AMERICAN Collective LP

Medical Plan Document and Summary Plan Description (SPD) For American Collective Unity Plans

August 1, 2025

For the Schedule of Benefits, See Page 8

For assistance in a non-English language, please call 888-701-2975.
Para obtener asistencia en Español, por favor llame al número arriba.

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INTRODUCTION

Welcome to the American Collective LP Welfare Benefits Plan. This Plan Document applies to the Unity Plan(s). This document explains the operation of your health plan. Please call 866-270-1554 if you have any questions.

Introduction
The Plan Sponsor has established the Plan to help offset the financial impact of an Injury or Sickness.

The Plan Document describes the terms for payment of covered medical and prescription charges.

Applicable Law
This Plan is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). To the extent not preempted by Federal law, the Plan shall be governed by the law of the State where the Plan Sponsor maintains its principal place of business.

Discretionary Authority
The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD. The Plan Administrator also has full discretionary authority to interpret the Plan and to determine all questions relating to the Plan as they relate to eligibility to participate in the Plan or the level of stipend offered under the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals, committees, or third parties.

Fiduciary
The Plan Administrator is the named fiduciary of the Plan.

Legal Entity; Service of Process
The Plan is a legal entity. Legal process may be served on the Plan Administrator. You must exhaust your appeal rights (other than external review) before bringing legal action.

Plan Contributions and Funding
The Plan is self-funded by the general assets of the Plan Sponsor and participants. The Plan Sponsor determines the level of required participant contributions.

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GENERAL PLAN INFORMATION

Plan Name	American Collective LP Welfare Benefits Plan
Plan Number	501
Plan Sponsor	American Collective LP 650 Poydras Street, Suite 1400, PMB #6807 New Orleans, LA 70130
Plan Sponsor FIEN	39-2150479
Plan Administrator	American Collective LP 650 Poydras Street, Suite 1400, PMB #6807 New Orleans, LA 70130 (866) 270-1554
Type of Plan	Welfare Benefits Plan
Funding Method of Plan	Self-Funded
Original Plan Effective Date	August 1, 2025
Plan Year	January 1 through December 31
Program or Policy Name	Unity Plan
Waiting Period	30 days
Agent for Service of Process	CT Corporation System 1999 Bryan St., Suite 900 Dallas, TX 75201
Partner Services	PartnerServices@AmericanCollectiveLP.com
Claims	ATTN: American Collective LP Medical Claim Premiere Administrative Solutions P.O. Box 211475 Eagan, MN 55121 Payor ID #: 29084 (866) 270-1554

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DEFINITIONS

Ancillary Services
Items and services provided by an out-of-network provider at a health care facility, as that term is defined in the No Surprises Act, that is in-network and for which balance billing is prohibited under the No Surprises Act.

Appeals Authority
The Plan Administrator, Third-Party Administrator or other persons or entities, as described in the Plan, that have the authority to grant or deny an appeal of a claim arising under the Plan.

Child(ren)
"Child" or "Children" has the meaning as defined in the "Who Are Eligible Dependents?" subsection.

COBRA Administrator
The entity designated by the Plan Administrator to fulfill the COBRA administrative functions of the Plan.

Code
The Internal Revenue Code of 1986, as amended from time to time.

Coinsurance
Percentage of covered expenses that you pay after meeting the applicable Deductible.

Copay
A flat fee that is paid to the provider of the medical service each time a service is provided.

Covered Expenses, Covered Services
Those services or supplies eligible for payment under the coverage you have selected. Please note, however, that even if a service is covered, it may not be covered at 100% (see Coinsurance and Maximum Allowance), or it may not be paid for if you have not yet met your Deductible.

Deductible
The amount you are required to pay each year before any payments are made by the medical coverage options for covered services, except for specified services to which the Deductible requirement does not apply.

Eligible Dependents
Individuals eligible for dependent coverage under the Plan. "Eligible Dependents" has the meaning as defined in the "Who Are Eligible Dependents?" subsection.

Employee
For purposes of this Plan, "Employee" means an individual who is a partner in the limited partnership.

ERISA
The Employee Retirement Income Security Act of 1974, as amended from time to time.

Experimental/Investigative
Experimental/Investigative is determined at the sole discretion of the Third-Party Administrator. For a detailed definition, see the "General Exclusions and Limitations" section.

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Maximum Allowable Charge
The amount that an in-network provider has agreed to accept as payment for a particular service. Also called a negotiated or contracted fee. The amount that is applied to your in-network Deductible and Out-of-Pocket Maximum is based on the Allowance.

Plan
The American Collective LP Welfare Benefits Plan.

Plan Document
This American Collective LP Welfare Benefits Plan document, together with all Appendices.

Plan Sponsor
The sponsor of the Plan as described in the Introduction section of this Plan document, or any successor entity with respect to this Plan.

Plan Year
The 12-month period for which current benefits, limits, Deductibles, and maximums apply. For the Plan, the Plan Year is the calendar year (January 1 - December 31). The initial Plan Year is a short Plan Year, running from August 1, 2025- December 31, 2025.

Preventive Care
To the extent not otherwise specified by an Insurer-provided documents or under applicable law or regulations, any medical, vision or dental service that is designed to avoid illness or promote wellness.

Qualified Medical Child Support Order (QMCSO)
Any court order or an equivalent administrative order which:

- Provides for child support with respect to a participant's Child or directs the participant to provide coverage under a health benefits plan under a state domestic relations law and conforms to the applicable requirement under ERISA regarding qualified medical child support order; or
- Enforces a law relating to medical child support described in Social Security Act, Section 1908, with respect to a group health plan law and conforms to the applicable requirement under ERISA regarding qualified medical child support order.

Spouse
"Spouse" has the meaning as defined in the "Who Are Eligible Dependents?" subsection.

Third-Party Administrator (or Plan Administrator)
The Third-Party Administrator as set forth in the section "General Plan Information."

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SCHEDULE OF BENEFITS

You, as the Plan Participant, are responsible for ensuring that any medical service you are planning or is being planned on your behalf is covered by this Plan. You should read this Plan Document, paying particular attention to this Schedule of Benefits and the list of Exclusions from the Plan. If, after reading this Plan Document you or a provider has questions about whether a medical service is covered and how it is covered, you should Call 866-949-3581 with your questions.

Reimbursement from the Plan may be reduced or denied due to the provisions in the Plan, such as coordination of benefits, subrogation, or medical necessity.

Maximum Allowable Charge Limitation
The Plan pays benefits based on the Maximum Allowable Charge, as defined in the "Definitions" section of this Plan Document, rather than billed charges. If a Provider charges more than the Maximum Allowable Charge (as determined by the Plan), the Plan Participant may be responsible for the amount in excess of the Maximum Allowable Charge, unless prohibited by applicable law.

The Plan has a fiduciary obligation to its participants to preserve Plan assets against charges that exceed the Maximum Allowable Charge. This excess amount is considered outside the scope of the Plan: it is not counted toward satisfaction of the Deductible, and it is not paid by the Plan even after satisfaction of the Deductible.

The Maximum Allowable Charge will not include charges for any items billed separately by the provider that are not customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

Advocacy
It is the Plan's position that a Provider should not balance bill a Plan Participant for amounts in excess of the Maximum Allowable Charge. It is the Plan's position that these Excess Charges are clearly excessive and exorbitant.

Physician Network
Your physician network name, **First Health**, phone number and website are displayed on the front of your ID card. American Collective has entered into an agreement with the displayed physician network. In-network physicians have agreed to charge reduced fees to Plan Participants.

The Plan may pay for services from physicians who are not contracted by the displayed network at the in-network benefit level if the Plan Participant has no in-network physician in the necessary specialty who is accepting patients within a 20-mile radius of their home, or

You have a free choice of any physician (i.e. in-network or out-of-network) and you, together with your physician, are 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.

If a physician is removed from the Plan's network, the Plan will notify Plan Participants who are receiving care from the physician that the physician is no longer in the Plan's network and that the Participant has the right to elect to continue receiving transitional care from the physician subject to the Maximum Allowable Charge Limitation.

Information and Records
Premier Administrative Solutions ("PAS") may require additional information to make a benefit determination on behalf of the Plan. The Plan Participant or Provider must send this information in the timeframe requested. Failure to send may result in denial of payment.

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Claims Review
PAS may use its discretionary authority to utilize an independent bill review and/or claim audit program.

PAS has the discretionary authority to reduce any charge to a Usual and Customary or Reasonable amount. The Usual and Customary amount will be determined based on the amount allowed by Medicare on the same date of service and in the same geographic area where the service was provided.

For professional services, the Usual and Customary amount will be determined at 140% of the amount allowed by Medicare.

Other services covered by the Plan will be determined at 150% of the amount allowed by Medicare.

Medical Benefits

Unity Plans only provide coverage for Office and Urgent Care visits with Medical Providers for Sickness, Accident, and Preventive Care. All benefits are outlined below and are detailed in the Plan Benefits and Exclusions sections which follow. **If a benefit is not included in the following Schedule of Benefits or in the Plan Benefits section, you should consider the benefit not covered.**

Sickness, Accident and Preventive Care services must be provided outside of a hospital. You may use Medical Providers contracted by the PPO network listed on the front of your ID card to avoid any balance billing by a provider. If you do not utilize a Medical Provider contracted with the PPO, we will utilize the Maximum Allowable Charge Limitation, and you may be subject to balance billing by the provider.

Note: This plan does not cover any services provided by a hospital (inpatient, outpatient, or rehabilitation), any diagnostic testing outside of those described in the preventive care benefits, surgery, anesthesia, emergency room, rehabilitation, medical equipment and supplies, or ambulance.

Benefits for Treatment of Sickness and Accidents During Office Visits and Urgent Care Visits

Covered Benefit	Unity 2 Plan	Unity 4 Plan	Unity 6 Plan
Deductible	There are No Deductibles		
Coinsurance/Out-of-Pocket Limit	There is no Coinsurance or Out-of-Pocket		
OFFICE VISITS FOR SICKNESS OR ACCIDENT			
Maximum Visits Per Year	2 Visits	4 Visits	6 Visits
Visit Limit Applies	Combined total of PCP, Specialist and Urgent Care		
Primary Care Physician (PCP)	$25 Copayment, then 100% of Allowed		
Providers Considered PCP	Internal Medicine, Pediatrician, Family Practice, General Practice, and Geriatrician (All Other Provider Types are considered to be Specialists)		
Specialist	$50 Copayment, then 100% of Allowed		
Urgent Care Center	$100 Copayment, then 100% of Allowed		

Note: Office visit charges, Diagnostic Labs and Radiology Completed in the Office; Specialist testing such as Cardiac Testing, Pulmonary Testing (Including Sleep Studies), Neurologic Testing, and Gastroenterology Testing are not covered.

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Prevention and Wellness Benefits

Covered Benefit	Unity 2 Plan	Unity 4 Plan	Unity 6 Plan
PREVENTION/WELLNESS CARE FOR ADULTS			
This does not apply to your annual sickness or accident office visit limit.			
Adult Benefit Apply For	Applicable to members between the ages of 18 and 64		
Benefit for Prevention/Wellness	100% of Maximum Allowable Benefits (No Deductible, Coinsurance or Copayments)		
Preventive Exam/Physical	Up to One Exam Every 12 Months		
Abdominal Aortic Aneurysm Screening	Up to One Exam Per Lifetime for Members who have smoked		
Alcohol Misuse: Unhealthy Alcohol Use Screening and Counseling	Up to One Alcohol and Drug Screening Per Year		
Anxiety Disorders in Adults	Up to One Anxiety Screening Per Year		
Aspirin: Preventive Medication	Low Dose Aspirin is covered for adults ages 50-59 with a high cardiovascular risk		
Blood Pressure Screening	For members up to Age 40, a least one Blood Pressure Screening every 2 years; For members Age 40 and above, one Blood Pressure Screening Per Year		
Cholesterol Screening	For Members with Heart Disease, Diabetes or a Family History of High Cholesterol, one Cholesterol Screening Per Year		
Colorectal Cancer Screening	For Members Ages 45-64, Up to One Colorectal Cancer Screening Every 10 Years; Up to One Fecal screening Test (Cologuard Every 2 Years)		
Depression Screening	Up to One Depression Screening Per Year		
Diabetes Screening	Up to One Diabetes Screening Per Year for those Ages 40-65 overweight or obese, or have other risk factors		
Healthy Diet and Physical Activity Counseling	Up to One Diet and Physical Activity Counseling Per Year for those at higher risk for chronic diseases		
Hepatitis B Virus Infection Screening	Up to One Hepatitis B Screening Per year for members at high risk (Not vaccinated as an infant or from a Country with a high prevalence of Hepatitis B)		
Hepatitis C Virus (HCV) Infection Screening	Up to One Hepatitis C Screening Per Year		
HIV Preexposure Prophylaxis for the Prevention of HIV Infection	These are Covered; Please see the subsection “Preventive Medications” for more information.		
HIV Screening and Counseling	Up to One HIV Screening Per Year for Members Over Age 15 or with Higher Risk		
Latent Tuberculosis Infection Screening in Adults	Up to One Tuberculosis Screening Per Year for Members at High Risk		

