not apply to charges Incurred while outside the United States for the purpose of business, travel, or education, so long as the charges meet all other criteria for a Covered Expense.

40. **Ultrasounds.** Charges for ultrasounds or other tests performed solely to determine a fetal age or fetal sex.

41. **Vision.** Charges Incurred in connection with eye refractions, or the purchase or fitting of eyeglasses or contact lenses. This exclusion will not apply to the initial purchase of eyeglasses or contact lenses following cataract Surgery or the necessary replacement due to prescription changes following such Surgery.

    Any expense for orthoptics and any other form of vision training and therapy, including any devices used in such training. Radial keratotomy, keratoplasty, keratomileusis, photorefractive keratectomy (PRK) or any other eye Surgery to improve nearsightedness, farsightedness and/or astigmatism, or to correct, treat or improve any related Conditions or causes of these Conditions.

42. **Vocational Services.** Charges for vocational or training services. However, this exclusion will not apply to education services rendered for diabetic counseling (subject to Plan limits), peritoneal dialysis, habilitative services covered by this Plan, or any other educational service deemed to be Medically Necessary by the Plan.

43. **War.** Charges Incurred as a result of war or any act of war, whether declared or undeclared, when the Covered Person is an active member of the armed forces of any country or caused during service by a Covered Person in the armed forces of any country. Excluded charges also include treatment of an Illness or Injury sustained due to a Covered Person's participation in any act of aggression or any terrorist activity.

44. **Weekend Admissions.** Charges for weekend admissions, including Friday, unless for Accidents, life-threatening Conditions, maternity or when Surgery is scheduled on that day or before 10:00 a.m. the following day.

45. **While Imprisoned.** Charges Incurred for treatment of an Illness or Injury sustained while a Covered Person was incarcerated, or in the custody of any Federal, State or Local authority.

With respect to any Illness or Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Illness or Injury if the Illness or Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

DEFINITIONS

Certain words and phrases used in this Summary Plan Description are listed below with the definition or explanation of the manner in which the term is used for the purpose of this Plan. **The following definitions are not an indication that charges for particular services or supplies are eligible for payment under the Plan; please refer to the appropriate sections of the Summary Plan Description for that information.**

ACA

"ACA" means the Affordable Care Act as amended by the Health Care and Education Reconciliation Act (March 2010).

Accident

"Accident" means an unintentional or unexpected happening which:

1. Causes Injury to the physical structure of the body;
2. Results from an external agent or trauma;
3. Is definite as to time and place; and
4. Happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.

"Accident" does not include a hernia of any kind, harm resulting from a disease, Illness, or allergic reactions, with the exception of insect venom reactions.

Active Service

"Active Service" means a Participant is employed by the Company for the minimum number of hours per week outlined in the General Eligibility Provisions. Such work may occur either at the usual place of business of the Company or at a location to which the business of the Company requires the Participant to travel, and for which he receives regular earnings from the Company. An employee will be deemed to be in Active Service if he is absent from work due to a health factor.

Adverse Benefit Determination

"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 Covered Person'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; and
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.

Explanation of Benefits (EOB)
"Explanation of Benefits" means a statement a health plan sends to a Covered Person which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

Ambulatory Surgical Center

"Ambulatory Surgical Center" means an institution or facility, either free standing or as part of a Hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures and in which a patient is admitted and discharged within a 24-hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, will not be considered to be an "Ambulatory Surgical Center."

Birthing Center

"Birthing Center" means an independent, licensed facility which is certified under the statutory requirements of the given state in which it is located and provides 24-hour nursing services by Registered Nurses and Certified Nurse Midwives. An obstetrician or a Physician qualified to practice obstetrics with hospital admitting privileges must be available for consultation and referral and on call during labor and delivery. A Birthing Center must be equipped, staffed, and operating for the purpose of providing:

1. Family centered obstetrical care for patients during uncomplicated pregnancy, delivery, and immediate postpartum periods;
2. Care for infants born in the center who are either normal or who have abnormalities which do not impair functions or threaten life; and
3. Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

A Birthing Center must have an agreement with an ambulance service and a hospital to accept transfer.

Brand-Name Drug

"Brand-Name Drug" means drugs produced and marketed exclusively by a particular manufacturer. These names are usually registered as trademarks with the Patent Office and confer upon the registrant certain legal rights with respect to their use.

Calendar Year

"Calendar Year" means a period of time commencing on January 1, and ending on December 31, in the same given year.

Certified IDR Entity

"Certified IDR Entity" means an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Claims Administrator

"Claims Administrator" means the firm employed by the Plan Administrator to provide ministerial services in connection with the operation of the Plan and any other function, including the processing and payment of claims.

Clean Claim

"Clean Claim" means 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 Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

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

Close Relative

"Close Relative" means a person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother and stepsister), child (includes legally adopted or stepchild), grandfather or grandmother.

COBRA

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

Coinsurance

"Coinsurance" means that portion of Eligible Expenses to be paid by the Plan and the Participant in accordance with the coverage provisions stated in the Plan. It is the basis used to determine the amount of Covered Expenses which are to be paid by the Participant.

Company

"Company" is as defined in the "Introduction" section.

Condition

See definitions of "Illness" and "Injury."

Copay

"Copay" means that amount shown in any benefit schedule which is the Covered Person's responsibility for charges Incurred for doctor's office visits, prescription drugs, or other services. When information is received by the Plan concerning direct support provided to a Covered Person by a drug manufacturer (including coupons for specific prescription drugs), the amount of such assistance will not apply to any out-of-pocket limit shown in any benefit schedule.

Cosmetic Procedure or Cosmetic

"Cosmetic Procedure" or "Cosmetic" means a procedure or treatment performed solely or primarily for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Charges or Covered Expenses

"Covered Charges" or "Covered Expenses" means the provider's charge for services rendered to the Covered Person for Medically Necessary treatments, services or supplies which are subject to Coinsurance and Deductibles, are not specifically excluded under the Plan and do not exceed the Maximum Allowable Charge.

With regard to a provider outside of the KSB network, the provider's charge will not be deemed a Covered Expense if the service or supply is for treatment of an Illness or Injury caused by the treating provider.

Any charge by a provider outside of the KSB network that is determined to be inaccurate or excessive as a result of a claim review or audit will also not be a Covered Charge under this Plan.

Covered Person

"Covered Person" means any Participant or Dependent. "Covered Person" will be deemed to include, where appropriate, a COBRA continuee or a person who qualifies under other classifications set forth in the General Eligibility Provisions, who meets the eligibility requirements of coverage as specified in this Plan and is properly enrolled in the Plan.

Craniomandibular Disorder

"Craniomandibular Disorder" means pain, muscular spasm, grinding, clicking, swelling, numbness, stiffness, headache, or other pathological Condition which creates a loss or decrease of function, involving chewing muscles of the upper and lower jaws, the postural muscles of the upper and lower jaws and of the neck, and the nerves, muscles, ligaments, glands and bones of the face, skull, neck, and spine.

Custodial Care

"Custodial Care" means that type of care or service, whichever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed and supervision over medication which can normally be self-administered.

Deductible

"Deductible" means a specified dollar amount of Covered Expenses which must be Incurred during a Calendar Year (unless otherwise stated in a benefit schedule) before any other Covered Expenses can be considered for payment according to the applicable benefit percentage. Copays do not apply toward satisfaction of the Deductible, unless otherwise specified.

Dependent

"Dependent" is as defined under the section "General Eligibility Provisions – Eligible Dependents".

Dependent Coverage

"Dependent Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of Eligible Expenses Incurred for an Illness or Injury of a Dependent.

Durable Medical Equipment

The term “Durable Medical Equipment” means equipment which is:

1. Able to withstand repeated tests.
2. Primarily and customarily used to serve a medical Illness or Injury.
3. Not generally useful for a person in the absence of Illness or Injury.

Eligible Expenses

See definition of “Covered Charges” or “Covered Expenses.”

