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NORTHERN COUNTIES HEALTH CARE, INC.

Employee Benefit Plan
Summary Plan Description
and Plan Document

Effective: January 1, 2025

NORTHERN COUNTIES HEALTH CARE, INC.
EMPLOYEE BENEFIT PLAN

INTRODUCTION

This document is a summary of the Northern Counties Health Care, Inc. Employee Benefit Plan (the "Plan").

This document is provided to help you understand how the Plan works. It highlights what types of Expenses are covered under the Plan, definitions you need to know, how to file claims and what your legal rights are under the Plan. It is important that you read this document carefully, so you are aware of the benefits available and your responsibilities under this Plan. Failure to follow the requirements of this Plan may result in a delay of coverage or no coverage at all. Coverage under the Plan can be reduced or denied because of certain provisions of the Plan, such as coordination of benefits, subrogation, exclusions, pre-certification and prior authorization requirements, and lack of Medical Necessity. These requirements are summarized in this document. If you have any questions, you should contact the Plan Administrator or the Contract Administrator.

Northern Counties Health Care, Inc. is sponsoring this welfare Plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan provides certain covered medical benefits for all covered Employees and all covered Dependents. The Plan Sponsor pays Plan costs as they are presented instead of having a pre-determined premium with an insurance carrier. Northern Counties Health Care, Inc. has contracted with the Contract Administrator to provide administrative claims Payment services. The Contract Administrator is Comprehensive Benefits Administrator, LLC dba CBA Blue, an independent licensee of the Blue Cross and Blue Shield Association. The Contract Administrator does not assume any financial risk or obligation with respect to claims under this Plan. Stop loss reinsurance has been purchased to protect the Plan Sponsor from unpredictable claims experience.

Each Covered Person is entitled to benefits under the Plan, as outlined in this Plan Document. To obtain benefits from the Plan, the Covered Person must ultimately submit a diagnostic bill to the Contract Administrator for processing. This claim submission is required for reimbursement to the Employee or direct Payment to the service Provider by the Northern Counties Health Care, Inc. Employee Benefit Plan.

In any event where a question may arise as to a Claim for Benefits or denial of a Claim for Benefits, the Employer, the Contract Administrator (also known as the third-party administrator) and any other persons that may be associated with the Plan's operation will be guided solely by this Plan Document, which is also the Summary Plan Description within the meaning of ERISA. A clerical error will neither invalidate the Employee's Coverage if otherwise validly in force nor continue coverage otherwise validly terminated.

In accordance with the Plan's status as a self-funded ERISA welfare plan, the Plan Administrator and Contract Administrator shall administer the Plan as required by applicable law, including to comply with any legally binding regulations under the Code of Federal Regulations (CFR) or related amendments, and any binding guidance from the executive departments and agencies of the federal government, that pertain to a Covered Person's access and eligibility to the ERISA-governed benefits described herein, including covered and/or excluded Expenses, filing procedures, deadlines, and review procedures. The Plan will be deemed amended to comply with applicable law as of the law's effective date, and the remainder of this Plan Document will remain in full force and effect.

As explained in this document, the Plan Sponsor expressly reserves the right to amend or terminate the Plan or any provision of the Plan at any time and for any reason or no reason at all in its sole discretion. The Plan Sponsor may reflect Plan amendments in a separate document called a "summary of material modifications" or "SMM". SMMs supplement, replace, and supersede any conflicting information contained in this Plan Document. You should read all SMMs you receive.

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GENERAL INFORMATION

Name of the Plan: Northern Counties Health Care, Inc. Employee Benefit Plan

Plan Sponsor/Plan Administrator: Northern Counties Health Care, Inc.
165 Sherman Drive
St. Johnsbury, VT 05819
(802) 748-9405

Plan Number: 501

Contract Administrator Group Number: 50788

Plan(s) Covered: The Plan is a welfare Plan providing medical and prescription drug coverage.