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Covered Benefit	Unity 2 Plan	Unity 4 Plan	Unity 6 Plan
PREVENTION/WELLNESS CARE FOR ADULTS, Continued			
This does not apply to your annual sickness or accident office visit limit.			
Lung Cancer Screening	Up to One Lung Cancer Screening Per Year for Members Over Age 50 or those who have quit smoking in last 15 years		
Sexually Transmitted Infections Counseling	Up to One Counseling Session Per Year for Adults at Higher Risk		
Syphilis Screening	Up to One Syphilis Screening Per Year for Members at High Risk		
Tobacco Use Counseling and Interventions	Up to One Tobacco Counseling Per Year for Tobacco Users		
PREVENTION/WELLNESS CARE FOR WOMEN			
This does not apply to your annual sickness or accident office visit limit.			
Well Women Exams	Up to one Well Women exam per Year		
Bone Density Screening	Up to One Bone Density Screening Per year for Women 64 and Under who have gone through menopause		
Breast Cancer Genetic Test (BRCA)	One-time Test for Women at Higher Risk (Risk must be established via screening)		
Breast Cancer Screening Via Mammogram	Mammogram screening every year for Women ages 40 and Older		
Breast Cancer Chemoprevention Counseling	Up to One Counseling Session Per year for Women at High Risk		
Cervical Cancer Screening	One Test Per year for Women Ages 21 to 65		
Chlamydia Infection Screening	One Test Per Year for Women at Higher Risk		
Diabetes Screening	For Women with a history of gestational diabetes who aren't currently pregnant or haven't been diagnosed with Type 2 diabetes previously		
Domestic and Interpersonal Violence Screening and Counseling	Up to One Screening and Counseling Session Per year		
Gonorrhea Screening	One Test Per Year for Women at Higher Risk		
Urinary Incontinence Screening	One Screening Per year		
PREVENTION/WELLNESS FOR PREGNANT WOMEN (OR THOSE WHO MAY BECOME PREGNANT)			
This does not apply to your annual sickness or accident office visit limit.			
Breastfeeding Support and Counseling	Programs provided by Trained Professionals for Pregnant and Nursing Women		
Breastfeeding Supplies	Rental or Purchase of a Breast Pump		
Birth Control	Up to One Patient Education and Counseling Session for Birth Control		

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Gestational Diabetes Screening	Up to One Screening for Women 24 weeks' pregnant or those at risk of developing gestational diabetes		
Maternal Depression Screening	Available at Each Well Baby Visit		
Covered Benefit	**Unity 2 Plan**	**Unity 4 Plan**	**Unity 6 Plan**
Preeclampsia Prevention and Screening	Available for Women with High Blood Pressure or other risk factors		
Rh Incompatibility Screening	Up to One Screening for pregnant women, with follow-up testing for Women at High Risk		
PREVENTION/WELLNESS FOR CHILDREN (APPLIES TO MEMBERS UNDER AGE 18)			
This does not apply to your annual sickness or accident office visit limit.			
Well Child Visits	Up to One Exam within each of the following timeframes/ages (Please refer to Immunization Schedule Below)		
	Birth to 3-5 Days		
	1 Month	Up to 1 Visit	
	2 Months	Up to 1 Visit	
	4 Months	Up to 1 Visit	
	6 Months	Up to 1 Visit	
	9 Months	Up to 1 Visit	
	12 Months	Up to 1 Visit	
	15 Months	Up to 1 Visit	
	18 Months	Up to 1 Visit	
	2 Years	Up to 1 Visit	
	30 Months	Up to 1 Visit	
	3 Years	Up to 1 Visit	
	4 Years	Up to 1 Visit	
	5+ Years	Up to 1 Visit	

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Covered Benefit	Unity 2 Plan	Unity 4 Plan	Unity 6 Plan
PREVENTION/WELLNESS CARE FOR CHILDREN, Continued			
This does not apply to your annual sickness or accident office visit limit.			
Alcohol, Tobacco and Drug Use Assessment for Adolescents	Up to One Assessment Per year for Children between 10 and 19 years old		
Autism Screening	One Screening at 18 Months and Another at 24 Months		
Behavioral Assessment	Up to One Assessment Per year for Children between 10 and 19 years old		
Bilirubin Concentration Screening	As needed for Newborns		
Blood Screening for Newborns	As needed for Newborns		
Depression Screening for Adolescents	Up to One Screening Per Year for Children Age 12 and Over		
Developmental Screening	Up to One Screening for Children Age 3 and Under		
Dyslipidemia Screening	Up to One Screening for Children between 9 and 11 years and between 17 and 21 years who are at risk for Lipid Disorders		
Gonorrhea Preventive Medication	Up to one administration of the medication for the eyes of all newborns		
Hearing Screenings	Up to One Screening for a Newborn and regular screenings is recommended by a medical provider		
Hematocrit or Hemoglobin Screening	Up to One Screening Per Child		
Hemoglobinopathies and/or Sickle Cell Screening for Newborns	Up to One Screening Per Newborn		
Hypothyroidism Screening	Up to One Screening Per Newborn		
Lead Screening	Screening based on Exposure to Lead		
Obesity Screening and Counseling	Up to One Screening and Counseling Session Per Year		
Oral Health Risk Assessment	Up to One Screening and Counseling Session Per Year for Children Ages 6 Months to 6 Years		
Phenylketonuria (PKU) Screening	Up to One Screening for Newborns		
STI Prevention Counseling	Up to One Counseling Session for Adolescents at Higher Risk		
Vision Screening	Up to One Screening Per Year		
IMMUNIZATIONS			
Frequency of Immunization	Varies based on Age with Standards detailed in https://www.cdc.gov/vaccines/hcp/imz-schedules		
Chickenpox (Varicella)	Covered based on CDC Recommended Schedule		
Diphtheria, Tetanus and Pertussis (DTaP)	Covered based on CDC Recommended Schedule		
Haemophilus Influenzae Type B	Covered based on CDC Recommended Schedule		
Hepatitis A	Covered based on CDC Recommended Schedule		
Hepatitis B Virus Infection Screening	Covered based on CDC Recommended Schedule		
Human Papillomavirus (HPV)	Covered based on CDC Recommended Schedule		
Inactive Poliovirus	Covered based on CDC Recommended Schedule		

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Influenza (Flu Shot)	Covered based on CDC Recommended Schedule		
Measles	Covered based on CDC Recommended Schedule		
Meningococcal	Covered based on CDC Recommended Schedule		
Covered Benefit	**Unity 2 Plan**	**Unity 4 Plan**	**Unity 6 Plan**
IMMUNIZATIONS, Continued			
Mumps	Covered based on CDC Recommended Schedule		
Pneumococcal	Covered based on CDC Recommended Schedule		
Rotavirus	Covered based on CDC Recommended Schedule		
Rubella	Covered based on CDC Recommended Schedule		

NOTE: You may be able to obtain your immunization(s) in your local pharmacy. In such cases the Pharmacy may charge you at the time the immunization is administered. If this occurs you must complete the Immunization Transmittal found in your web portal and mail it to Premiere Administrative Solutions at the address shown in the table above. Your submission must include an itemized statement from the Pharmacy and a receipt indicating your payment.

Preventive Medications

In accordance with the Patient Protection and Affordable Care Act (PPACA) certain preventive medicines are covered at 100 percent with no member out of pocket cost. All medicines, including over-the-counter items, require a prescription from the doctor and must be provided by a participating retail, or through the home delivery pharmacy.

Below is information about the medicines available. A summary of the categories includes:

- Low-dose aspirin to prevent cardiovascular disease for men age 45-79 and to prevent cardiovascular disease and preeclampsia for women age 13-79.
- Generic bowel prep medicines required for the preparation of a preventive colonoscopy screening.
- Generic breast cancer prevention medicines for women age 35 and older.
- Fluoride supplements for children ages 6 months through 5 years old.
- Folic acid supplements for women.
- Statins for primary prevention of cardiovascular diseases in adults: low to moderate intensity statins are recommended for adults who are between the ages of 40-75, have no history of cardiovascular disease (CVD), have one or more risk factors for CVD and have a calculated 10-year CVD event risk of 10% or greater. Lovastatin and pravastatin are covered.
- Smoking cessation: Generic, brand-name with no generic equivalent (single source) and over the counter smoking cessation medicines. The day supply limit applied to these FDA-approved tobacco cessation medicines is 180 days per member per 365 days. Brand smoking cessation medicines that do have a generic equivalent (multi-source) are covered with copayment/cost sharing, or according to your benefit design.
- Routine immunizations for children, adolescents and adults as recommended from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (covered under medical benefit)
- Iron supplementation for children ages 6 months to 1 year old who are at increased risk for iron deficiency anemia.
- Contraceptives: Generic contraceptives are covered with no cost share. Brand contraceptive products that do have a generic equivalent (multi-source) and brand name contraceptives with no generic equivalent (single source) are covered with copayment/cost sharing.
- Pre-Exposure Prophylaxis (PrEP) for the prevention of HIV infection.

Available Pharmacy Benefit

Medications Available at No Cost	
No Cost Drugs	Only Drugs included on Revive's Preferred Drug List are available at no cost. There are over 70 Preferred Drugs available at the retail Pharmacy and over 1,100 Preferred

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	Drugs available through Mail Order. The list of Preferred Drugs is found using the QR code reflected below:
Retail Pharmacy	You may obtain up to a 30-Day supply of medications on Revive's Preferred Drug List for the treatment of acute conditions, like antibiotics and steroids. These are available at any Retail Pharmacy contracted with Revive. Contracted Pharmacies can be identified on the Revive Web Portal or by calling (888) 220-6650.
Mail Order Pharmacy	You may obtain up to a 90-Day supply of medications on Revive's Preferred Drug List for ongoing use or for the treatment of chronic conditions by using Revive's Mail Order Pharmacy. Instructions for getting set up with Revive are shown below. Please note: Up to 4 deliveries of Mail Order Drugs are available at no cost. If you request more than 3 refills per year, shipping cost will be charged to you for the extra deliveries.
Medications Available at Discounted Cost	
Drugs which are not included on Revive's Preferred Drug List may be subject to a 20-50% discount by showing your ID Card at a contracted Pharmacy.	

Your Pharmacy Plan

About Revive

The Revive Prescription Benefit Program provides members with free access to over 1,100 commonly prescribed maintenance medications delivered directly to their homes. It also includes more than 70 urgent care medications available for pickup at over 70,000 pharmacies- all at no cost with membership.

Available Drugs

Scan the QR Code to view the list of drugs available with Revive

How to get Set Up with Revive

Revive provides access to healthcare benefits through its member portal or the Revive app, so you can access care whenever it's convenient for you. Complete your enrollment today and gain instant access to on-demand, personalized care.

Sign-up Instructions:

1. Scan the QR Code or go to member.myrevive.health/selfsignup
2. You will be taken to a web page where you will be prompted to enter a code. Enter **tczK7bzr3s**
3. Next, enter your First and Last Name, Email Address, then click **Submit**
4. You will receive an email to login and complete the registration process to access the program
5. When asked, create a unique password and click **Submit**
6. You will now be sent to your personal portal to access the care services that have been selected for you.

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Access your Revive Personal Health Care Portal

Go to https://member.myrevive.health

Revive Customer Support

Should you have any trouble with registration, accessing your benefits, or scheduling an appointment, reach out to the revive customer care team at:

- Phone: (888) 220-6650
- Email: customercare@revive.health

COVERED EXPENSES

Members are covered or not covered for the following health care facilities, providers, and services, as specifically described below.

For services that are deemed covered and received from a Practitioner or Medical Professional CONTRACTED by the PPO reflected on the front of the ID card, charges for those services will be covered, subject to medical necessity and program limitations. For services that are deemed covered and received from a Practitioner or Medical Professional NOT CONTRACTED by the PPO reflected on the front of the ID card, charges for those services will be covered, subject to the Maximum Benefit Limit, medical necessity and program limitations.

Annual Preventive Exams

Annual Preventive Exams, Screening, Counseling, Testing and Immunizations are covered by the Unity Plan(s), subject to the frequency and other limitations outlined in the Schedule of Benefits.

Audiological Procedures

Hearing treatment, if provided in an Office Visit or Urgent Care Center, is covered subject to the benefits and limitations applicable to Office Visits and Urgent Care visit for Sickness or Accident. Other treatment, such as surgery is NOT covered in your Unity Plan.

Cologuard

Cologuard fecal testing is covered for Ages 45 to 64 every two years, at 100%.

Colonoscopy

Diagnostic colonoscopies are covered for Ages 45 to 64 every 10 years.

Diagnostic Imaging

All Diagnostic Imaging with the exception of Preventive Mammography and Bone Density Testing described in the Schedule of Benefits is NOT covered under your Unity Plan. This includes X-Rays, MRI, MRA, Ultrasound, CT Scans, and PET Scans.

Mammograms

Mammograms are covered as part of your Unity Plan Preventive Services, at a frequency identified in the Schedule of Benefits.

Mental Health

Mental health and substance abuse counseling is NOT covered except to the extent required as a preventive service.

Physician Services

Physician services include the diagnosis, treatment, management or prevention of an Illness or Injury. Office visits for Primary Care, Urgent Care, and Specialty Care are eligible for sharing subject to a Copayment and 100% coverage for treatment of

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sickness and accident. There is a limit based on the Unity Plan in which you enrolled, of the number of office visits for sickness and accident which are covered each year you are enrolled. Each year, at the anniversary of your enrollment, your office benefit maximum benefit will reset. For Preventive/Wellness Services provided by a Physician, coverage will be at 100% for the specific services outlined in the Schedule of Benefits.