Emergency Medical Condition

“Emergency Medical Condition” means a medical Condition, including a Mental or Nervous Disorder or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or, (ii) serious impairment to bodily functions; or, (iii) serious dysfunction of any bodily organ or part.

Emergency Services

“Emergency Services” means, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Covered Person is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the attending emergency Physician or treating health care provider determines that the Covered Person is able to travel using non-medical transportation or non-emergency medical transportation, and the Covered Person is in a condition to, and in fact does, give informed consent to the provider to be treated as a Non-Network Provider.

Employer

“Employer” is the Company, as defined in the “Introduction” section.

ERISA

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

Essential Health Benefits

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

The determination of which benefits provided under the plan are Essential Health Benefits will be made in accordance with the benchmark plan of the State of Utah as permitted by the Departments of Labor, Treasury, and Health and Human Services.

Experimental, Investigational/Investigative or Unproved

"Experimental", "Investigational", "Investigative", or "Unproved" shall mean a drug, device, medical Treatment, or procedure that meets any one of the following:

1. The drug or device cannot be lawfully used or marketed without approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to, the U.S. Federal Drug Administration (FDA). For purposes of this subparagraph, an FDA approved drug or device being used for an indication or at a dosage that reliable evidence shows is an accepted off-label use will not be considered to be "experimental", "investigative" or "unproved".

   Off-label use of FDA approved drugs will be allowable under the Plan when considered Medically Necessary and all of the conditions and requirements of this Plan are met (refer to the definition of Medically Necessary for coverage criteria).

2. The drug, device, medical Treatment or procedure, or the patient informed-consent document utilized with the drug, device, Treatment, or procedure, is subject to an ongoing review by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval.

3. Reliable Evidence shows that the drug, device, medical Treatment, or procedure is the subject of an ongoing clinical trial, which is research, experimental, a study or investigational arm of an ongoing clinical trial, 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 the trial is designed exclusively to test toxicity or disease pathophysiology; 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.

"Reliable Evidence" shall mean only consensus findings, opinions or recommendations published in the authoritative medical and scientific literature or peer-reviewed literature; reports of clinical trial committees and other technology assessment bodies; consensus opinions of local and national health care providers in the specialty or subspecialty that would typically manage the sickness or injury for which the drug, device, technology, treatment, supply or procedure is proposed; 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 procedures; 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 will rely on various sources to assist in determining "Experimental, Investigative or Unproved" services. These sources may include but are not limited to: The DATTA program of the American Medical Association, the Hayes Manual, the National Institute of Health, the U.S. Food and Drug Administration, the National Cancer Institute, Office of Health Technology Assessment and Congressional Office of Technology Assessment.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental, Investigational/Investigative or Unproved.

Extended Care Facility

See definition of “Skilled Nursing Facility.”

Family

“Family” means a Participant and eligible Dependents.

Felonious Act

“Felonious Act” means a crime or offense which carries with it the punishment associated with a felony conviction, as determined by common law or statute within the presiding jurisdiction of law enforcement. An occurrence of driving under the influence of a drug or alcohol is not considered a “Felonious Act” under this Plan.

Generic Drug

“Generic Drug” means drugs not protected by a trademark, usually descriptive of a drug’s chemical structure.

Health Breach Notification Rule

“Health Breach Notification Rule” means 16 CFR Part 318.

HIPAA

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

Home Health Care Agency

“Home Health Care Agency” means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Nurse to govern the services provided, and it must provide for full-time supervision of such services by a Physician or Registered Nurse;
3. It maintains a complete medical record on each individual; and
4. It has a full-time administrator.

Hospice

“Hospice” means a health care program providing a coordinated set of services rendered at home, in Inpatient settings or in institutional settings for Covered Persons suffering from a Condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (N.H.O.) and applicable state licensing requirements.

Hospice Benefit Period

"Hospice Benefit Period" means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the Covered Person's attending Physician certifies a diagnosis of terminally ill, and the Covered Person is accepted into a Hospice program. The period will end the earliest of six months from this date or at the death of the Covered Person. A new benefit period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof may be required by the Plan Administrator before such a new benefit period can begin.

Hospital

"Hospital" means an institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
2. It is constituted, licensed, and operated in accordance with the laws of the jurisdiction in which it is located which pertain to Hospitals;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical or surgical treatment of an Illness or an Injury, other than specialty Hospitals such as physical therapy and psychiatric Hospitals;
4. Such treatment is provided for compensation by or under the supervision of Physicians with continuous 24-hour nursing services by Nurses;
5. It qualifies as a Hospital, a psychiatric Hospital, physical therapy Hospital or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Hospitals (J.C.A.H. (unless accreditation is limited by the jurisdiction of the J.C.A.H. due to the location of the Hospital or is accredited by the proper authority in the country in which the Hospital is located)); or a Substance Abuse Treatment Facility certified by the Division of Community Services and licensed by the Department of Health; and
6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics or a nursing home.

Hospital Miscellaneous Expenses

"Hospital Miscellaneous Expenses" means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person, and which are not otherwise excluded under the Plan. "Hospital Miscellaneous Expenses" do not include charges for Room and Board or for professional services (including intensive nursing care) regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Hours of Service

"Hours of Service" means each hour for which the employee is paid, or entitled to payment, for performance of duties for the Company; and each hour for which the employee is paid, or entitled to payment by the Company for a period of time during which no duties are performed due to vacation, holiday, Illness or incapacity (including disability), layoff, jury duty, military duty or Leave of Absence (as defined in 29 CFR 2530.200b-2(a)).

Hours of Service do not include:

1. Any hour of service performed as a bona fide volunteer.
2. Any hour of service to the extent those services are performed as part of a federal work-study program as defined under 34 CFR 675 or a substantially similar program of a state or political subdivision thereof.
3. Any hour of service to the extent the compensation for those services constitutes income from sources outside the United States.

4. Any hour of service performed by an individual who is subject to a vow of poverty as a member of that order when the work is in the performance of tasks usually required (and to the extent usually required) of an active member of the order.

The Company will establish a Measurement Period for crediting an employee's Hours of Service that is consistent with the method as prescribed by the Shared Responsibility for Employers Regarding Health Coverage rules under section 4980H of the Internal Revenue Code (Code), enacted by the Affordable Care Act.

Illness

"Illness" means a disorder or disease of the body or mind, or pregnancy as classified in the ICD.10.CM Manuals (or updated version). All Illnesses due to the same cause, or to a related cause, will be deemed to be one "Illness."

Incurred

"Incurred" means the date when a service is performed, a supply is provided, or a purchase is made. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Freestanding Emergency Department

"Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

Injury

"Injury" means a Condition caused by an Accident which results in damage to the Covered Person's body.

Inpatient

"Inpatient" refers to the classification of a Covered Person when that person is admitted to a Hospital, Hospice or Convalescent Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment; or when a Covered Person is confined in a Hospital for 24 consecutive hours or more.

Intensive Outpatient Plan or Partial Hospitalization

"Intensive Outpatient Plan" or "Partial Hospitalization" means a distinct and organized intensive ambulatory treatment service, less than 24-hour daily care specifically designed for the diagnosis and active treatment of a Mental or Nervous Disorder or Substance Abuse when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

Programs must provide diagnostic services; services of social workers; psychiatric Nurses and staff trained to work with psychiatric patients; individual, group and Family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

Leave of Absence

"Leave of Absence" means a period of time during which the Participant must be away from his or her primary job with the Employer, while maintaining the status of Participant during said time away from work, generally requested by a Participant 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 Guardianship

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

Legal Separation

"Legal Separation" means an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Maintenance Care

"Maintenance Care" means any service or activity which seeks to prevent disease, prolong life, or promote health of an asymptomatic Covered Person who has reached the maximum level of improvement and whose Condition is resolved or stable.