Vaccines Administered by Pharmacists
Vaccination services administered by pharmacists are covered, subject to the list of covered Immunizations and frequency identified in the Schedule of Benefits. If you receive vaccines from a Pharmacist, you may be required to pay for the vaccine when it is administered by the Pharmacist. In such cases, you must file a Transmittal for Reimbursement available on your Member Portal with a copy of the Pharmacist's printout of services rendered and your receipt.

Well Baby Visits
Well baby visits, including immunizations, are eligible for sharing within the first year of birth.

Well Child Exam
Well Child Exams, Screening, Counseling, and Immunizations are covered by your Unity Plan subject to the list of specific services and limitations listed in the Schedule of Benefits.

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AMERICAN Collective LP

GENERAL EXCLUSIONS AND LIMITATIONS

It is very important to review the Schedule of Benefits and the Description of Covered Services in the previous Section. This Section details General Exclusions and Limitations applicable to the Plan.

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

2. **ADD/ADHD/SPD and Similar Chemical Imbalances**
   Treatment of purported chemical imbalances not demonstrable by lab tests, such as for Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, Sensory Processing Disorder, and similar disorders. Please note: Office visits where medication reviews are completed ARE COVERED, up to the maximum number of office visits in the Unity plan.

3. **Alcohol/Drug-Related Problems**
   Services, supplies, care or treatment for an injury and/or disease and/or bodily malfunction which occurred as a result of that Partner's abuse and/or use of alcohol or drugs/pharmaceuticals, including Drug and/or Alcohol Rehabilitation Treatment are not covered.

4. **Allergy Testing**
   Allergy testing, including skin tests, blood tests, and provocation tests, is not covered.

5. **Alternative Medicine and Non-Conventional Treatments**
   An "alternative medical treatment" or "non-conventional treatment" is a treatment proposed by a member for a condition lawfully diagnosed by a licensed medical professional, but which treatment was not prescribed by the member's provider. Expenses of Alternative Treatment are not covered.

6. **Ambulance**
   Ambulance transportation, including Emergency and/or Non-Emergency land or air ambulance transportation, is not covered.

7. **Ambulatory Surgery**
   Ambulatory surgery, also referred to as "day surgery" or "outpatient surgery," is not covered.

8. **Anesthesia**
   Anesthesia, inclusive of that related to surgery and spinal injections, is not covered.

9. **Anti-Aging or Aging "Reversal"**
   Treatments and devices for the normal changes or declines in bodily functions that typically occur with age (e.g., sexual aids, eyeglasses, hearing aids, dentures, etc.) are not covered.

10. **Armed Conflict**
    Injuries or illness resulting from a member's participation as a combatant in an armed conflict, but not including actions taken purely in self-defense or in defense of an immediate family member, are not covered.

11. **Audiological Therapy**
    Hearing Therapy by a licensed audiologist is not covered.

12. **Breast Implants**

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The placement, replacement or removal of breast enhancement devices and complications related to breast implants are not covered.

13. **Cardiac Therapy**
    Cardiac Therapy, in accord with a Physician's order to improve body function, is not covered.

14. **Charges before or after Active Membership**
    Medical care, treatment, or supplies for which a charge was incurred before a person was enrolled, or after membership ceased or became inactive, is not covered.

15. **Chemotherapy and Radiation Therapy**
    Chemotherapy and Radiation Therapy are not covered.

16. **Chiropractic Therapy**
    Treatment of skeletal or musculoskeletal disease or injury by a person holding a Doctor of Chiropractic degree (abbreviated as "D.C.") is not covered.

17. **Circumcision**
    Circumcision is not covered.

18. **Civil Disobedience/Protests/Riots**
    Injuries or illness resulting from or occurring during participation in an act of civil disobedience, demonstrating, protesting or rioting is not covered.

19. **Complications of Non-Eligible Treatments**
    Care, services, or treatment required as a result of complications from a treatment not eligible for sharing is not covered.

20. **Cosmetic Procedures**
    Cosmetic care or treatment is not covered, including but not limited to:
    - Pharmacological regimens,
    - Nutritional procedures or treatments,
    - Cosmetic surgery,
    - Plastic surgery,
    - Salabrasion,
    - Chemosurgery, and
    - Other such skin abrasion procedures associated with the removal or revision of scars, tattoos or actinic changes.

21. **CT Scan**
    CT Scans are not covered.

22. **Custodial Care**
    Services or supplies provided mainly as a rest cure, maintenance, custodial care, or other care that does not treat an Illness or Injury, are not covered.

23. **Dental Care**
    Dental prostheses and care or treatment of the person's teeth above or below the gums is not covered.

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24. **Durable Medical Equipment**
    The purchase, rental or replacement of durable or reusable equipment or devices is not covered, including, but not limited to:
    - Orthotics,
    - Hearing aids,
    - Tubing,
    - Masks, and
    - Their associated expenses.

25. **Emergency Room**
    Emergency Room services are not covered. This is regardless of the medical necessity of the ER visit and/or whether the enrolled member is admitted to the facility. When the ER facility is not covered, neither are the services of any medical professional who treated the patient while they were in the ER.

26. **Excess Charges**
    The part of an expense for care and treatment of an injury or illness that is in excess of the Maximum Allowable Charge is not covered.

27. **Exercise Programs**
    Exercise programs for treatment of any condition, except for Physician- supervised cardiac rehabilitation and/or physical therapy are not covered.

28. **Experimental, Investigational, Unproven or Unapproved Services**
    Care and treatment that is either Experimental, Investigational, or Unproven, or that has not been approved by the American Medical Association, FDA, or other industry recognized authoritative bodies, or that is illegal by U.S. law, is not covered.

29. **Euthanasia/Assisted Suicide**
    Expenses for intentionally terminating or assisting with the termination of a human life are not covered.

30. **Eye Care**
    Eye exercise therapy, radial keratotomy or other eye surgery to correct near-sightedness, routine eye examinations, including refractions, lenses for the eyes, and exams for their fitting, are not covered.

31. **Failure to Follow Medical Advice**
    Expenses for care and treatment of an injury or illness, the need for which was the result of a failure to follow medical advice or an unreasonable delay in following medical advice, are not covered.

32. **Genetic Testing**
    Genetic Testing including the process of analyzing cells or tissue to look for changes in genes, chromosomes, or proteins that may be a sign of a disease or condition, such as cancer, is not covered. This includes:
    - Pre-symptomatic and predictive testing,
    - Carrier testing,
    - Pharmacogenetics,
    - Prenatal testing,
    - Newborn screening, and
    - Preimplantation testing.

    The only exception to this exclusion is BRCA testing for women where there is a confirmed high risk of breast cancer.

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33. **Goods and Services Purchased from Relatives**
Purchases of Services from a relative are not covered.

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

35. **Hearing Aids and Exams**
Charges for services or supplies in connection with routine hearing exams, hearing aids, or exams for their fitting, are not covered.

36. **Hazardous Hobbies**
Care and treatment of an injury or illness that results from engaging in a hazardous hobby is not covered. A hobby is hazardous if it is an activity which is characterized by a constant or recurring threat of danger or risk of bodily harm. Examples of hazardous hobbies include, but are not limited to:
    - Rock/cliff climbing,
    - Spelunking,
    - Scuba diving,
    - Skydiving,
    - Bungee jumping,
    - Hang gliding,
    - Kite surfing,
    - Paragliding,
    - Base jumping, and
    - All other extreme sports.

37. **Hemophilia**
No form of Hemophilia is covered.

38. **Home Health Care**
Skilled care services at home are not covered.

39. **Homeopathic**
Homeopathic treatments and prescriptions are not covered.

40. **Hospice Care**
Hospice Care services are not covered.

41. **Hospital Charges**
Medical Services provided by a Hospital on Inpatient or Outpatient basis are not covered.

42. **Hyperbaric Oxygen Therapy**
Hyperbaric Oxygen Therapy is not covered.

43. **Illegal Acts**
Charges for services received as a result of the following are not covered:
    - Injury or illness caused by engaging in an illegal act or occupation,

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- By committing or attempting to commit any crime, criminal act, assault, or other felonious behavior, including but not limited to:
    - Illegal drug activity,
    - Crimes against persons,
    - Crimes against property,
    - DUI, and
    - Gun offenses.

44. Impotence
Surgical and non-surgical services for the treatment of impotence are not covered.

45. Infertility
Diagnostics, testing, surgical repair, non-surgical repair, surgical impregnation, in vitro fertilization, or other procedures and Prescription Drugs for the treatment of infertility, are not covered.

46. Infusion Therapy
Infusion therapy, at home, in a Physician's Office, or Facility (Hospital, Rehabilitation Hospital, Skilled Nursing Facility or any other facility), is not covered.

47. In-Office Surgery and Therapeutic Injections
Surgery which can be performed in the office of a Medical Professional is not covered. Therapeutic injections completed in a Medical Professional's office are not covered.

48. Interest/Late Charges/Penalties
Costs incurred for interest charges, late charges, or penalties from any Provider are not covered. Interest or finance charges from a credit card or lending institution that a Member borrows from to pay medical bills are also not covered.

49. Long-Term Care
Nursing home and other long-term care is not covered.

50. Mental Health Services
Charges for psychiatric or psychological counseling, mental disability, learning disability, bereavement counseling, biofeedback therapy, and psychological testing are not covered.

51. MRIs
MRIs are considered a Diagnostic Radiology service and are not covered.

52. Naturopathic Care
Naturopathic adjustments, manipulations, and other treatments are not covered.

53. Negligent Acts
Expenses resulting from an Illness or Injury as to which the Partner or covered family member has acted with negligence or with reckless disregard to safety, as evidenced by medical records, are not covered.

54. Non-Medical Expenses
Expenses not directly related to provided medical services are not covered (e.g., phone chargers, cots and/or meals for visitors, etc.).

55. No Obligation to Pay

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Charges incurred for which the patient has no legal obligation to pay are not covered.

56. Not a Medically Necessary Service

Care and treatment that does not meet the criteria of a Medically Necessary Service or is not specified as a Medically Necessary Service; care, treatment, services, or supplies not recommended and approved by a Physician; or treatment, services, or supplies received when the Sharing Member is not under the regular care of a Physician are not covered. American Collective reserves the right to review billing submitted by providers for payment, and upon review by a qualified medical professional, decline to share expenses deemed to be Not a Medically Necessary Service.

57. Nutritional Supplements

Nutritional products, supplements, consultations, education, and educational materials are not covered.

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58. **Nutritionist**
Services of nutritionists and dietary consultants are not covered.

59. **Occupational Therapy**
Occupational therapy is not covered.

60. **Optometric Vision Therapy**
Optometric vision therapy is not covered.

61. **Organ/Tissue Donation**
Expenses related to organ or tissue donation are not covered.

62. **Organ Transplant**
Expenses incurred in connection with any organ or tissue transplant are not covered.

63. **Outpatient Prescribed or Non-Prescribed Medical Supplies**
Outpatient prescribed or non- prescribed medical supplies are not covered. This is including, but not limited to:
    - Over-the-counter drugs and treatments,
    - Elastic stockings,
    - Tubings,
    - Masks,
    - Ostomy supplies,
    - Insulin infusion pumps,
    - Ace bandages,
    - Gauze,
    - Syringes,
    - Diabetic test strips, and
    - Similar supplies.

64. **Personal Comfort Items**
Personal comfort items or other equipment are not covered, such as, but not limited to:
    - Air conditioners,
    - Air-purification units,
    - Humidifiers,
    - Electric heating units,
    - Orthopedic mattresses,
    - Blood pressure instruments,
    - Scales,
    - Elastic bandages or stockings,
    - Non-prescription drugs and medicines and first-aid supplies, and
    - Non-hospital adjustable beds.

65. **Physical Therapy**
Physical therapy is not covered.

66. **Pre-Employment and Pre-School/Athletic Physicals**
Pre-Employment, Pre-School/Athletic Physicals are not covered if outside a normal schedule of wellness and preventive care provided by the patient's regular physician.

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67. Professional Racing or Competitive Events

Charges for treatment of injuries or illness while racing or competing as an amateur or professional are not covered. "Professional" means that such activity is one's primary vocation and means of financial support. "Amateur" means competing in similar events, but with no resulting financial rewards for success. Racing and competitive events include, but are not limited to:

- Automobile,
- Motorcycle,
- Watercraft,
- Ski, or
- Rodeo races or competitions.

68. PSA Test

PSA tests are not covered.

69. Relatives Providing Services

Professional services performed by a person who ordinarily resides in the Member's home or is related to the Member as a Spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law are not covered.

70. Replacement Braces

Replacement of braces of the leg, arm, back, or neck are not covered.

71. Respiratory Therapy

Respiratory therapy is not covered.

72. Self-Inflicted Injuries

Any medical expense due to injuries that are self-inflicted or otherwise intentionally caused to oneself, while sane or insane, are not covered.

73. Sex Changes

Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This includes:

- Medications,
- Implants,
- Hormone therapy,
- Surgery, or
- Medical or psychiatric treatment.

74. Speech Therapy/Speech Pathology

Speech therapy is not covered.

75. Sports-Related Safety/Performance Devices and Programs

Devices used specifically as safety items or to affect performance primarily in sports-related activities are not covered. All membership, registration or participation costs as they relate to physical conditioning programs are not covered. This includes:

- Athletic training,
- Bodybuilding,
- Exercise,
- Fitness flexibility, and
- Diversion or general motivation.