Maximum Allowable Charge

"Maximum Allowable Charge" means the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see the section "No Surprises Act – Emergency Services and Surprise Bills") if no negotiated rate exists, the Maximum Allowable Charge will be the Qualifying Payment Amount, or an amount deemed payable by a Certified IDR Entity or a court of compete jurisdiction, if applicable.

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

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Measurement Period

"Measurement Period" means the period of time established by the Company during which an employee's hours are calculated to determine whether the employee has averaged the number of Hours of Service required to qualify as a full-time Eligible Employee.

The Company will utilize a measurement method prescribed by the Shared Responsibility for Employers Regarding Health Coverage rules under § 4980H of the Internal Revenue Code and may use different methods and Measurement Periods for different categories of employees. Absent anything to the contrary, the Measurement Period will begin on November 1 and end on October 31 of the following year.

Medical Record Review

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

Medically Necessary or Medical Necessity

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

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the diagnosis or treatment of an Illness or Injury.
4. It must meet the following definition of standard of care.

   Standard of care refers to an acceptable level of patient care provided by a medical practitioner. It considers how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.

   Standard of care is sometimes referred to as "standard therapy" or "best practice" and is generally satisfied by any medicine or treatment that experts agree is consistent with generally accepted standards of medical practice, is appropriate, accepted, and widely used for a certain type of patient, illness, or clinical circumstance. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Plan Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary.
5. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

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

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the Food and Drug Administration (FDA).
2. The prescribed drug use is supported by one of the following standard reference sources:
   a. Micromedex® DRUGDEX®.
   b. The American Hospital Formulary Service Drug Information.
   c. Medicare approved compendia.
   d. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.
3. The drug is otherwise Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

Medicare

"Medicare" means the program of health care established by Title XVIII of the Social Security Act of 1965, as amended.

Mental or Nervous Disorder

"Mental or Nervous Disorder" means any Illness or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA

"The Mental Health Parity Provisions" means in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Abuse disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Abuse disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance abuse disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Abuse disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

Named Fiduciary

"Named Fiduciary" means the Company, which has the authority to control and manage the operation and administration of the Plan.

Network

"Network" means the KSB network or facilities, providers and suppliers who have by contract via a medical provider network agreed to allow the Plan access to discounted fees for service(s) provided to Covered Persons, and by whose terms they have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Charges. The applicable provider network will be identified on the Plan identification card.

Nurse

"Nurse" means any of the following:

1. Certified Registered Nurse Anesthetist (C.R.N.A.)
2. Certified Nurse of the Operating Room (C.N.O.R.)
3. Certified Surgical Technologist (C.S.T.)
4. Certified First Assistant (C.F.A.)
5. Licensed Nurse Practitioner (L.N.P.)
6. Licensed Practical Nurse (L.P.N.)
7. Nurse Midwife (N.M.)
8. Registered Nurse (R.N.)

Open Election/Enrollment Period

"Open Election/Enrollment Period" means the time period set forth in the General Eligibility Provisions.

Orthotic Appliance

"Orthotic Appliance" means an external device intended to correct any defect in form or function of the human body.

Outpatient

"Outpatient" refers to the classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office including telephone and online consultations, or a Hospital, if not a registered bedpatient at that Hospital, an Outpatient Psychiatric Facility, or an Outpatient Alcoholism Treatment Facility.

Outpatient Alcoholism Treatment Facility

"Outpatient Alcoholism Treatment Facility" means an institution which provides a program for diagnosis, evaluation and effective treatment of alcoholism; provides detoxification services needed with its effective treatment program; provides infirmary level medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed Nurses who are directed by a full-time Nurse; is supervised by a Physician; and meets applicable licensing standards.

Outpatient Psychiatric Facility

"Outpatient Psychiatric Facility" means an administratively distinct governmental, public, private, or independent unit or part of such unit that provides Outpatient mental health services, and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

Participant

"Participant" means a person directly employed for the minimum number of hours specified in the "General Eligibility Provisions" who is in the regular business of, and compensated for services by, the Company, who is eligible for, has elected and has enrolled for Participant Coverage.

Participant Coverage

"Participant Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of an Injury or Illness of a Participant.

Participating Health Care Facility

"Participating Health Care Facility" means a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Physician

"Physician" will include the following health care providers, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency and acting within the scope of that license to perform services eligible under this Plan:

1. **Physician.** "Physician" means a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, optometrist, Physician assistant, physical therapist, speech therapist, occupational therapist, audiologist, speech language pathologist, certified consulting psychiatrist, psychologist or licensed or certified mental health/Substance Abuse provider to the extent they, within the scope of their license, are permitted to perform the services provided in this Plan.
2. **Mental Health/Substance Abuse Provider.** "Mental Health/Substance Abuse Provider" means a legally licensed psychiatrist, psychologist, licensed or certified social worker, clinical psychiatric counselor, or psychiatric Nurse clinician. In states where licensing and certification are not available, this Plan will recognize a provider that holds a master's level degree in the field of mental health or Substance Abuse.
3. **Nurses.** Nurses, as defined herein.

Plan

"Plan" means the Company's employee welfare benefit plan, which is described in this Summary Plan Description.

Plan Administrator

"Plan Administrator" means the Company.

Pre-admission Testing

"Pre-admission Testing" means the tests performed in a Hospital or other facility prior to confinement as a resident Inpatient, provided such tests are related to a scheduled Hospital confinement.

Preventive Care

"Preventive Care" means certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;

https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;

https://www.hrsa.gov/womensguidelines/.

For more information, Covered Persons may contact the Plan Administrator / Employer.

With regard to the HDHP Plan, "Preventive Services" include medical services, items and drugs permitted by the IRS in Notice 2019-45 when prescribed to a Covered Person with the specified chronic Condition.

Psychiatric Care

"Psychiatric Care," also known as psychoanalytic care, means treatment for a mental Illness or disorder, a functional nervous disorder, alcoholism, or drug addiction; with the type of care consisting of psychotherapy, group therapy, psychological testing or Family interviews designed to obtain information and to assist in treating the patient.

QMCSO

The term "QMCSO" means a Qualified Medical Child Support Order. This is a medical child support order or national medical support notice which meets all of the requirements of applicable law.

Qualifying Payment Amount

"Qualifying Payment Amount" means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Claims Administrator (if calculated by the Claims Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

Recognized Amount

"Recognized Amount" means the lesser of a Provider's billed charge or the Qualifying Payment Amount.

Residential Treatment Facility

"Residential Treatment Facility" means a facility which provides a program of effective treatment for a Mental or Nervous Disorder or Substance Abuse and which meets all of the following requirements:

1. It is licensed by the state in which it operates and is operated in accordance with applicable state law for residential treatment programs.
2. It provides a program of treatment under the active participation and direction of a Physician that requires full-time residence and full-time participation by the patient.
3. It provides all of the following basic services 24-hours per day:
   a. Room and board.
   b. On-site nursing services.
   c. Evaluation and diagnosis.
   d. Counseling.
   e. Referral and orientation to specialized community resources.
4. It is accredited by one of the following: Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities, or Accreditation Association for Ambulatory Health Care.

A Residential Treatment Facility does not include half-way houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities.

Room and Board

"Room and Board" refers to all charges by whatever name called which are made by a Hospital, Hospice or Convalescent Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

Skilled Nursing Facility

"Skilled Nursing Facility" means an institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Nurse under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;
2. Its services are provided for compensation from its patients and under full-time supervision of a Physician or Registered Nurse;
3. It provides 24-hour-per-day nursing service by licensed Nurses, under the direction of a full-time Registered Nurse;
4. It maintains a complete medical record on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, persons with intellectual developmental disorders, Custodial Care, educational care, or care of mental disorders; and
7. It is approved by Medicare and licensed by the state in which it is located.

This term will also apply to expenses Incurred in an institution referring to itself as a "Skilled Nursing Facility," "Extended Care Facility," "Convalescent Nursing Home" or any such other similar nomenclature.