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76. Surgery

Surgery is not covered, regardless of the setting for the surgery, including a Medical Office, outpatient or Ambulatory Surgery Facility, or Inpatient Surgery. Surgery includes the following:

- A cutting operation,
- Suturing of a wound,
- Treatment of a fracture,
- Reduction of a dislocation,
- Radiotherapy (including radioactive isotope therapy) if used in lieu of a cutting operation for removal of a tumor,
- Electro cauterization,
- Diagnostic and therapeutic endoscopic procedures, and
- Injection treatment of hemorrhoids and varicose veins.

77. Surgical Sterilization or Reversal

Charges for care and treatment for, or reversal of, surgical sterilization, including vasectomy and tubal ligation, are not covered.

78. Surrogacy

Expenses related to a surrogate pregnancy are not covered.

79. Temporomandibular Joint Dysfunction (TMJ)

Charges for care and treatment of, for, related to, or in connection with Temporomandibular Joint Dysfunction are not covered.

80. Travel or Accommodations

Charges for travel or accommodations, whether or not recommended by a Physician, are not covered.

81. Vision Therapy

Vision Therapy is not covered.

82. War

Any cost incurred that is due to any declared or undeclared act of war, act of terrorism, or military activity.

83. X-Rays

X-Rays are not covered.

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PARTICIPATION

Before you can receive benefits under this Plan, there are certain rules you must satisfy. First, you must meet the eligibility requirements. After that, the next step is to actually join the Plan on the entry date established by the Plan Administrator. To enroll in the Plan, you must complete the application process established by the Plan in a timely manner.

Who Is Eligible To Be A Participant?

You must be a partner in the American Collective limited partnership to be eligible to participate in the Plan.
Participants in the Plan may also enroll their spouses and/or Children for certain coverages, so long as they qualify as Eligible Dependents. The term "Eligible Dependent" is defined below.

For the rest of this document, American Collective limited partners may be referred to as "eligible Employees" or sometimes just "you."

The Employer's classification of an individual as an eligible Employee or a non-employee (or independent contractor) is conclusive and binding for purposes of determining eligibility for Plan participation. If, for any reason, a person is reclassified from a non-employee to an employee, that person will not be retroactively eligible for benefits. Instead, benefits eligibility will begin prospectively on the date the re-classification is made.

Who Are Eligible Dependents?

The following individuals are Eligible Dependents:

- Your Spouse
- Your Child under age 26, without regard to marital, student or financial status.

An Eligible Dependent does not include anyone who:

- Is enrolled as an Employee,
- Is enrolled as an Eligible Dependent of another Employee, or
- Resides outside of the United States.

The Plan Administrator has the discretion to make all factual determinations on whether a person is an Eligible Dependent.

"*Child*" means:

- Your natural born child,
- Your legally adopted child,
- A child placed with you for adoption,
- Your stepchild, or
- Dependents who are eligible as a result of a Qualified Medical Child Support Order (QMCSO). See the subsection "Qualified Medical Child Support Orders (QMCSO)" for more information.

Foster children are not eligible for coverage.

"*Spouse*" refers to a person who is a husband or wife in a marriage (whether opposite-sex or same-sex) as recognized for federal tax purposes. Due to difficulties in verifying common law marriage, if you have a Spouse by common law marriage, you must provide a court decree (or similar official documentation acceptable to the Plan Administrator) recognizing such marriage.

How To Enroll

Participation in the Plan does not begin unless you actually enroll. You will receive enrollment information from the Third-Party Administrator, including an enrollment notice. The deadline for new hire enrollment in the Plan is 30 days following the date of

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hire (or 30 days following the first date of new eligibility, if later). Generally, you can complete your enrollment via the Plan's enrollment web site as provided in the enrollment information. If you prefer to enroll or make changes to your benefit elections by paper, you should contact the Plan Benefits Staff at (888) 868-9767. No additional charge applies for enrollment by paper.

Each year, usually sometime in the fall, you will be able to choose or change the coverages in which you wish to participate under the Plan. During this "Annual Enrollment Period," you may make any available coverage changes you wish for any reason, subject to specific limitations that may apply. The coverages you elect during the Annual Enrollment Period will generally be effective for the entire twelve-month period of the plan year beginning on January 1st.

When Participation Begins

Except as specifically provided otherwise in this document, actual coverage for each type of benefit under the Plan cannot begin until you have timely completed all eligibility and enrollment requirements.

New Hires

If you complete the enrollment process for yourself and for any of your Eligible Dependents within 30 days following the date of hire, generally your (and any enrolled Eligible Dependents') participation can begin the 31st day.

Mid-Year Coverage Changes

The elections you make during annual enrollment will remain in effect from the next January 1 through December 31. You may add new Eligible Dependents to the coverage you elected. If you elected medical coverage, you may add and remove the following coverage options during the plan year: dental, AD&D and critical illness. If you did not elect any medical coverage during annual enrollment, you may add medical coverage at any time during the plan year and that coverage will remain in effect through the next December 31st. You may not change medical coverage from Unity to Prestige mid-year.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Third-Party Administrator.

Other Information Regarding Coverage

The Plan may not, with respect to medical or other health coverage, establish eligibility rules or set any individual's premium or contribution rate based on:

- Whether an individual is confined to a hospital or other health care institution,
- An individual's ability to engage in normal life activities, or
- Whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor is treated, for purposes of the Plan, as being actively at work.

Notwithstanding the foregoing, the Plan may establish an eligibility rule that requires an individual to begin work for the Employer before coverage becomes effective, provided that such eligibility rule applies regardless of the reason for the absence. Further, eligibility rules and individuals' premium or contribution rates may be established in accordance with the rules relating to "similarly situated individuals" as defined in Department of Labor Regulation §2590.702(d). For example, different eligibility rules or premium contribution rates may apply based on:

- A bona fide employment based on classifications (such as full-time vs. part-time),
- Whether the individual is an employee or a dependent, or

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- A dependent's relationship to the employee (e.g., as a spouse or an eligible child).

For this purpose, eligibility rules mean any rules relating to enrollment, effective date of coverage, waiting periods, late and special enrollment, eligibility for benefit packages, benefits, continued eligibility, or termination of coverage.

When Your Participation Ends

Your participation in the Plan ordinarily ends when:

- You are no longer actively employed by the Employer or are no longer a limited partner for any reason (other than vacation or holidays),
- You otherwise cease to meet the eligibility requirements (whether as a result of a status change or a Plan amendment),
- You cease to make the required contributions for coverage,
- You fail to complete dependent eligibility verification requirements,
- Fraud, intentional misrepresentation, or misconduct attempted by you with regard to any coverage or benefits under the Plan, or
- Your death.

We say "ordinarily ends" because there are several possible exceptions and also because each coverage under the Plan also may have its own, additional eligibility requirements. Any such specific rule takes precedence over the general rule described here.

The actual date on which coverage terminates may vary depending on the covered dependent and/or the circumstances involved. Plan coverage will end, for you and your covered dependents, midnight on your last day of work in which your employment terminates. As long as you are covered, most coverages generally continue for your dependent child until midnight of the day before your child turns age 26.

When Your Dependent's Participation Ends

Your dependents cease to participate in the Plan if you cease to participate in the Plan. A dependent's participation also ceases if the dependent no longer meets the definition of Eligible Dependent.

Choices Available When Participation Ends

In certain circumstances, it is possible to temporarily continue health coverage under the Plan beyond the time it would normally end. For information on temporary health coverage continuation, see the section, "Continuation Coverage Under COBRA."

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HEALTH CARE COVERAGE

Medical Coverage

The benefit provided by this feature of the Plan is the payment of medical expenses. If your contribution is not received for any reason within 30 days following the date it is due, medical coverage for yourself and your Eligible Dependents may be discontinued in accordance with the Plan's policy.
The available medical coverage options are set forth in the section "Schedule of Benefits."

Your Coverage

When you initially enroll, you decide which medical coverage option will apply to you and your dependents for the remainder of that Plan Year (*i.e.*, calendar year). And then, each year at annual enrollment, you decide which medical coverage option will apply for the following Plan Year, which begins on January 1.
The following are some special eligibility requirements:

- You may only cover your dependents for the same medical option as you choose for yourself. You cannot cover your dependents if you choose No Coverage for yourself.
- If an eligible Employee is married to another eligible Employee, the Employees can each take his/her own coverage, or one Employee can choose to cover his/her Spouse as a dependent. Only one of you, however, may cover a Child who is an Eligible Dependent.

Medical Coverage Options

The medical coverage available under the Plan is described in the section "Schedule of Benefits."

Covered and Non-Covered Medical Services

Each of the medical coverage options pays benefits only as set forth in the section "Schedule of Benefits" and for services that are Medically Necessary as determined by the Third-Party Administrator. Medical coverage does not pay for certain services, which are described in the section "General Exclusions and Limitations." The list of non-covered services, which is determined by the Third-Party Administrator, is subject to change without advance notice. If you are uncertain whether a certain medical service is covered, please contact the Third-Party Administrator.

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CONTINUATION COVERAGE UNDER COBRA

This section contains important information about COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. Below is a general explanation of COBRA coverage, when it may become available to you and your eligible family members, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this section) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan or by the Employer.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage under the Plan. If, upon reading this section, you have additional questions about your COBRA coverage rights and obligations under the Plan and under federal law, you should contact the Plan Benefits Staff at (888) 868-9767. Unless this Plan Document specifically provides otherwise, the Plan provides no greater COBRA rights than what COBRA requires—nothing in this section is intended to expand your rights beyond COBRA's requirements.

Instead of enrolling in COBRA continuation coverage, there may be other more affordable 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. 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. Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in coverage through the Marketplace through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

What Is COBRA Coverage?

COBRA coverage is a temporary continuation of group health coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event occurs and any required notice of that event is properly provided, COBRA coverage must be offered to each "qualified beneficiary," *i.e.*, you and your covered Eligible Dependents who lost (or would otherwise lose) group health coverage under this Plan because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. See below for details.)

A qualified beneficiary who timely elects and pays for COBRA continuation coverage receives the same coverage as similarly situated participants in the group health plan who have not experienced a qualifying event. For example, changes in coverage, Deductibles, Coinsurance amounts, Copayments and insurance carriers applicable to participants who have not incurred a qualifying event will apply equally to each qualified beneficiary.

Each qualified beneficiary will also have the same rights as a similarly situated participant who has not experienced a qualifying event, to participate in annual enrollment periods and to make changes in his or her coverage, including, for example, the right to add a Spouse or Children. (Note, however, that a Spouse or Child added in this manner is not – and cannot become – a qualified beneficiary, because the individual was not covered by the Plan at the time of the original qualifying event.)

Unless otherwise specifically provided in this Plan Document, qualified beneficiaries who elect COBRA must pay the applicable premium for such coverage plus a 2% administrative charge. The applicable premium is the actual cost to the Plan of providing the same group health coverage to Plan participants and beneficiaries who have not experienced a qualifying event.

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To the extent NALP enrolls in any the Plan, NALP agrees that a portion of the monthly payment made for benefits under the Plan shall include an administrative fee to cover administrative expenses of the Plan. The amount of the administrative fees shall be determined by the General Partner, in his discretion, and may change from time to time.

Who Is Entitled to Elect COBRA?

If you are an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan due to either of the following qualifying events:

- Reduction in your hours of employment, or
- Termination of your employment for any reason other than gross misconduct.

If you are the Spouse of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan due to any of the following qualifying events:

- Your Spouse dies,
- Your Spouse's hours of employment are reduced,
- Your Spouse's employment ends (for any reason other than gross misconduct),
- You become divorced or legally separated from your Spouse. Also, if your Spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation, or
- Your Spouse becomes entitled to Medicare (under Part A or B, or both).

A person enrolled as your Child will be entitled to elect COBRA if he or she loses group health coverage under the Plan due to any of the following qualifying events:

- The parent-Employee dies,
- The parent-Employee's hours of employment are reduced,
- The parent-Employee's employment ends (for any reason other than gross misconduct),
- The Child ceases to qualify as an "Eligible Dependent" under the Plan, or
- The parent-Employee becomes entitled to Medicare (under Part A or B, or both).

Children born to, adopted by, or placed for adoption with, the covered Employee during COBRA continuation coverage are considered qualified beneficiaries when born or placed for adoption, provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected COBRA coverage for himself or herself. The Child's COBRA coverage begins when the Child is enrolled in the Plan's group health coverage, whether through special enrollment or open enrollment, and it can last up to the end of the COBRA coverage period during which the Child was born, adopted or placed for adoption. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements.

When is COBRA Coverage Available?

The Plan will offer COBRA coverage to qualified beneficiaries only after it has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B or both), or commencement of a proceeding in bankruptcy with respect to the Employer, the Employer must notify the COBRA Administrator of the qualifying event (see the section "General Plan Information").

You Must Give Notice of Some Qualifying Events

For qualifying events other than the Employee's termination of employment, reduction in employment hours or death, (*e.g.*, divorce or legal separation of the Employee and Spouse, or Child's loss of Eligible Dependent status), COBRA will be available to you only if you notify the Benefits Service Center in writing no later than 60 days after the later of:

- The date of the qualifying event, and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

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In providing this notice, you must follow the notice procedures specified in this Continuation Coverage under COBRA section. If the notice procedures are not followed in a timely manner, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

A qualifying event is considered to occur when the event occurs, not when health coverage under the Plan is lost. Except as otherwise specifically provided in this document, any extension of coverage after such an event will count toward the maximum COBRA coverage period.