Stability Period

"Stability Period" means the period of time established by the Company during which an employee's status for coverage, as determined during the associated Measurement Period, is locked provided the employee does not terminate employment with the Company or as otherwise outlined in the regulations relating to Code § 4980H of the Internal Revenue Code. A Stability Period applies only if the Company is using the look back measurement method.

A Stability Period begins at the end of the associated Measurement Period and includes any applicable administrative period established by the Company during which administrative and enrollment functions are performed.

The Company may use different Stability Periods for different categories of employees in a manner that is consistent with the Shared Responsibility for Employers Regarding Health Coverage rules under section 4980H of the Internal Revenue Code (Code), enacted by the Affordable Care Act.

Substance Abuse and/or Substance Use Disorder

"Substance Abuse" and/or "Substance Use Disorder" means any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

Substance Abuse Treatment

"Substance Abuse Treatment" means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician or psychologist, court-ordered evaluations, programs which are primarily for diagnostic evaluations, care in lieu of detention or correctional placement or Family retreats.

Substance Abuse Treatment Facility

"Substance Abuse Treatment Facility" means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse, and which is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

Summary Plan Description

"Summary Plan Description" means this Plan Document and Summary Plan Description, which constitutes both the Plan Document and the "Summary Plan Description", or "SPD" required by ERISA.

Surgery

"Surgery" means only the following:

1. A cutting operation;
2. Suturing of a wound;
3. Treatment of a fracture;
4. Reduction of a dislocation;
5. Radiotherapy, if used in lieu of a cutting operation;

6. *Electrocauterization;
7. *Injection treatment of hemorrhoids and varicose veins;
8. Any procedure defined as a surgical procedure by the American Medical Association; or
9. *Diagnostic and therapeutic endoscopic procedures.

*** For the purpose of complying with the Plan's utilization review requirement, these procedures will not be considered "Surgery."**

TMJ Dysfunction

"TMJ Dysfunction" means pain, swelling, clicking, grinding, popping, dislocation, locking, malposition, bite discrepancies or other pathological Conditions which create a loss or decrease of function in, around or caused by one or both of the jaw joints.

Totally Disabled

"Totally Disabled" means a physical or mental state of a Covered Person resulting from Illness or Injury which prevents a Participant from performing the normal duties of his occupation, or a Dependent from performing the activities of a person of like age and sex.

Traumatic Event

"Traumatic Event" means a sudden, unexpected, violent happening which causes Injury to the body.

Urgent Care

"Urgent Care" means any claim for medical 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 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.

Waiting Period

"Waiting Period" means the amount of time that must pass before an individual is eligible to be covered for benefits under the terms of the Plan.

Well Baby Care

"Well Baby Care" means medical treatment, services or supplies rendered to a newborn child solely for the purpose of health maintenance and NOT for the treatment of an Illness or Injury prior to its discharge from the Hospital following birth.

Well Child Care

"Well Child Care" means medical treatment, services or supplies rendered to a child solely for the purpose of health maintenance and NOT for the treatment of an Illness or Injury.

COORDINATION OF BENEFITS PROVISION

The coordination of benefits provision is intended to prevent payments of benefits which exceed expenses. It applies when a Covered Person is **also covered** by any **Other Plan or Plans**. When more than one coverage exists, one plan normally pays its benefits in full and the Other Plans pay a reduced benefit. Only the amount paid by this Plan will be charged against the Plan maximums.

This Plan coordinates benefits in the **carve-out method** defined as follows: this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the Other Plan or Plans, will not exceed the amount which would be paid under this Plan in the absence of any Other Plan or Plans.

The coordination of benefits provision applies whether or not a claim is filed under the Other Plan or Plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the Other Plan or Plans, or to recover overpayment. All benefits under this Plan are subject to this provision.

There is no coordination of benefits within this Plan. Coordination of benefits is applicable only with OTHER PLANS.

Definitions

The term **"Plan"** as used herein will mean any plan providing benefits or services for or by reason of medical or dental treatment, whose benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis, including but not limited to:
    a. Hospital indemnity benefits; and
    b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity benefits at the time of claims;
2. Hospital or medical service organizations on a group basis, group practice, and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A licensed Health Maintenance Organization (H.M.O.);
5. Any coverage under a governmental program, and any coverage required or provided by any statute;
6. Group motor vehicle insurance including, without limitation, medical reimbursement coverages;
7. Individual motor vehicle insurance coverage on a motor vehicle leased or owned by the Company;
8. Individual motor vehicle insurance under "no-fault" coverage, personal Injury protection coverage, medical payments or reimbursement coverage, financial responsibility coverage, "no-fault" medical payments coverage, underinsured coverage, uninsured coverage, and any other medical payment coverage;
9. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefits organization plans, and similar medical payable coverage;
10. Medical reimbursement coverage available under homeowners' insurance, or any other type of Insurance policy;
11. "School" or team insurance or any coverage for students which is sponsored by or provided through a school or other educational institution.

The term "Other Plan" will be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract

or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

The term “Allowable Expenses” means any Covered Expense under this Plan. Any expense excluded under this Plan in the absence of coordination of benefits will also be excluded under this Plan in the presence of coordination of benefits, regardless of whether or not the expense is covered by any Other Plan. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of these services rendered will be deemed to be both an Allowable Expense and a benefit paid. In the case of an HMO (Health Maintenance Organization) plan, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

The term “Claim Determination Period” means a Calendar Year or that portion of a Calendar Year during which the Covered Person for whom a claim is made has been covered under this Plan.

Coordination Procedure

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits payable under all plans will not exceed the total amount payable under this Plan under any Claim Determination Period.

Excess To Any Other Insurance

If at the time of Injury, Illness, 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, including any similar coverage under a different name in a particular state.
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.

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the exclusions in this Plan up to the maximum amount available to the Covered Person under applicable state law, regardless of a Covered Person’s election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles, or classifications.

Payments

Each Plan makes its claim payment according to the following order if Medicare is not involved:

1. If a plan contains no provision for coordination of benefits, it pays before all other plans.
2. If a person is a covered employee under one plan, and a covered dependent under another plan, the plan that covers the person as an employee is the primary plan.

3. If a child is covered under more than one plan and the parents are not legally separated or divorced, the primary plan is:

    a. The plan of the parent whose birthday falls earlier in the calendar year will be the primary plan; or,

    b. If both parents have the same birthday, the plan which has covered the parent the longest will be the primary plan.

    If the other plan does not have this rule but instead has a rule based upon the gender of the parent, the rule in this plan will override the rules of the other plan in determining the order of benefits.

4. If a child is covered under more than one plan and the parents are legally separated or divorced, the primary plan is determined as follows:

    a. The plan of the natural parent having responsibility for the child's health care expenses by court decree pays first. If the court decree splits the responsibility equally between the divorced parents, the primary plan is the plan of the parent whose birthday, excluding year of birth, falls earlier in the calendar year. If both parents have the same birthday, then the plan which has covered the child the longest will be the primary plan;

    b. In the absence of a court decree, -
        (1) The plan of the natural parent having legal custody pays; then,
        (2) The plan of the spouse (if any) of the natural parent with legal custody pays; then,
        (3) The plan of the natural parent without legal custody pays last.

5. If a person is a covered active employee under one plan and a covered retired or laid off employee under another plan, the plan that covers the person as an active employee or a dependent of an active employee is the primary plan.

6. If a person covered under a right of continuation pursuant to federal or state law is also covered under another plan, the plan that covers the person as an employee, member or subscriber is the primary plan and the plan providing continuation coverage is secondary.

7. If the order described above fails to establish the order of payment, then the plan which the person has been covered for the longest period of time is the primary plan.

8. In the event that you or your Dependent is covered by another group medical plan which, by its terms:

    a. The plans cannot agree on the primary versus secondary order; or

    b. Provides that it is secondary to other health plans, and the provisions of this Plan would make coverage under this Plan secondary to other applicable health plan coverage;

    Then the payments by this Plan will automatically be reduced by 50% and will be paid to the health provider or the employee as applicable and this Plan will have no further obligations with respect to such medical expenses.