Notice to Qualified Beneficiary

Within 14 days after receiving notice of a COBRA qualifying event, the COBRA Administrator will notify all qualified beneficiaries of their right to elect continuation coverage under COBRA, using the latest address shown on the records of the COBRA Administrator.

Where qualified beneficiaries are the Employee, Spouse and/or Children, and the latest record of the COBRA Administrator shows that all qualified beneficiaries reside at the same address, notice will be given by first-class mail addressed to the Employee and Spouse at that address. If, according to the COBRA Administrator's records, any qualified beneficiary lives at another address, a duplicate notice will be given by first-class mail addressed to that qualified beneficiary at the other address, except that notice to the Spouse will be considered notice to all other qualified beneficiaries who reside with the Spouse.

Where the qualified beneficiaries are the Spouse and/or Children, and, according to the COBRA Administrator's latest records, all qualified beneficiaries reside at the same address, notice will be given by first-class mail addressed to the Spouse at that address. (Notice to the Spouse is considered notice to all other qualified beneficiaries residing with the Spouse.) If any qualified beneficiary lives at another address according to the COBRA Administrator's records, a duplicate notice will be given by first-class mail addressed to that qualified beneficiary at the other address.

Where the qualified beneficiary is only one or more Children, notice will be given by first-class mail addressed to each qualified beneficiary at the last known address, according to the COBRA Administrator's records, of that qualified beneficiary.

Electing COBRA

Each qualified beneficiary has 60 days to elect continued coverage under COBRA. (If the COBRA election notice from the COBRA Administrator arrives before the date of the qualifying event, the qualified beneficiary will have 60 days from the date of the qualifying event – or, if later, 60 days from the date the COBRA election notice is provided – to elect continued coverage under COBRA.) Election of COBRA continuation coverage is made by returning to the COBRA Administrator such properly completed and signed forms as the COBRA Administrator may require. The COBRA election form may be returned at any time during the 60-day period described above. The coverage offered for election is the same coverage that the qualified beneficiary had immediately before the qualifying event. Upon valid election, coverage will generally be provided retroactively to the date of the qualifying event, subject to timely receipt by the insurer of the required COBRA premium payment.

Election of continuation coverage is an individual election of each qualified beneficiary in accordance with the following rules:

- When an Employee, Spouse and Children are eligible for COBRA, if an Employee elects continuation coverage for the Employee, Spouse and Children, the election is effective for the Employee, Spouse and Children; the Spouse and Children do not have a separate election.
- When an Employee, Spouse and Children are eligible for COBRA, if an Employee fails to elect continuation coverage for the Spouse and/or Children (regardless of whether the Employee elects continuation coverage for the Employee), the Spouse and/or Children are entitled to elect continuation coverage independently of the Employee.
- If a Spouse elects continuation coverage for the Spouse and/or Children, the election is effective for the Spouse and/or Children; the Children do not have a separate election.
- If neither the Employee nor the Spouse elect continuation coverage for a Child, the Child is entitled to elect continuation coverage independently.

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In the case of a Child that, during Continuation Coverage, is born to or adopted by a qualified beneficiary who is a former Employee, Continuation Coverage for the Child will be immediately available only if you enroll the Child by contacting the Benefits Service Center within the 60-day period beginning with the date of birth, adoption or placement for adoption.

Though the form supplied by the COBRA Administrator is the preferred and usual method for making the election, any other reasonable method will be accepted if it contains all of the information necessary to process the election, so long as the notice is in writing and is submitted in a timely manner to the COBRA Administrator.
Failure to elect COBRA continuation coverage within the 60-day deadline described in this section is a complete, final and permanent waiver of COBRA continuation coverage rights.

Note: Where a qualified beneficiary returns the form during the 60-day period showing an election not to take COBRA continuation coverage, the qualified beneficiary may still change his or her mind and elect continuation coverage if he or she completes, signs and returns another form within the same 60-day period. In that case, the continuation coverage will be provided prospectively only (not retroactively to the qualifying event).

How Long Does COBRA Coverage Last?

COBRA coverage is temporary. COBRA coverage cannot last more than 36 months if the qualifying event is the death of the Employee, the covered Employee's divorce or legal separation, the Employee becoming entitled to Medicare (under Part A or B, or both), or a Child's losing his or her status as an Eligible Dependent. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage generally lasts for only up to 18 months.

There are ways in which this 18-month period of COBRA coverage can be extended:

Medicare-Related Extension for Dependents
When the qualifying event is the end of employment or reduction of the Employee's hours of employment and the Employee became entitled to Medicare (under Part A or B, or both) less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries – other than the Employee – can last for up to 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 coverage for his Spouse and Children who lost coverage as a result of his termination 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).

Disability Extension of COBRA Coverage
Coverage may be extended up to an additional 11 months if the qualified beneficiary (or any other COBRA-covered qualified beneficiary in the family) is determined by the Social Security Administration to be disabled. The Benefits Service Center must be notified in a timely fashion (see below). Also, the disability must have started at some time before the 61st day after the covered Employee's termination of employment or reduction of hours and must last at least until the end of the 18-month period of continuation coverage.

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

- The date of the Social Security Administration's disability determination,
- The date of the covered Employee's termination of employment or reduction of hours, and
- The date on which coverage is (or would be) lost under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

You must provide this notice within 18 months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must follow the procedures specified in the "COBRA Notice Procedures" subsection below. If these procedures are not followed or if the notice is not provided to the Benefits

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Service Center during the 60-day notice period and within 18 months after the covered Employee's termination of employment or reduction of hours, THEN DISABILITY EXTENSION OF COBRA COVERAGE WILL NOT BE AVAILABLE.

A qualified beneficiary receiving extended continuation coverage due to disability must notify the COBRA Administrator of any final determination that the person is no longer disabled and must do so within 30 days after receiving the determination.

Second Qualifying Event Extension

If your family experiences another qualifying event while receiving COBRA coverage on account of the covered Employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the Spouse and Children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, provided that notice of the second qualifying event is properly given to the Plan and required premiums continue to be paid in a timely manner. This extension may be available to the Spouse and any Children receiving COBRA coverage if the Employee or former Employee dies or gets divorced or legally separated, if the Employee becomes eligible for Medicare (Part A or B, or both), or if the Child stops being eligible under the Plan as an Eligible Dependent, but only if the event would have caused the Spouse or Child to lose coverage under the Plan had the first qualifying event not occurred.

This extension due to a second qualifying event is available only if you notify the Benefits Service Center in writing of the second qualifying event within 60 days after the date of the second qualifying event. In providing this notice, you must follow the procedures specified below, entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the Benefits Service Center during the 60-day notice period, THEN EXTENSION OF COBRA COVERAGE WILL NOT BE AVAILABLE.

The COBRA coverage periods described above are maximum coverage periods. If a period of COBRA continuation coverage is terminated before the end of its maximum duration, the qualified beneficiary will be provided a specific notice of that fact describing the reason for termination of the coverage, the date of coverage termination; and any rights the qualified beneficiary may have under the Plan or under applicable law to elect an alternative group or individual coverage. The following are situations that will result in automatic termination of COBRA coverage:

- The qualified beneficiary first becomes covered under any other group health plan after the date of the election of COBRA coverage, unless the other group health plan excludes or limits coverage for a pre-existing condition that the qualified beneficiary has and that exclusion or limitation is not satisfied by the qualified beneficiary's previous coverage, or
- The qualified beneficiary first becomes covered by Medicare after the COBRA election, or
- The continuation coverage is by reason of disability and the individual ceases to be disabled, or
- Payment of the required COBRA premium is not timely made, or
- The Employer (and its affiliates as may be considered the same employer for COBRA purposes) ceases to provide any group health plan coverage.

If the Plan's group health coverage under which a qualified beneficiary is receiving COBRA continuation coverage terminates, but the Employer (and its affiliates as may be considered the same employer for COBRA purposes) continues to provide one or more other group health coverages, the qualified beneficiary will be afforded the same opportunity as participants with respect to whom a qualifying event has not occurred to participate in another group health coverage provided by the Employer.

Payment for Continuation Coverage

Unless otherwise specifically provided in this Plan Document, qualified beneficiaries who elect COBRA must pay the applicable premium for such coverage plus a 2% administrative charge. The applicable premium is the actual cost to the Plan of providing the same group health coverage to Plan participants and beneficiaries who have not experienced a qualifying event.

As an exception, qualified beneficiaries who are receiving an additional 11 months of continuation coverage due to disability must pay an amount equal to 150% of the applicable premium during those additional 11 months. Also, where the qualifying event is the Employee's absence due to service in the uniformed services of the United States (meeting the requirements of the

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federal Uniformed Services Employment and Reemployment Rights Act of 1994) and the Employee performs such service for less than 31 days, the charge for COBRA coverage is limited to the contribution required of active Employees.

Payment for all months up to and including the month in which the qualified beneficiary returns the election form to the COBRA Administrator must be made within 45 days after the election form is returned to the COBRA Administrator. Payment for months following the month in which the election form is returned to the COBRA Administrator must be made by the first of the month for which payment is due, and in no event more than 30 days after the date the payment was due. You must pay the COBRA premium for the entire month of coverage; you may not prorate the COBRA premium for partial months of COBRA coverage.

Please note: It is the responsibility of the qualified beneficiary to make timely premium payments. The COBRA Administrator is not required to send bills or reminder notices. In certain circumstances, a Plan may be automatically converted to COBRA. COBRA may be terminated by the Plan Participant at any time. A portion of the monthly payment shall include an administrative fee to cover any otherwise nondeductible expenses.

Alternate Recipients under QMCSOs

A Child of the covered Employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the employer during the covered Employee's period of employment with the employer is entitled to the same rights to elect COBRA as an Eligible Dependent Child of the covered Employee.

Other Options besides COBRA

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.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to one of the contacts identified below. For more information about your rights under 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 the EBSA website at 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.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your employer 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 Benefits Service Center.

Contact Information

The contact information for the COBRA Administrator is listed in the section "General Plan Information." This contact information may change from time to time. The most recent information will be included in the Plan's most recent summary plan description (or the most recent update to the summary plan description). If you do not have a copy, you may request one from your employer.

COBRA Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

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Notices Must Be Written and Submitted
Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable.

How, When, and Where to Send Notices
You must mail or fax your notice to the COBRA Administrator at the Benefits Service Center at the address or fax number listed in the section "General Plan Information." If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the subsections above entitled "You Must Give Notice of Some Qualifying Events," "How Long Does COBRA Coverage Last?," and "Second Qualifying Event Extension.")

Information Required for All Notices
Any notice you provide must include the following:

- The name of the Plan,
- The name and address of the Employee who is (or was) covered under the Plan,
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event,
- The qualifying event and the date it happened, and
- The certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event
If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Benefits Service Center that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Benefits Service Center that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability
Any notice of disability that you provide must include the following:

- The name and address of the disabled qualified beneficiary,
- The date that the qualified beneficiary became disabled,
- The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage,
- The date that the Social Security Administration made its determination,
- A copy of the Social Security Administration's determination, and
- A statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event
Any notice of a second qualifying event that you provide must include the following:

- The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage,
- The second qualifying event and the date that it happened, and
- If the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices
The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. Generally, a notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

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Notwithstanding the deadlines above, your deadline for electing COBRA and/or making premiums payments may be extended beyond the normal deadlines pursuant to COVID relief issued by the federal government. These rules are complex. Please contact the COBRA Administrator or the Plan Benefits Staff if you would like more information about these extended deadlines.

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COBRA Administration

There are a number of different entities involved in the Plan's COBRA administration, as described in this section.

- COBRA administrative services are provided by the COBRA Administrator (see the section "Definitions" for the definition of the COBRA Administrator).
- The Plan Administrator has the final authority to determine matters regarding an individual's eligibility for COBRA coverage.

Correction of Mistakes

If at any time it is determined that a mistake has been made with regard to administration of COBRA continuation coverage, regardless of whether the mistake is favorable or detrimental to the Employee, former Employee, Spouse or Child, the Plan Administrator is authorized, to the extent not prohibited by applicable law, to take any and all feasible steps to correct the mistake by returning all affected parties to the position in which they would have been had the mistake not occurred, including, if necessary and due to material misrepresentation or fraud (as determined by the Plan Administrator in its discretion), retroactive collection or refund of COBRA premiums and retroactive provision or denial of coverage.

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ADMINISTRATION, APPEALS, SUBROGATION, AND RIGHT OF RECOVERY

Administration

The Plan Administrator has the responsibility for administering the Plan. Except as otherwise specifically provided, the Plan Administrator has all rights, duties and powers to administer the Plan, including:

- The discretionary authority to interpret the Plan,
- Determine the status and rights of participants, beneficiaries, and other persons,
- Make rulings,
- Make regulations and prescribe procedures,
- Gather needed information,
- Prescribe forms,
- Exercise all of the power and authority contemplated by ERISA and the Internal Revenue Code with respect to the Plan,
- Employ or appoint persons to help or advise in any administrative functions, and
- General do anything needed to operate, manage, and administer the Plan.