Regardless of the order outlined above, in the event a Covered Person is injured in any way due to an Accident, and any no-fault, personal injury protection ("PIP") and/or medical payments coverage(s) are found to be available, these First Party coverages are primary and must be paid out (exhausted) in their entirety before a payment under this Plan is to be considered eligible.

The Plan Administrator has the right:

1. To obtain or share information with an insurance company, Plan Administrator, or other organization regarding coordination of benefits without the claimant's consent;

2. To require that the claimant provide the Plan Administrator with information on such Other Plans so that this provision may be implemented; and

3. To refund the amount due under this Plan to an insurer, plan, or other organization if this is necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

Accumulation of Benefit Savings

This Plan does not accumulate benefit savings in a secondary payer capacity to be used to cover the cost of previous Deductibles, Coinsurance, and ineligible expenses.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan will be fully discharged from liability.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in absence of this provision.

Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Plan will have the right to recover such payments, to the extent of such excess, in accordance with the provisions of this Plan.

COORDINATION WITH MEDICARE

If You or Your Dependent are Eligible for Medicare:

Coordination of Benefits with Medicare will conform with Federal Statutes and Regulations. As such, eligibility for Medicare Part A and Part B will not affect Plan benefits for:

1. An active employee or spouse of an active employee age 65 or over.
2. An employee or his covered Dependent who is less than age 65 and covered under the Plan by virtue of his current employment status (as defined by Medicare) and eligible for Medicare by reason of a disability condition other than End Stage Renal Disease. However, this provision does not apply when the Company has less than 100 employees.
3. A Covered Person eligible for Medicare due to End Stage Renal Disease during the period defined by Federal regulations in effect at the time the claim is incurred.

For all other Covered Persons who become eligible for Medicare Part A and Part B, Plan benefits will be coordinated with Medicare in the **carve-out method** as described herein. The benefits of Medicare and this Plan are combined to cover your medical expenses up to the benefits you would have received if Medicare did not exist. When Medicare is the primary payer of benefits, the allowable expense is limited to the Maximum Allowable Charge approved by Medicare when the provider accepts Medicare assignment. This limitation will not apply if the service provider does not accept Medicare assignment. This coordination of benefits will apply regardless of whether or not the Covered Person has enrolled for Medicare coverage.

Active Employees Age Sixty-Five And Over

Note: For persons enrolled in the High Deductible Health Plan option: The HDHP option has been designed to be a "qualified high deductible health plan" (HDHP). An individual who is covered under a qualified HDHP is eligible to establish a Health Savings Account ("HSA"). However, your enrollment under this Plan does not automatically satisfy all IRS regulations for an HSA. For example, if you are covered by any other health plan, you are not eligible to contribute to an HSA unless the other plan is also a qualified HDHP. In addition, you cannot be enrolled in Medicare (Part A or Part B) or claimed as a dependent on another person's tax return to be eligible to contribute to an HSA. Please consult the IRS website (www.irs.gov) for information regarding qualifications for Health Savings Accounts.

If you will soon be age 65, check your eligibility for Medicare prior to your 65th birthday. As long as you are an employee in Active Service past the age of 65, you will be eligible for the same health benefits as employees under age 65 in Active Service.

If your spouse is also enrolled in this Plan, this provision would apply to your spouse during the period of time your spouse is age 65 or over, regardless of your age.

If you are an employee in Active Service, over age 65 or soon to be age 65, it is extremely important that you sign up for both Medicare Part A and Medicare Part B in advance of losing coverage under this Plan. Unless you sign up for coverage under Medicare, and meet all of the other requirements of Medicare, you will not receive Medicare coverage.

Federal law prohibits an employer with more than 20 employees to offer group health coverage that is supplemental to Medicare. Therefore, while you are in Active Service, this Plan will be the primary payer and Medicare the secondary payer of benefits. You (or your spouse) are free to reject this Plan coverage. However, if such an election is made, you (or your spouse) will no longer be eligible for medical coverage under the Plan.

This provision does not apply to employees or spouses entitled to Medicare because of total disability (when the Company has less than 100 employees), or end stage renal disease after the initial treatment period.

FIRST AND/OR THIRD-PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(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 Person(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 Person(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 Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(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 Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(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 Covered Person(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 Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(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 Person(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 Person(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 Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person 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 Person 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 Person(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 Person(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, including any similar coverage under a different name in a particular state.
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 Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(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 Covered Person(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 Person(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 Covered Person's/Covered Persons' 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 Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person 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 Person(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 Person(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 Illness, Injury, or disability.

Covered Person is a Trustee Over Plan Assets

Any Covered Person 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 Person 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 Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person 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 Person disputes this obligation to the Plan under this section, the Covered Person 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 Person, 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 Covered Person(s) ("Incurred") prior to the liable party being released from liability. The Covered Person's/Covered Persons' 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 Covered Person 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 To Any Other Insurance

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

The Plan's benefits shall be excess to 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, including any similar coverage under a different name in a particular state.
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 Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(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 Person(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 Person(s) and all others that benefit from such payment.

Obligations

It is the Covered Person's/Covered Persons' 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 Illness, 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 Person 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 Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person 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 Person over settlement funds is resolved.

If the Covered Person(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 Person(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 Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Covered Person 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 Person'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 Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

In the event the Covered Person(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.

PRIVACY STANDARDS

The Plan provides each Covered Person with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Covered Person's personal health information. It also describes certain rights the Covered Person has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling the Human Resources Department at (815) 285-5617.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Human Resource Manager
Staff designated by Human Resource Manager
Chief Financial Officer
Plan Auditor
Privacy Officer
Any other individual named in the Company's HIPAA Compliance documents

(2) The access to and use of PHI by the individuals described in subsection (1) above will be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(3) In the event any of the individuals described in subsection (1) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

k. Notify participants of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).

l. Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).

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

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

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

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

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Professional Benefit Administrators, Inc., to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures will be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI

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

SECURITY PRACTICES

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

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

1. Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

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 Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI;

4. Report to the Plan any Security Incident of which it becomes aware;

5. Notify participants of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18); and

6. Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).

Any terms not otherwise defined in this section will have the meanings set forth in the Security Standards.

CLAIM PROCEDURES

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan.

Claims

All claims are to be filed as shown on your Plan ID card. All questions regarding claims should be directed to Professional Benefit Administrators, Inc. (PBA). The Plan Administrator will 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 and Summary Plan Description may be delegated to Professional Benefit Administrators, Inc. (PBA); provided, however, that Professional Benefit Administrators, Inc. (PBA) is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan will 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 or that the benefit or disability is covered under the Plan. If the Plan Administrator in its sole discretion determine that the claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant fails to furnish such proof as is requested, no benefits or further benefits will be payable under the Plan.

Under the Plan, there are four types of health claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   A "Pre-service Urgent Care Claim" is any claim for medical 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 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.

   It is important to remember that, if a claimant needs medical care for a Condition which could seriously jeopardize his 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.

2. 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.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed

Post-service Claims (which must be Clean Claims) must be filed with Professional Benefit Administrators, Inc. (PBA) within one year of the date charges for the service were Incurred. However, should the Plan be terminated, claims must be filed within 90 days following the date of termination. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given, or supplies are provided. **Claims filed later than that date will be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by Professional Benefit Administrators, Inc. (PBA) in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by Professional Benefit Administrators, Inc. (PBA), together with a properly completed standard medical billing statement (such as Form HCFA, Form UB92, or UB04) or ADA Dental Claim Form:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges and repricing information;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Upon receipt of the appropriate information, the claim will be deemed to be filed with the Plan.