The Plan has other fiduciaries, advisors, and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. For each type of benefit available under the Plan, the Plan Administrator has delegated its fiduciary duties with respect to claims processing, benefit determination, appeals of adverse benefit determinations, and payment of benefits to the respective insurers/claims administrators listed in the section "General Plan Information." The Plan Administrator retains fiduciary obligations with respect to all other Plan functions.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary.

The Plan Administrator and other Plan fiduciaries have the requisite discretionary authority and control over the Plan to required deferential judicial review of its decisions, as set forth by the U.S. Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*.

Changing or Ending the Plan

Changing the Plan

The Plan Sponsor is authorized to adopt and to execute any amendment or amendments to the Plan which is required by law or deemed advisable. In addition, the Plan Administrator reserves the right to amend the provisions of the Plan to any extent and in any manner where such amendment, as determined by the Plan Administrator, (1) is necessary or desirable to comply with applicable law (including regulatory guidance), or (2) is not expected to result in a material increase in the cost of maintaining the Plan.

Ending the Plan

The Plan Sponsor has no obligation whatsoever to maintain the Plan or any benefit under the Plan for any given length of time. The Plan Sponsor reserves the right to terminate the Plan or any benefit option or procedure under the Plan at any time by a written document executed by the Plan Sponsor. Upon termination or discontinuance of the Plan, all elections with respect to the Plan shall terminate, and payments with respect to benefits shall be made only with respect to claims incurred on or prior to the date of the Plan's termination.

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Claims Procedure

For purposes of this section, a "claim for benefits" under the Plan is a request for a benefit made according to the Plan's procedures for filing benefit claims. If you or your Eligible Dependent file a claim for specific benefits and that claim is denied for lack of eligibility, the coverage determination is treated as a claim for benefits and is subject to the claims and appeals procedures described below.

A request for a determination of whether you are eligible to enroll or participate in the Plan is not a "claim for benefits."
"Casual inquiry" about benefits or the circumstances under which benefits might be paid under the terms of the Plan is not a claim governed by the claims and appeals procedures described below.
A claim for benefits may be made by you or your Eligible Dependent. **In this section, the word "you" should be read to refer to whomever is filing the claim for benefits or appealing a denied claim – that is, you or, if applicable, your Eligible Dependent.**

For purposes of this section, the following situations each constitute an "adverse benefit determination:"

- Denial, reduction, or termination of a benefit,
- Failure to provide or make payment (in whole or in part) for a benefit, or
- Rescission of health benefit coverage, whether or not the rescission has an adverse impact on any particular benefit at this time.

Authorized Representative

You are entitled to have a representative act on your behalf when pursuing a benefit claim or an appeal.
To verify that a person is an authorized representative, you must submit to the Third-Party Administrator a letter that states the person is your duly authorized representative and the scope of the representative's authority. That authorized representative's address must be included in the letter. Once you have selected an authorized representative, the Third-Party Administrator will generally send all information and notifications to the authorized representative and not to you, unless you state otherwise in the letter appointing the authorized representative.
Notwithstanding the foregoing, if you are physically or mentally unable to designate an authorized representative, a health care professional with knowledge of your medical condition may act as your authorized representative for purposes of this Plan with regard to an Urgent Health Care Claim.

You are solely responsible for any costs, fees, or charges of the authorized representative that may be incurred if you obtain an authorized representative.

How to File a Claim

You can file a claim with the Third-Party Administrator by filing a claim form provided by the Third-Party Administrator or by such other means as the Third-Party Administrator may prescribe.

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AMERICAN Collective LP

Claim Determination Time Limits

For Claims Regarding:	Follow this procedure:
Plan Eligibility	If you have any questions about a denied eligibility claim, contact the Plan Benefits Staff for an additional explanation. If your eligibility claim is denied in whole or in part, you may file a final appeal of the eligibility claim by writing to the Plan Administrator, as described in the Appeals Procedure section of this Plan.
Medical Programs Medical coverage, including prescription drug coverage	Please refer to the section "General Plan Information" for the appropriate contact numbers and addresses. Except as otherwise provided in this document, the following rules apply: **Urgent Health Care Claims** In the case of an Urgent Health Care Claim, you will be notified of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan. However, if you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, you will be notified as soon as possible (but not later than 24 hours after receipt of the claim by the Plan) of the specific information necessary to complete the claim. You will be given a reasonable amount of time (but not less than 48 hours) to provide the information required to complete the claim. If you were required to submit additional information, the determination of the Urgent Health Care Claim will be made within 24 hours of when the additional information is submitted. If you request an extension of a course of treatment beyond the time or number of treatments that have been approved, and the request involves an Urgent Health Care Claim, a decision will be made on the request as soon as possible, taking into account the medical exigencies. You will be notified of the Plan's benefit determination (whether adverse or not) within 24 hours after receipt of the claim by the Plan, provided that you make the request at least 24 hours before the scheduled termination of the treatment. **Concurrent Care Decisions** You will be notified of any decision to reduce or terminate coverage of an ongoing treatment (other than by Plan amendment or termination) within a time frame that allows you to appeal such decision, and to obtain a determination of the appeal prior to the reduction or termination of coverage. **Post-Service Claims** You will be notified of the Plan's determination of a Post-Service Claim within 30 days of the Plan's receipt of the claim. However, this limit may be extended by 15 days if you are notified of the need for an extension within the initial 30-day period. If you fail to submit information necessary for the Plan to decide the claim, you will have 45 days from receipt of a notice of such failure to submit the required information.

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For Claims Regarding:	Follow this procedure:
Other Coverages Hospital Indemnity	After you submit a claim, the Third-Party Administrator will review your claim and notify you of its decision. The Third-Party Administrator will generally notify you of its decision within 90 days from the date the claim was submitted, unless the Third-Party Administrator determines that special circumstances require an extension of time for processing the claim. The Third-Party Administrator will notify you prior to the expiration of the initial 90-day period if the Third-Party Administrator determines that an extension of time is required, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed, the Third-Party Administrator will notify you of its decision within 180 days from the date the claim was submitted. If the Third-Party Administrator denies a claim in whole or in part, the notification will state the reason why the claim was denied. If the claim is denied because the Third-Party Administrator did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. If you have any questions about a denied claim, contact the Third-Party Administrator for additional explanation. If a claim is denied in whole or in part, you may file an appeal in writing to the Third-Party Administrator, as described below.

Calculating Time Periods

The period of time within which a benefit determination is to be made begins at the time a claim is filed, without regard to whether the filing includes all of the information necessary to make a benefit determination on review. If a period of time is extended because you do not submit the information that is necessary to decide the claim, the period for making the benefit determination is suspended from the date on which a notice of the extension is sent to you until the date on which you respond to the request for additional information.

Manner and Content of Notice of Benefit Determination

Notice of an adverse benefit determination will be in writing and will contain:

- The specific reason(s) for the adverse determination. For medical benefit claims, the reason(s) will include any applicable denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim,
- Reference to the specific Plan provisions on which the determination is based,
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, and
- A description of the Plan's appeals procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse determination on appeal.

In addition, in the case of an adverse benefit determination for a medical benefit, the notice will include:

- If any internal rule, guideline, or protocol or other similar criterion was relied upon in making the adverse determination, a copy of the actual rule, guideline, protocol or other criterion, or a statement that the rule, guideline, protocol or other criterion was used and how you can request a copy free of charge;

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- If the adverse determination was based on medical necessity, experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination based on the Plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request;
- In the case of an adverse benefit determination of a medical benefit claim, (1) information sufficient to identify the claim involved, including the date of service, the health care provided, and the claim amount (if applicable), (2) a statement describing the availability, upon request, of the diagnosis code, the treatment code, and their corresponding meanings and (3) a statement describing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes; and
- In the case of an adverse determination regarding an Urgent Health Care Claim, an explanation of the expedited review process for such claims.

In the case of an adverse benefit determination concerning an Urgent Health Care Claim, the information described above may be provided to you orally, provided that a written notification is furnished to you not later than 3 days after the oral notice.

Appeals Procedure

If a claim is denied and you disagree with the denial and want to pursue the matter, you must file an appeal in accordance with the procedure set forth below. You cannot take any other steps unless and until you have exhausted the appeal procedure. For example, if a claim is denied and you do not use the appeal procedure, the denial of the claim is conclusive and cannot be challenged, even in court.

For detailed information on how to file an appeal, please see the procedures below. You will need to state the reasons why you disagree with the denial of your claim. You must do this within the specified time period after the claim was denied. The Appeals Authority needs complete, accurate information in order to decide your appeal. By making an appeal, you are authorizing the Appeals Authority to get additional, relevant information from any sources, including from the Employer.

You are entitled to see all documents, records or other information pertinent to your appeal. Just ask the Plan Administrator or Third-Party Administrator. Whether a document, record, or other information is relevant to a claim will be determined by considering:

- Whether it was relied upon in making the benefit determination;
- Whether it was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
- Whether it demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that the benefit claim determination was made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; and
- Whether it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The Appeals Authority will perform a review that takes into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Appeals Authority may, in its sole discretion, hold a hearing. The Appeals Authority will issue a written decision within the specified time period. The decision will explain the reasoning of the Appeals Authority and refer to the specific provisions of this Plan on which the decision is based. If your appeal involves an adverse determination that is based in whole or in part on a medical judgment, including determinations of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved or in medical judgment. This professional will be an individual who was not consulted in connection with the initial adverse determination that is the subject of your appeal nor a subordinate of that individual.

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The Plan will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial adverse determination, without regard to whether the advice was relied upon in making the determination. You will be entitled to continue coverage pending the outcome of your appeal to the extent mandated by the ACA, which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. Before issuing a final determination based on a new or additional rationale, you shall be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the decision is required to be provided, as described below, to give you a reasonable opportunity to respond prior to that date.

Please keep in mind that the Appeals Authority has a duty under federal law to administer the Plan in accordance with its terms. The Appeals Authority does not have any authority to depart from the terms of the Plan, no matter how compelling the circumstances.

Voluntary External Review Program for Group Health Claims

For group health claims, we will notify claimants of the option to request an external review of adverse benefit determinations following the required internal appeal process. We will, through the relevant claim administrator or group health insurer providing coverage under the Plan:

- Provide claimant with the necessary procedures to obtain the external review, which notice will be designed to comply with ERISA,
- Coordinate submission of the claimant's case to an independent review organization, and
- Notify the claimant of the final external review decision.

A claimant may have the right to have an independent group of health care professionals who have no association with the Plan review the claim following a denial on appeal if the claim involves:

- Medical judgment, as determined by an external reviewer,
- A rescission of coverage, or
- Items and services within the scope of the requirements under the No Surprises Act (i.e., Emergency Services provided by an out-of-network provider, air ambulance services provided by an out-of-network provider, ancillary services, and other non-emergency services), except that external review is not available when:
    - Adjudication of the claim results in a decision that does not affect the amount the Covered Person owes,
    - The dispute only involves payment amounts due from the Plan to the provider, and/or
    - The provider has no recourse against the Covered Person.

For Appeals Regarding:	Follow this procedure:
Plan Eligibility	**Appeals Authority: Plan Administrator** (Refer to the section "General Plan Information" for the address of the Plan Administrator.) If you have any questions about a denied eligibility claim, contact the Third-Party Administrator for an additional explanation. If your claim is denied in whole or in part, you may file a final appeal of the eligibility claim by writing to the Plan Administrator. This request must be submitted within 60 days of the date your eligibility claim was totally or partially denied. It should include any documents, records, questions, or comments necessary for a complete review. The Plan Administrator will review your request and notify you in writing of its final decision, the specific reasons for such decision, and specific references to Plan provisions. This decision will be made within 60 days after receiving your request, unless

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For Appeals Regarding:	Follow this procedure:
	there are special circumstances. If there are special circumstances, you will be notified within 120 days. The Plan Administrator has the discretionary authority to interpret the terms and application of the Plan as they relate to your application for eligibility to participate in the Plan and to make a final determination of all claims. Its decision will be final and binding. The Appeals provisions applicable for Medical Coverages or Other Coverages (rather than this eligibility appeal provision) will apply if the claim relates to: • A denial, reduction, or termination of a benefit, • A failure to provide or make payment (in whole or in part) for a benefit, or • Rescission of health benefit coverage, whether or not the rescission has an adverse impact on any particular benefit at this time. This is the case even if the denial, reduction, termination, or failure to provide or make payment is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan.
Medical Coverages Medical coverage, including prescription drug coverage	The following procedures apply. **Appeals Authority** • 1st Level: Third-Party Administrator. • 2nd Level: Third-Party Administrator. • Voluntary External Review Upon Exhausting Appeals: Obtained through Third-Party Administrator. **Appeal of an Adverse Benefit Determination** If your initial health claim is denied, you may appeal the denial within 180 days of your receipt of the written denial. You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim. You may, upon appeal, submit written comments, documents, records, and other information relating to the claim for benefits. A decision on review will be made: • As soon as possible following the Plan's receipt of a written request for review of an Urgent Health Care Claim, but not later than 72 hours after receipt of the claim; • Within a reasonable period of time following the Plan's receipt of a written request for review of a Pre-Service Claim, but not later than 15 days after receipt of the claim; and • Not later than 30 days following the Plan's receipt of a written request for review of a Post-Service Claim. If your initial appeal for a Pre-Service Claim is denied, you may appeal the denial of the initial appeal within 30 days of your receipt of the written denial. In that case, the decision on review will be made within a reasonable period of time following the Plan's receipt of the second written request for review of a Pre-Service Claim, but not later than 15 days after receipt of the appeal. If your initial appeal for a Post-Service Claim is