Professional Benefit Administrators, Inc. (PBA) will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by Professional Benefit Administrators, Inc. (PBA) within 45 days (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 declined or reduced.**

Timing of Claim Decisions

The Plan Administrator will 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:

1. Pre-service Urgent Care Claims.
   a. 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.
   b. 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:
      (1) The Plan's receipt of the specified information; or
      (2) The end of the period afforded the claimant to provide the information.

2. Pre-service Non-urgent Care Claims.
   a. 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.

b. 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. 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).

3. Concurrent Claims.

   a. 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.

   b. 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, 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.

   c. 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).

4. Post-service Claims.

   a. If the claimant has provided all of the information needed to process the claim, 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.

   b. 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, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

5. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

6. 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.

7. 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.

8. Calculating Time Periods. The period of time within which a benefit determination is required to be made will begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator will provide a claimant with a notice, either in writing or 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 and Summary Plan Description 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. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted;
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 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 judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical 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.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

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 pertinent 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;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate Named Fiduciary of the Plan, who will be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
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, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

6. That a claimant will be provided, 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 in possession of the Plan Administrator or Professional Benefit Administrators, Inc. (PBA); information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; 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, will be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Before the Plan Administrator issues a final internal Adverse Benefit Determination on a claim on review, the claimant will automatically be provided with any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with the claim. Such new information will be provided to the claimant as soon as possible, and sufficiently in advance of any applicable deadline, including extensions, to give the claimant a reasonable opportunity to respond before that date.

First Appeal Level

Requirements for First Appeal

The claimant must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, claimant may telephone:

Professional Benefit Administrators, Inc. (PBA) at 630-655-3755

To file an appeal in writing, the claimant's appeal must be addressed as follows:

Professional Benefit Administrators, Inc. (PBA)
900 Jorie Boulevard, Suite 250
Oak Brook, IL 60523-3827
Attn: Claim Appeals

Upon receipt, an appeal will be deemed to be filed with the Plan provided all of the information listed below is included.

It is 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 Employee/claimant;
2. The Employee/claimant's individual identification number printed on the Plan I.D. Card;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will 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**;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. 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, in the case of a health claim, the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Plan Administrator will notify the claimant of the Plan's benefit determination on review within the following timeframes:

1. 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.
2. Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
3. Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made will 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.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan Administrator will 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 and Summary Plan Description on which the denial is based;
3. The identity of any medical 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 additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures;
9. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims;
10. 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. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted;
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator will provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the denial of benefits. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal

The Plan Administrator will notify the claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.
2. Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.
3. Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made will begin at the time the second 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.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for:

1. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed;
2. A description of the Plan's review procedures and the time limits applicable to the procedures; and
3. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claim.

See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator will provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal

The decision by the Plan Administrator or other appropriate Named Fiduciary of the Plan on review will be final, binding, and conclusive unless such claimant has a right to an external review. **All claim review procedures provided for 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 the Plan's claim review procedures have been exhausted.**

External Review

A claimant has a right to have certain claim decisions reviewed by an independent review organization that has no association with the Plan, the Plan Sponsor, or the Plan Administrator. This external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant fails to meet the requirements for eligibility under the terms of this Plan.

The external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a final internal Adverse Benefit Determination) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a claimant is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

The claimant may submit a request for external review within 4 months after receipt of a denial of benefits to:

Professional Benefit Administrators, Inc. (PBA)
900 Jorie Boulevard, Suite 250
Oak Brook, IL 60523-3827
Attn: Claim Appeals

PBA will forward the claimant’s request for external review to an independent review organization as required by law. For standard external review, a decision will be made within 45 days of receiving the claimant’s request. If the claimant has a medical condition that would seriously jeopardize his or her life or health or would jeopardize the claimant’s ability to regain maximum function if treatment is delayed, the claimant may be entitled to request an expedited external review of the denial. The decision of the independent review organization will be final, binding, and conclusive.

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. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from Professional Benefit Administrators, Inc. (PBA). However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the claimant's medical Condition to act as the claimant's authorized representative without completion of this form. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

Assignments

For this purpose, the term “Assignment of Benefits” (or “AOB”) is defined as an arrangement whereby a Covered Person of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copays and Coinsurance amounts, to a medical provider. If a provider accepts said arrangement, the provider’s rights to receive Plan benefits are equal to those of the Covered Person, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copays, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Covered Person of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the Covered Person, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment 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 Person, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan, or following his or her termination as a Covered Person, 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. A medical provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Recovery of Payments

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

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State’s health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or

demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a claimant, provider or other person or entity to enforce the provisions of this section, then that claimant, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the claimant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

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

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

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

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

COBRA CONTINUATION COVERAGE

Note: Wherever the term "spouse" is used in this section, an eligible civil union partner is also meant to be included. A civil union partner will be a Qualified Beneficiary entitled to independent COBRA election rights and termination or dissolution of a partnership will be considered a Qualifying Event for the partner and any enrolled Dependent children.

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by, or on behalf of, the person, or subsidized by the Plan Administrator. Coverage will end in certain instances, including if timely payment of premiums is not made. You should check with your employer to see if COBRA applies to you and your Dependents.

Any questions regarding COBRA Continuation Coverage should be addressed to the Plan Administrator through the Human Resources Department. The Plan Administrator of this Plan is:

Katherine Shaw Bethea Hospital
403 E. First Street
Dixon, IL 61021
(815) 285-5617

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

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your employer's plan) are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

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

If you are the spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;

4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
   Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.
5. You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-Covered Employee dies;
2. The parent-Covered Employee's hours of employment are reduced;
3. The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
   Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan. If this Plan does not provide for retiree coverage this paragraph does not apply.

The employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the Qualifying Event.

You must give notice of some Qualifying Events

Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a Covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided, has subsequently been determined by the SSA to no longer be disabled.

NOTE: A "Notice of Change" form is available, free of charge, from the Plan Administrator and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

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

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

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed) or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual will satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

1. Name and address of the Covered Employee or former employee;
2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
3. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
4. In the case of a Qualifying Event that is divorce or Legal Separation, name(s), and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;

6. In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age or other);
7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s), and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or Legal Separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. **If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.**

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

If the Qualified Beneficiary is totally incapacitated and is not legally competent to make an election for COBRA continuation coverage, the 60-day election period is tolled until such time as the Qualified Beneficiary is able to make an election or a guardian or legal representative is appointed who is able to make the election on behalf of the Qualified Beneficiary.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event; however, if the first Qualifying Event is the Covered Employee's entitlement to Medicare benefits, followed by termination or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of (i) 36 months after the date the Covered Employee became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or Legal Separation, or a dependent child's losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage

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

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

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

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

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

1. The date your employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the failure to make timely payment of any required premium by, or on behalf of, the Qualified Beneficiary;
3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you .

Additional Information

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

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

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

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator will make a charge of $.25 for each page.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including your Company, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare 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 from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay 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. 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 would 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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.

GENERAL PLAN INFORMATION

Name of Plan

The name of the Plan is the Katherine Shaw Bethea Hospital Employee Health Benefit Plan.

Plan Sponsor

The Plan Sponsor is the Company. The Plan Sponsor will have the authority to amend and terminate the Plan, determine its policies, appoint, and remove other supervisors, fix their compensation, and exercise general administrative authority over them.

Plan Status Under the Affordable Care Act

Non-Grandfathered

Plan Sponsor's Employer Identification Number

The Plan Sponsor's Employer Identification Number (EIN) is 36-1000540.

Named Fiduciary, Plan Administrator

The Named Fiduciary and Plan Administrator is the Company. The Plan Administrator may delegate certain ministerial functions which do not require the use of discretionary authority to the Claims Administrator.

Plan Year

January 1 through December 31

Plan Number

505

Plan Type

Medical

Contributions to the Plan

Contributions are to be made on the following basis:

The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed (if any) by each Participant, in its sole discretion. Any employee contributions are used by the Plan for the payment of claims.