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For Appeals Regarding:	Follow this procedure:
	denied, you may appeal the denial of the initial appeal within 60 days of your receipt of the written denial. In that case, the decision on review will be made within a reasonable period of time following the Plan's receipt of the second written request for review of a Post-Service Claim, but not later than 30 days after the receipt of the appeal. The review of an appeal of a denied claim will be made by a person different from the person who made the initial determination (or, in the case of a second appeal, by a different person from the person who decided the initial appeal) and will not grant deference to the initial denial (or, in the case of a second appeal, to the initial denial or initial appeal). The decision maker will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of medical judgment, a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment will be consulted. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate of that person (or, in the case of a second appeal, will not be the individual consulted during the initial determination or initial appeal, or a subordinate of that person). For an appeal of a medical benefit claim: • If new or additional evidence was considered, relied upon, or generated by the Third-Party Administrator in connection with the claim, the Third-Party Administrator will provide you, free of charge, with such new or additional evidence as soon as possible and sufficiently in advance of the date on which the notice of 2nd level appeal denial determination is provided in order to give you a reasonable opportunity to respond prior to that date; and • If 2nd level appeal denial determination is based on a new or additional rationale, you will receive the rationale, free of charge, as soon as possible and sufficiently in advance of the date on which the notice of 2nd level appeal denial determination is provided in order to give you a reasonable opportunity to respond prior to that date. The Third-Party Administrator has the discretionary authority to interpret the terms and application of the Plan as they relate to your application for benefits and to make a final determination of all claims. Its decision will be final and binding. Your beneficiary should follow these same instructions to appeal a claim that follows your death. **Voluntary External Review Program for Group Health Claims** You have an option to request an external review of adverse benefit determinations following the required internal appeal process. Specifically, we will, through the Third-Party Administrator: • Provide you with the necessary procedures to obtain the external review, which notice will be designed to comply with ERISA, • Coordinate the submission of your case to an independent review organization, and • Notify you of the final external review decision. This Plan intends to comply with the state and federal external review procedures, as applicable, and you will be provided with information describing your rights to file a

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For Appeals Regarding:	Follow this procedure:
	request for any external review of a claim denial in accordance with those procedures if applicable.
Other Coverages Hospital Indemnity coverage	The following procedures apply, except as otherwise indicated in applicable coverage booklets from the insurer. **Appeals Authority: Plan Administrator** If your claim is denied in whole or in part, you may file an appeal of the denial in writing to the Third-Party Administrator. State why you think your claim should be granted, and include any documents, records, questions, or comments you think are necessary or will aid in a complete review. Upon written request, the Third-Party Administrator will provide you with copies of documents, records and other information relevant to your claim. Your review request must be made within 60 days of the date your claim was totally or partially denied. The Plan Administrator will furnish you with a written decision providing the final determination of the claim. The Plan Administrator's review will take into account all comments, documents, records and other information related to the claim, regardless of whether such items were considered in the initial claim decision. The Plan Administrator's decision on review will be final and binding on you, your dependents and any other interested party.

Notice of Benefit Determination on Appeal

A notice of the appeal determination will be in writing. If an appeal is denied, in whole or in part, the notice will contain the following information:

- The specific reason(s) for the determination, including (1) any applicable denial code and its corresponding meaning, (2) a description of the standard, if any, that was used in denying the claim, (3) a discussion of the denial decision, and (4) a statement describing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes;
- Information sufficient to identify the claim involved, including the date of service, the health care provided, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, the treatment code, and their corresponding meanings;
- A reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- A statement that the individual has the right to bring an action under section 502(a) of ERISA.

In addition, in the case of an adverse appeal determination for a medical benefit, the notice will include:

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

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- If the adverse determination was based on medical necessity, experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination based on the Plan terms and your medical circumstances (or a statement that such information will be provided free of charge upon request);
- A statement that the identity of any medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination, will be provided free of charge upon request; and
- A statement regarding how to look into other voluntary alternative dispute resolution options that may be available, such as mediation (e.g., by contacting the local U.S. Department of Labor office and the State insurance regulatory agency).

Discretionary Authority

Benefits will be paid only if the entity or its delegate responsible for deciding claims and appeals (if applicable) as listed above decides, in its discretion, that the applicant is entitled to benefits. Similarly, eligibility for participation will be granted only if the Plan Administrator decides, in its discretion, that the applicant is eligible to participate with respect to the particular benefits. In exercising such discretion, the Plan Administrator and each of its delegates responsible for deciding claims shall give controlling weight to the intent of the sponsor of the Plan.

All decisions of the Plan Administrator in the exercise of its authority under the Plan shall be final and binding on the Plan, the Plan Sponsor and all participants and beneficiaries.

External Review or Legal Action

A claimant cannot initiate an external review or bring an action in an appropriate court under state law or Section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation by the Plan was:

- De minimis,
- Was not likely to cause (or did not cause), prejudice or harm to the claimant,
- Attributable to good cause or matters beyond the Plan's control,
- In the context of an ongoing good-faith exchange of information between the claimant and the claims administrator, and
- Not reflective of a pattern or practice of non-compliance by the Plan.

Use and Disclosure of Protected Health Information

The Plan will use protected health information (PHI) to the extent and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy and Security Rules. For purposes of this section of the Plan, the term "Plan" refers only to the Medical and prescription drug portions of the Plan.

The Plan will Use and Disclose PHI for purposes related to Payment, Health Care Operations and the other purposes described in the Plan's Privacy Notice. The Plan may also Disclose PHI to the Employer in certain instances as described in greater detail, below.

Definitions Related to the Use and Disclosure of Protected Health Information

The following special definitions apply only for purposes of this section:

Disclose, Disclosing or Disclosure

The release, transfer, provision of access to, or divulging in any other manner of PHI.

Health Care Operations

Include, but are not limited to, the following activities:

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- Quality assessment;
- Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan; and
- Business management and general administrative activities of the Plan, including, but not limited to:
    - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, and
    - Customer service, including the provision of data analyses for the Employer.

Individual
The person who is the subject of the PHI and shall include a person who qualifies as a personal representative in accordance with the Privacy Rule.

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

- Determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, plan maximums, Coinsurance amounts, and Copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing Employee contributions;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review, and retrospective review; and
- Disclosure to consumer reporting agencies of the Individual's name and address, date of birth, Social Security number, payment history, account number, and name and address of the Plan, but solely for purposes related to obtaining reimbursement for the Plan of any amount the Individual owes the Plan.

Privacy Rule
Means the Final Rules on Standards for Privacy of Individually Identifiable Health Information set forth in Federal regulations at 45 CFR Part 160 and Part 164, Subparts A and E.

Protected Health Information or **PHI**
Information (including demographic information collected from an Individual) that is transmitted or maintained in any form or medium (i.e., electronic, written or oral) that:

- Relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future payment for the provision of health care to an Individual;
- Is created by a health care provider, health plan, employer, or health care clearinghouse; and
- Identifies the Individual, or there is a reasonable basis to believe that the information can be used to identify the Individual.

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Required by Law
A mandate contained in law that compels an entity to Use or Disclose PHI and that is enforceable in a court of law. The phrase "Required by Law" includes but is not limited to: court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; and statutes or regulations that require the production of information, including those that require such information if payment is sought under a government program providing public benefits.

Secretary
The Secretary of the U.S. Department of Health and Human Services.

Security Rule
The Final Rule on Security Standards for the Protection of Electronic Protected Health Information set forth in Federal regulations at 45 CFR Part 160, Part 162, and Part 164.

Security Incident
The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Summary Health Information
Means information:

- That summarizes the claims history, claims expenses, or type of claims experienced by Individuals for whom the Employer has provided health benefits under a group health plan; and
- From which the information described at 45 CFR section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

Use
The sharing, employment, application, utilization, examination, analysis, de-identification, or commingling with other information, of information by a party that holds that information.

Disclosure of PHI to the Employer

This section describes the situations in which the Plan may Disclose PHI to the Employer.

- The Plan may disclose an Individual's PHI to the Employer pursuant to the Individual's authorization. For example, if an Individual asks his or her local human resources representative and/or advocacy service for assistance in obtaining benefits under the Plan, the Individual must complete and sign an authorization before the Plan will Disclose the Individual's PHI to the human resources representative and/or advocacy service; if the Individual does not sign an authorization in this situation, the Plan will not be able to Disclose any of the Individual's PHI to the human resources representative and/or advocacy service. In that case, the human resources representative and/or advocacy service may not be able to provide the Individual with effective assistance. Similarly, if a person seeks assistance from a human resources representative and/or advocacy service regarding another Individual, the Individual must appoint the person as his or her personal representative; if, for example an Employee seeks assistance in obtaining benefits under the Plan for his or her Spouse, the Spouse must designate the Employee as his or her personal representative before the Employee will be given access to the Spouse's PHI or allowed to take any action for the Spouse.
- The Plan may Disclose an Individual's PHI to the Employer as Required by Law.
- The Plan may Disclose to the Employer whether an Individual is participating in (or has stopped participating in) the Plan. This information may be needed to determine the Employee contributions (if any) that are withheld from an Employee's pay to pay for the benefits provided under the Plan.
- The Plan may Disclose PHI to the Employer for purposes related to Payment or Health Care Operations, or for any such other purpose described in the Plan's Privacy Notice. These Disclosures may be necessary because Employees of the

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Employer perform many of the administrative functions necessary for the management and operation of the Plan, such as conducting cost-management and planning-related analyses for the Employer regarding the Plan.

- The Plan may Disclose Summary Health Information to the Employer. The Employer must limit its use of that information to: (1) Obtaining quotes from insurers, Third-Party Administrators, and other plan providers; or (2) Modifying, amending or terminating the Plan.

For purposes of the last three bullet points listed above, only the following Employees or classes of Employees may be given access to PHI:

- The Plan Benefits Staff,
- The members of the Employer
- Human resources representatives of the Employer as named on the Plan Benefits Staff contact list, and
- Members of the Employer's Accounting Department who are responsible for allocating the cost for group health benefits for Individuals terminated as part of a Layoff to individual business units of the Employer.

The person who holds any position described in the previous sentence may only have access to, and Use and Disclose PHI, to the extent that the person performs management or administrative functions for the Employer that are related to the Plan. The Plan Sponsor has certified to the Plan that the Plan has been amended (pursuant to these provisions) to reflect the above-described restrictions on the Use and Disclosure of PHI.

Employer Conditions with Regard to PHI

The Employer agrees that, with respect to any PHI Disclosed to the Employer by the Plan, the Employer will:

- Not Use or further Disclose PHI, other than as permitted or required by the Plan document or as Required by Law;
- Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- Not Use or Disclose PHI for employment-related actions and decisions unless authorized by an Individual;
- Not Use or Disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an Individual;
- Report to the Plan any Use or Disclosure of PHI that is inconsistent with the Uses or Disclosures provided for in this Plan document of which it becomes aware;
- Make PHI available to an Individual in accordance with the Privacy Rule's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rule;
- Make available the information required to provide an accounting of Disclosures in accordance with the Privacy Rule;
- Make internal practices, books and records relating to the Use and Disclosure of PHI received from Plan available to the Secretary for the purposes of determining the Plan's compliance with the Privacy Rule; and
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of that PHI when no longer needed for the purpose for which Disclosure was made (or if return or destruction is not feasible, limit further Uses and Disclosures to those purposes that make the return or destruction infeasible).

Security with Regard to PHI

The Plan Sponsor will, in accordance with the Security Rule:

- 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.
- Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use electronic PHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration.
- Ensure that any agent or subcontractor to whom electronic PHI is provided agrees to implement reasonable and appropriate security measures to protect the information.
- Report to the Plan any Security Incident of which it becomes aware.

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Noncompliance Issues

The Employer has developed a mechanism for resolving issues of noncompliance, including disciplinary sanctions, if the persons described above in the section captioned "Use and Disclosure of PHI" make an impermissible Use or Disclosure of PHI. Any failure to comply with the policies and procedures described in this Plan document for handling PHI is a violation of the Employer's policies and procedures and applicable standards of conduct. Such behavior may result in disciplinary action, up to and including discharge. In addition, impermissible Use or Disclosure of PHI may result in the imposition of civil and/or criminal penalties under the Privacy Rule and/or Security Rule. The Employer will take any necessary steps to mitigate any harmful effects to the affected Individual resulting from the Employer's improper Use or Disclosure of PHI. If you believe the Plan or the Employer has violated your privacy or security rights with respect to your PHI, you may file a complaint with the Plan's Privacy and Security Officer at P.O. Box 2078, Carlsbad, NM 88221. The Plan will not penalize you for filing a complaint. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

Subrogation And Right Of Recovery

For medical coverage, in addition to certain other programs as may be described in the attached Appendices, the Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered person in a time of need, however, the Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Plan later received reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

- **Assignment of Rights (Subrogation)**
  The covered person automatically assigns to the Plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for non-medical charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By that assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.
- **Equitable Lien and other Equitable Remedies**
  The Plan shall have an equitable lien against money or property the covered person (or anyone else on behalf of, or for the benefit of, the covered person, such as an agent, representative, attorney, or a trust) may obtain as a result of the covered person's rights of recovery (sometimes referred to as "proceeds"), including amounts from an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the Employer will be deemed to mean that such a determination has been made. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Administrator, the Plan may reduce any future covered expenses otherwise available to the covered person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien. This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the U.S. Supreme Court's decision in *Great-West Life & Annuity Insurance Co. v. Knudson* and in *Sereboff v. Mid-Atlantic Medical Services, Inc.* The provisions of the Plan concerning subrogation, equitable liens

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and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

- **Assisting in the Plan's Reimbursement Activities**
  The covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to:
    - Cooperate fully in the Plan's exercise of its right to subrogation and reimbursement,
    - Not do anything to prejudice those rights (such as settling a claim against another third party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan),
    - Sign any document deemed by the Plan Administrator to be relevant to protecting the Plan's subrogation, reimbursement or other rights, and
    - Provide relevant information when requested.

The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator (or its designee) to enforce the Plan's rights.

Failure by a covered person to follow the above terms and conditions for Subrogation and Rights of Recovery may result, at the discretion of the Plan Administrator, in a reduction from future benefit payments available to the covered person under the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan.

MISCELLANEOUS AND STATEMENT OF ERISA RIGHTS

Miscellaneous Limitations on Rights

The Plan does not constitute a contract between you and the Employer, nor is it to be consideration or inducement for your employment. Nothing contained in the Plan gives you the right to be retained in the service of the Employer or to interfere with the right of your Employer to discharge you at any time, with or without cause (subject only to the provisions of any employment agreement), regardless of the effect which that discharge will have upon you under the Plan.

Qualified Medical Child Support Orders (QMCSO)

If the Plan Benefits Staff receives a child support order that (1) is a judgment, decree or order of a court (including approval of a settlement agreement) (or else issued through an administrative process established under state law that has the force and effect of law under applicable state law), that (2) provides for child support for a Child of an eligible Employee and (3) either relates to benefits under the health care coverages of the Plan or enforces a federally prescribed state law relating to Medicaid recipients, then the Plan Benefits Staff will notify you and the Child that the order has been received and describe the procedure that the Plan Benefits Staff will follow in deciding whether to honor the order.
Next, the appropriate vendors will separately account for health care claims filed that, in the absence of the order, would not be paid. Payment of these claims will be neither approved nor denied while the Plan Benefits Staff decides whether to honor the order. The Plan will not honor a child support order unless it constitutes a "Qualified Medical Child Support Order" under the law. That means the Plan will not honor a child support order unless it specifies:

- That it applies to this Plan,
- The name and last known mailing address of the affected Employee,
- The name and last known mailing address of the Child,
- A reasonable description of the type of coverage to be provided by the Plan to each Child or the manner in which the coverage is to be determined, and
- The time period to which the order applies.

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Also, the Plan will not honor a child support order that purports to require the Plan to provide any type or form of benefit, or any option, that is not already provided for in the Plan (except as necessary to satisfy a federally prescribed state law relating to Medicaid recipients). Upon making the decision whether the order is a "Qualified Medical Child Support Order" under the law, the Plan Benefits Staff will notify the Employee and the Child and act in accordance with the decision.

Family and Medical Leave

While on a Leave of Absence to which you are entitled under the federal Family and Medical Leave Act of 1993, you will not suffer the loss of any "employment benefit" (as defined for the purpose of the Family and Medical Leave Act) under any feature of the Plan which had accrued before you took the leave and which would not have been lost if you had remained actively at work. But you will not accrue any additional "employment benefits" under any feature of the Plan during the leave, except as specifically set forth in any particular feature. The Company also may allow you to continue to receive all other Plan coverages under your FMLA leave. If you receive pay during your leave, then your paycheck will continue to be reduced by an amount necessary to pay for the cost of eligible coverage which you wish to receive. If you do not wish to receive during your FMLA leave some or all of the eligible coverage which you were receiving just prior to your leave, you must inform the Company prior to the start of your leave. If, however, your FMLA leave is unpaid and you wish to continue participation in the Plan, you must make arrangements with the Company to pay for the eligible coverages maintained during your leave. Your eligibility to continue any coverage which requires payments from you may be cancelled if you do not make the required payments during the period of your FMLA leave. If the Company advances money by making any or all of these required payments for you, it can recoup the amounts advanced through payroll deductions upon your return to employment following your FMLA leave to the extent permitted by law. If you fail to return from your FMLA leave, and the reasons for your failure are not beyond your control, you are indebted to the Company for the full amount of the cost of health coverage provided during your FMLA leave. The Company intends to deduct, or cause to be deducted, any such amounts owed by you from any compensable time payments owed to you upon your termination for failure to return from an FMLA leave to the extent permitted by law.
You should consult your Human Resources department before embarking on any FMLA leave.

Military Service

Upon re-employment in accordance with the federal Uniformed Services Employment and Reemployment Rights Act of 1994 (which has rules about honorable discharge and time limits on returning to work), you regain entitlement to all rights and benefits which are determined by length of service that you had under the Plan when the military service began, plus any additional such rights and benefits that you would have accrued if you had remained continuously employed during the military service. In addition, no exclusion or waiting period will be applied under any health feature of the Plan that would not have been applied if you had remained continuously employed, except with respect to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

Designation of Primary Care Providers and/or OB/GYN

Some of the medical benefit options may require or permit the designation of a primary care provider. You have the right to designate any primary care provider who participates in your insurer's network and who is available to accept you or your family members. For Children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator at the information described in this booklet. You do not need prior authorization from the Plan, your insurer, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following for making referrals.

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Utilization Test

With regard to those features of the Plan that constitute a "cafeteria" plan, while the Plan makes the same benefits available to all eligible Employees, regardless of the level of their compensation, it is possible for the top-level Employees to actually take advantage of those features to a significantly greater extent than other Employees. In that case (which we see as highly unlikely), the Internal Revenue Code denies the tax advantage to these top-level Employees. (Everyone else still enjoys the full tax advantage.) The Plan Administrator will monitor this situation and notify any top-level Employee who is affected by it. The Plan Administrator also has authority to cut back the utilization of top-level Employees in order to avoid the problem.

Service of Process

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

Plan Sponsor's Employer Identification Number; Plan Number

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Plan Sponsor is shown in the table at the front of this document. The Plan Number assigned to the Plan is 501.

Type of Plan

The Plan is a welfare benefits plan. The Plan's components include medical coverage (which includes prescription drug coverage), dental, accidental death & dismemberment (AD&D) coverage, and fixed indemnity critical illness and hospital coverage.

Commented [aa1]: Do you want Dan's comment from dental added here too? ...dental coverage, accidental death & dismemberment (AD&D), and critical illness?

Plan Administrator and Administration of Plan

Contact information for the Plan Administrator, and information about how the Plan is administered, can be found in the section "Information About the Plan Administrator and Vendors."

Indemnification

To the maximum extent permitted by law, the Employer agrees to indemnify and hold harmless the Plan Administrator and its members (if a committee) against any and all expenses and liabilities including, without limitation, the amount of any settlement or judgment, costs, counsel fees and related charges reasonably incurred in connection with a claim asserted or a proceeding brought against the Plan Administrator or the settlement thereof, which may be incurred in the course of the Plan Administrator's duties under or relationship with the Plan, or which arises out of its actions or failure to act in executing the duties assigned under the Plan. The Employer may purchase fiduciary liability insurance to insure its obligations under this provision. This right of indemnification is in addition to any other rights to which the Plan Administrator may be entitled. The Employer may, at its own expense, settle any claim asserted or proceeding brought against the Plan Administrator when such settlement appears to be in the best interests of the Employer.

Circumstances Which May Affect Benefits

The Plan and the Employer are committed to conducting the benefits operations in a safe manner and will not tolerate actions which may endanger those involved in the provision of benefits. In the event that a Plan participant, in the opinion of benefits operations personnel (including personnel of benefits vendors or carriers) commits an act or threat of violence involving or affecting Employees or contractors, its benefits vendors or insurance carriers, the Plan Administrator may take action up to and including prohibiting the participant from participating in the Plan.

Finally, if the Plan Administrator determines that you or any dependent have attempted to obtain benefits, or obtained benefits, under the Plan fraudulently or by intentional misrepresentation of facts, participation in the Plan may be terminated, retroactively if appropriate, for (1) the individual who committed or attempted to commit the fraud or misrepresentation, and (2) for any individual who assisted such individual to commit, or to attempt to commit, such fraud.

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Source of Plan Contributions

The contributions required to provide coverage available under the Plan are made from the Employer from its general assets, by contributions from the Plan participants, or by a combination of both. For each available type of coverage under the Plan, the amount or levels of contributions required to be paid by the Plan participant are determined by the Plan Sponsor from time to time, generally on an annual basis, and are shown on your applicable enrollment documents or other Employee communications.

Funding Medium for Providing Benefits

Benefits are paid from the Employer's general assets. The Plan has no separate funding vehicle; provided, however, that in the event any separate funding becomes available for the Plan, such assets may be used to pay for Plan benefits and/or administrative expenses at the discretion of the Plan Administrator.

Employees are still responsible for any copay, coinsurance, and deductibles as required under the terms of the coverage provided through this Plan. For details on copays, coinsurance, deductibles, and other dollar limitations, refer to the charts under the subsection "Medical Benefits."

Nontransferability

To the extent permitted by law, the right of any participant or any beneficiary in any benefit or to any payment under the Plan cannot be subject in any manner to attachment or other legal process for the debts of such participant or beneficiary; and any such benefit or payment under the Plan cannot be subject to anticipation, alienation, sale, transfer, assignment, or encumbrance.

Employment

Neither this Plan nor any action taken hereunder may be construed as giving any Employee any equitable or legal right against the Employer, except as specifically provided in this document, or any right to be retained in the employ of the Employer.

Incompetence of Participants and Beneficiaries

In the event the Plan Administrator deems any person incapable of receiving benefits to which he/she is entitled by reason of minority, illness, infirmity, or other similar incapacity, the Plan Administrator may make payment directly for the benefit of such person to the court-appointed representative of such person. Such payment shall, to the extent thereof, discharge all liability of the Employer and Plan Administrator.

Waiver

Failure by the Plan Administrator or its designee to insist upon compliance with any provisions of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether or not the circumstances are the same.

Errors and Mistakes

An error cannot give a benefit to you if you are not actually entitled to the benefit. In the event of a mistake as to the eligibility or participation of an employee, or the allocations made to the account of any participant, or the amount of distributions made or to be made to a participant or other person, the Plan Administrator may, to the extent administratively feasible and not prohibited by applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding, or causing the withholding of, any amounts due the Plan or the Employer from compensation paid by the Employer.

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Discretion/Nondiscrimination

Wherever it is provided in the Plan, the Company may perform or not perform any act, or permit or consent to any action, non-action or procedure, or whenever it shall be given discretionary power or authority, it shall have exclusive discretion in the premises; provided, however, that it shall not exercise its discretion in such a manner as to violate the Internal Revenue Code or ERISA or knowingly to unlawfully discriminate either for or against any employee, participant or covered individual or any group of such persons.

Right to Require Information and Reliance Thereon

The Plan Administrator shall have the right to require any participant to provide it and its agent with such information, in writing, and in such form as it may deem necessary to the administration of the Plan and may rely on that information in carrying out its duties hereunder. Any payment to a participant in accordance with the provisions of the Plan in good faith reliance upon any written information provided by the participant shall be in full satisfaction of all claims by the participant.

Conclusiveness of Records

The records of the Employer with respect to age, employment history, compensation, absences, illnesses, and all other relevant matters shall be conclusive for purposes of the administration of, and the resolution of claims arising under, the Plan.

End of Plan Year

The date of the end of the Plan Year for purposes of maintaining the Plan's fiscal records is December 31.

Governing Law

To the extent not superseded by Federal Law, the laws of the State of Florida will control in all matters related to this Plan, without regard to any conflicts of law provisions.

Statement of ERISA Rights

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

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, all Plan documents, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

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 Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently

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and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied, in whole or in part, you have the 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 Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part (and you have exhausted the Plan's internal appeal procedure), you may file suit in a state or 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 should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or 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.

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NO SURPRISES ACT

If you use an out-of-network provider, that provider may send you a bill for any amounts that are not covered by the Plan (subject to certain legal restrictions under the federal No Surprises Act described below). This practice, often called "balance billing," means that the out-of-network provider can bill you not only for the Plan's Deductible and Coinsurance but also for any difference between the billed charges and the Plan's Allowable Expenses, with no maximum/cap. These amounts can be significant.

The No Surprises Act prohibits balance billing in the following circumstances:

- if you receive emergency services from an out-of-network provider (e.g., a provider, hospital, or both),
- if you receive ancillary services from an out-of-network provider at an in-network facility,
- if you receive air ambulance services from an out-of-network provider,
- if you receive Other Non-Emergency Services from an out-of-network provider at an in-network facility, and you decline to waive the balance billing protections of the No Surprises Act.

NOTE: An out-of-network provider may ask for your consent to balance bill. If you do consent to balance billing by that out-of-network provider, the Plan will only pay Covered Expenses at the out-of-network provider level. You will be responsible for the out-of-network provider Cost-Sharing as well as the difference between the billed charges and the Plan's allowable expenses (i.e., the balance billed by the out-of-network provider), with no maximum/cap.

All provisions of the Plan will be construed and administered in a manner consistent with the requirements of the Consolidated Appropriations Act of 2021, including but not limited to the No Surprises Act, that are applicable to the Plan.

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