In the event that the Plan Sponsor terminates the Plan, then as of the effective date of termination, the Plan Sponsor and Participants will have no further obligation to make additional contributions to the Plan for claims Incurred after the date of termination.

Plan contributions for PARTICIPANT and DEPENDENT Coverage are shared by the Company and employee.

If you elect to have your contribution for coverage deducted from your pay on a pre-tax basis under the Company's Section 125 plan, you will only be allowed to change your coverage election during the annual Section 125 election period or, if sooner following a change in family status as defined in the Company's Section 125 plan.

Contributions and Benefits

The tax treatment of contributions and/or benefits under this Plan is governed by Section 105(b) and Section 152 of the Internal Revenue Code and is the sole responsibility of the Participant.

Effective Date

The effective date of the Plan is March 1, 1985.

Claims Administrator

The Claims Administrator of the Plan is Professional Benefit Administrators, Inc. ("PBA"), 900 Jorie Boulevard, Suite 250, Oak Brook, Illinois 60523-3827.

The Company, Plan Sponsor, Plan Administrator and Agent for Service of Process

The agent for service of process is

Plan Administrator
Katherine Shaw Bethea Hospital
403 E. First Street
Dixon, IL 61021
(815) 288-5531

The Plan is a distinct legal entity separate from the Company. As such, legal notice may be filed with, and legal process served upon, the Plan Administrator.

Plan Construction, Type of Administration and Funding

This Summary Plan Description will be construed in accordance with ERISA and, where not preempted, the laws of the state in which the Plan Sponsor is located.

This is a self-funded Plan with a Claims Administrator. The Plan Administrator is responsible for all claim decisions, and the Plan Sponsor is responsible for providing funds for the payment of the claims out of its general assets.

All Plan terms will be applied on a gender-neutral basis. Masculine pronouns used in this Summary Plan Description will include masculine or feminine gender unless the context indicates otherwise.

Wherever any words are used herein in the singular or plural, they will be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Purpose

The purpose of this Summary Plan Description is to set forth the provisions of the Plan which provide for the payment or reimbursement of a portion of the eligible medical expenses. The Plan Sponsor's purpose in establishing the Plan is to help to offset, for Eligible Employees, the economic effects arising from a non-occupational Injury or Illness. To accomplish this purpose, the Plan Sponsor and the Plan Administrator must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Summary Plan Description, to allow for allocation of the resources available to help those individuals participating in the Plan to the maximum feasible extent.

GENERAL PROVISIONS

Amendments or Changes

The terms of this Plan will not be amended or changed except as provided below under the section entitled "Amending and Terminating the Plan."

Plan Is Not A Contract

This Plan will not be deemed to constitute a contract of employment, give any Participant the right to be retained in the service of the Company or interfere with the right of the Company to discharge or otherwise terminate the employment of any Participant.

Protection Against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or to become due to any Participant (or former Participant), the Plan Administrator, in its sole discretion, may terminate the interest of such person. In such case, the Plan Administrator will determine how to apply the payment to the benefit of the Participant (or former Participant) or his/her estate. Any such application shall be complete discharge of all liability with respect to such benefit payment.

Free Choice of Physician and Treatment

The Covered Person has free choice of any Physician or surgeon, and the Physician-patient relationship will be maintained. The Covered Person, together with his 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 such care. Providers who are members of any Network used by the Plan 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 provider. The Plan will not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any officer or employee or on the part of any Physician in the course of performing services for Covered Persons.

Alternate Care and Treatment

Alternate forms of care and treatment, which can be provided without impairing the quality of care, if recommended by utilization management, and if approved by the Plan Administrator can be considered a Covered Charge. Alternate treatment or care which is not included in the Plan, is included in the Plan but is limited, or is included in the Plan but on a basis that differs from the care and treatment now recommended, will be payable under the Plan on the same basis as the care and treatment for which they are substituted if it can be shown to be cost effective. This is subject to the approval of the Plan Administrator, Covered Person, the Covered Person's Family, and the Attending Physician.

This provision is not intended to override the Experimental or Investigational treatment exclusion, or any lifetime maximum contained in the Plan.

Workers' Compensation Not Affected

This Plan is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that the Participant received or is eligible to receive workers' compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement the Participant receives from workers' compensation. The Plan will exercise its right to recover against the Participant.

A Participant is required to notify the Plan Administrator immediately when a claim for coverage under workers' compensation is filed if a claim for the same Injury or Illness is or has been filed with this Plan.

Personnel Policies

The Plan is intended to automatically comply with the Company's current established written personnel policies regarding waiting periods, continuation of coverage or reinstatement of coverage during the following situations regardless of whether or not the Plan has been specifically amended or modified: Company certified disability, an approved Leave of Absence, layoff, reinstatement, hire or rehire. The Plan will at all times comply with the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA).

During an emergency declaration or Executive Order issued by a federal, state, or local governing authority, covered employees will remain eligible for coverage in the event they are unable to attend the workplace, or other location they are authorized to work, due to:

1. A short-term pandemic-related illness, including a quarantine, self-quarantine, or isolation order by a healthcare provider or other federal or state governing authority, or other absences required directly by the event; or,
2. The temporary closure of business operations as a direct result of such order; or,
3. A short-term reduction in work hours for otherwise Eligible Employees, including a temporary layoff/furlough, as a direct result of a disruption in normal operations; or,
4. Any other such event of similar nature that may arise if approved by the Plan Administrator or required by law.

This provision runs concurrent with FMLA when permitted, and any applicable federal law or regulation governing the Employer. COBRA continuation coverage will be offered at the end of this extension. The maximum COBRA continuation coverage period will be measured beginning on the date this extension ends.

Rights in Recovery

Whenever payments have been made by the Plan Administrator with respect to allowable expenses in excess of the amount of payment necessary to satisfy the intent of this Plan, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to recover such excess payments. Further, the Plan Administrator reserves the right to deduct the amount of any excess payment from future benefits to which a Participant or any of his covered Dependents may become entitled. This right of recovery also applies when a Covered Person, or any plan that pays benefits for which benefits are also paid by the Plan, receives duplicate payments under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, or any liability plan.

Physical Examination/Consultation/Peer Review

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

The Plan Administrator also has the right to seek and utilize the professional opinion of consultants, peer review and other such entities for the purpose of determining the eligibility of both individuals and claims under this Plan. The expenses related to these services will be considered an eligible expense under this Plan, but only for a Covered Person.

Legal Proceedings

No action at law or in equity shall be brought to recover from the Plan prior to the expiration of 90 days after all administrative remedies under the Plan have been exhausted, nor will such action be brought at all

unless brought within one year from the time all administrative remedies under the Plan have been exhausted.

Conformity With Law

This Plan will be deemed to automatically be amended to conform as 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 terms of this Summary Plan Description. It is intended that the Plan will conform to the requirements of Federal civil rights laws, ERISA, and ACA, as it applies to group health plans, as well as any other applicable law.

This Plan will be deemed to automatically be amended to conform with Federal civil rights laws governing provisions of this Plan. As such, all Plan terms will be applied on a gender-neutral basis. Any gender-specific pronouns used in the Summary Plan Description are accordingly modified without specific amendment of this Plan.

GINA

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

The term "Genetic Information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
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 metabolite that detect genotypes, mutations, or chromosomal changes.

This Plan will not discriminate in any manner with its participants on the basis of such Genetic Information.

Rescission

The Plan may rescind coverage for a Covered Person if the individual (or a person seeking coverage on behalf of the individual):

1. Performs an act, practice or omission that constitutes fraud; or
2. Makes an intentional misrepresentation of a material fact.

Both such items are prohibited by the terms of this Plan. The Plan Administrator will determine whether an action or inaction constitutes fraud or an intentional misrepresentation of a material fact.

The Plan will provide 30 days advance written notice of any rescission. The rescission can affect the Covered Person's entire family, even if only one individual committed the fraud or misrepresentation.

Examples of fraud include, but are not limited to, the following:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which 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.

In the event of any rescission, the Plan's notice of rescission of coverage is considered to be an Adverse Benefit Determination under the law. Claimants have the right to appeal an Adverse Benefit Determination. A description of how to file an appeal is outlined under the "First Appeal Level" and "Second Appeal Level" of the "Claim Procedures" section. The first appeal must be filed within 180 days following receipt of the Plan's notice of rescission of coverage. After the claimant has exhausted the internal appeals process, the claimant has a right to submit a request for external review.

Plan Administration

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of Professional Benefit Administrators, Inc. to provide certain claims processing and other technical services.

The Plan is administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

When the Company acquires a new unit, whether through acquisition, merger or any other transaction, the employees of the new unit may become eligible under this Plan, waiving any and all Waiting Periods. The Plan Sponsor maintains the right to make the election to do this on an acquisition, merger, or transaction basis, as business needs dictate.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. In the event of administrative error or oversight, the Plan Administrator has the right to determine the effective date or termination date of coverage. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, will receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

The Company may make special eligibility arrangements for new or separating employees when necessary to serve a valid business purpose.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status, and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third-party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
11. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Balance Billing

In the event that a claim submitted by a Network or Non-Network provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any provider's actions, including balance billing.

In addition, with respect to services rendered by a Network provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Network provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network provider.

The Covered Person is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Right to Audit or Review

For charges Incurred outside of the KSB network, once a written claim for benefits is received, the Claims Administrator, acting on the authority and discretion of the Plan Administrator, may elect to have such claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but not be limited to, identifying:

1. Charges for items/services that may not be covered or may not have been delivered or performed,
2. Duplicate charges or billing mistakes,
3. Charges beyond the Maximum Allowable Charge guidelines as determined by the Plan,
4. Charges that have been unbundled, up coded, or otherwise coded inappropriately based on industry accepted practices or guidelines; and,
5. Charges for items/services that are determined to be excessive or beyond that which is generally accepted as being Medically Necessary to treat or diagnose an Illness or Injury.

When an audit or review 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 Covered Charges according to the review and/or audit results.

Any charge Incurred outside of the KSB network that is determined to be inaccurate or excessive by the Plan Administrator as a result of a claim review or audit will not be deemed a Covered Charge under this Plan.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which will be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. Notice will be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination will be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action will be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan will become effective as of a date established by the Plan Sponsor.

Contributions by the Plan Sponsor will continue to be issued for the purpose of paying benefits under this Plan with respect to claims arising before such termination.

Indemnification of Employees

Except as otherwise provided by ERISA, no director, officer or employee of the Company or the Claims Administrator will incur any personal liability for the breach of any responsibility, obligation or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan; and each such director, officer and employee will be indemnified and held harmless by the Company from and against any such liability, including all expenses reasonably Incurred in their defense if the Company fails to provide such defense.

Clerical Error

Clerical error on the part of the Plan Administrator or Claims Administrator in keeping the records in connection with a Participant's coverage will not invalidate coverage otherwise in force, nor continue coverage otherwise terminated.

Manuals

Manuals and reference material used by the Plan in order to determine the appropriate administrative procedures, appropriate diagnosis, usual and customary allowances, and Medical Necessity of claims submitted in compliance with this Summary Plan Description include, but are not limited to, the following:

1. ICD.10.CM (or updated version)
2. Usual and Customary Data Bases, Fee Schedules, and Claims Edit Programs
3. 1964 California Relative Value Study (C.R.V.S.)
4. CPT 4 (or updated version)
5. Physician's Desk Reference
6. Merck Manual
7. Taber's Cyclopedic Medical Dictionary
8. The Kennedy Series Medical/Disability and Dentistry Handbooks
9. The Medical Disability Advisor
10. The Hayes Manuals
11. The Trilogy Consulting Group Manuals (as modified by PBA administrative memos)
12. Others as developed or needed
13. Red Book or other NDC References.

Provision Enforcement

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect the right to enforce any other provision of this Plan.

Severability

If any provision within the Plan Document is found to be invalid or illegal, that finding only applies to those such provisions and such a finding will not have any affect or change the obligations of the parties as to the remaining sections and be severable.

Section Titles

Section titles are for convenience of reference only and are not to be considered in interpreting this Plan.

Active Military Duty

Reservists who are covered under the Plan and who are called to active military duty will be eligible for coverage as outlined in the USERRA Act of 1994 according to the following:

1. Employees - who return under the parameters of the USERRA Act of 1994.
2. Employees - on the day they return to full-time Active Service with the Company.
3. Dependents - on the day the Dependent meets the definition of an eligible Dependent under the Plan.

Continued coverage through USERRA runs concurrent with COBRA coverage. Credit will be given toward satisfaction of any required Waiting Period and reinstatement of coverage will comply with HIPAA.

Quality of Care Provision

This provision allows the Plan Administrator, based upon a case management recommendation, to approve as an Eligible Expense, a treatment technique not addressed by this Plan. If the Plan utilizes a Preferred Provider Organization ("PPO"), the Plan Administrator may recommend and approve a non-PPO Physician or Hospital that is recognized, in its opinion, to be significantly superior in the treatment of the applicable diagnosis to warrant this special consideration, and to pay this Physician and facility as if they were PPO providers.

Foreign Claims

In the event a Covered Person incurs a Covered Expense in a foreign country due to an unexpected Illness or Injury, the Covered Person will be responsible for providing the following information to the Claims Administrator before reimbursement of any benefits due are payable.

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. Proof that the bills have been paid. Benefits cannot be assigned to a non-U.S. provider.

A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must also be submitted with the claim.

Unclaimed Payments

Any benefit payment issued under the Plan that is not cashed by the payee within the 12-month period immediately following its date of issue will be considered void and will only become a Plan liability upon receipt of the employee's written request for re-issuance. Such request must be made within the 24-month period immediately following the date the benefit payment was issued. Any request that is filed later will be denied.

YOUR RIGHTS UNDER FEDERAL LAW

Newborns' and Mothers' Health Protection Act of 1996 (The Newborn's Act)

According to The Newborn's Act, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours) or provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under The Newborn's Act.

Mental Health Parity

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

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

WHCRA requires that group health plans provide coverage for the following services for any person receiving Plan benefits in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

If you receive benefits from the Plan for a mastectomy and you then elect to have reconstructive surgery, the Plan must provide coverage in a manner determined by consulting with your attending Physician and you. The Plan's benefits for breast reconstruction and related services will be the same as the benefits that apply to other services covered by this Plan (i.e., coverage may be subject to annual Deductibles and Coinsurance).

It is important to note that the Plan covers these expenses. However, the law requires that we provide this notice each year. A group health plan may not deny eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely to avoid the WHCRA requirements.

Family and Medical Leave Act (FMLA)

If you meet FMLA eligibility requirements, FMLA entitles you to take up to 12 weeks of unpaid, job-protected leave during any 12-month period for one or more of the following reasons:

- The birth of a child or placement of a child with you for adoption or foster care.
- To care for a spouse, child or parent who has a serious health condition (parents-in-law are not included).
- A serious health condition that makes you unable to perform the essential functions of your job. A serious health condition is defined as an illness (including pregnancy), injury, impairment, or physical or mental condition which involves (1) inpatient care in a hospital, hospice, or residential treatment facility or (2) continuing treatment by a health care provider.

- For qualifying exigencies arising from the military deployment of a spouse, child, or parent to a foreign country.

FMLA also entitles you to take up to 26 workweeks of FMLA leave in a single 12-month period to care for a spouse, child, parent or next of kin who is a covered servicemember with a serious injury or illness (military caregiver leave).

Please see your Human Resources Department for information concerning eligibility and scheduling requirements for an FMLA leave. If the leave is foreseeable, you must provide your Human Resources Department with at least 30 days' notice before the date you want to begin FMLA leave. If circumstances require leave to begin in less than 30 days, you must provide notice as soon as possible.