Plan Sponsor's Federal Tax Identification Number: 51-0199559

Plan Effective Date: January 1, 2025

Plan Anniversary Date: January 1st

Plan Year Ends: December 31st

Contract Administrator/Pre-Certification Administrator:
Comprehensive Benefits Administrator, LLC dba CBA Blue
P.O. Box 2365
South Burlington, VT 05407-2365
Customer Service & Pre-Certification: (888) 222-9206

Agency for Service of Legal Process: Northern Counties Health Care, Inc.
165 Sherman Drive
St. Johnsbury, VT 05819

Service of process may also be made upon the Plan Administrator

Contributions: The Plan provides Contributory Coverage, meaning that Employees must contribute towards the cost of coverage under the Plan. The Plan Sponsor will determine the amount of contributions that Employees will be required to pay for coverage each year, in its sole discretion but subject to applicable law. The Plan Sponsor will be responsible for any amounts in excess of the contributions required by Employees. Operating Expenses may be paid out of Plan Sponsor and/or Employee contributions.

Eligibility Requirements: All active full-time Employees regularly performing at least twenty-four (24) hours of service per week.

The Plan Sponsor will identify those Employees who have performed sufficient hours of service to be considered "full-time" Employees eligible to participate in the Plan. To do so, the Plan Sponsor may use any method permitted by the final "Employer Shared Responsibility" regulations issued by the IRS and the Department of Treasury (the Employer Shared Responsibility Regulations) under the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act). Depending on the Plan Sponsor's application of the Employer Shared Responsibility Regulations, in certain circumstances, an Employee may be eligible for coverage under the Plan during periods in which the Employee performed fewer than thirty (30) hours of service per week. Contact the Plan Sponsor if you have questions about your eligibility to receive coverage under the Plan.

Dependent Children's Coverage: Married or unmarried Dependent children up to twenty-six (26) years of age.

Effective Date of Coverage: First of the month following date of hire.

Termination Date: See "Termination of Benefits" section.

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Northern Counties Health Care, Inc.
PPO Plan
Schedule of Benefits

BENEFIT CATEGORY	In-Network/Preferred Provider Network/BlueCard®	Out-of-Network/Non-Preferred Provider
Calendar Year Deductible The amount an individual or family must pay each calendar year before Payments begin for medical covered Expense. Does not include prescription drug benefits. Prescription drugs are subject to a separate prescription drug Deductible. Deductible amounts do not cross accumulate.	Single: $1,500 Two Person: $3,000 Family: $4,000	Single: $3,000 Two Person: $6,000 Family: $8,000
Medical Out-of-Pocket Maximum Limit The maximum amount of money that any individual or family will have to pay towards medical covered Expenses during any one calendar year. Includes the calendar year Deductibles, prescription drug Deductible, Coinsurance, medical and prescription Copayments. Does not include premium Payments or amounts over the Maximum Allowable Benefit. Out-of-Pocket amounts do not cross accumulate.	Single: $1,500 Two Person: $3,000 Family: $4,000	Single: $6,000 Two Person: $12,000 Family: $18,000
Plan Coinsurance	Plan pays 100% (unless otherwise stated), after the Deductible has been met	Plan pays 70% (unless otherwise stated), after the Deductible has been met
PREVENTIVE SERVICES	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**	**Out-of-Network/Non-Preferred Provider (You Pay)**
Routine Preventive Care Examinations Includes certain immunizations, flu shots, pap tests, preventive laboratory, and x-rays.	No charge	30% (after Deductible)
Routine Annual Gynecological Exam	No charge	30% (after Deductible)
Contraceptive Services and Supplies for Women FDA approved only; includes education and counseling, surgical services such as tubal ligation, contraceptive devices, and Physician services. Excludes reversals	No charge	30% (after Deductible)
Well-Child Care Includes certain immunizations and physical exams	No charge	30% (after Deductible)
Routine Prenatal and Postnatal Maternity Care Services	No charge	30% (after Deductible)
Routine Colorectal and Mammogram Screening	No charge	30% (after Deductible)
PHYSICIAN'S SERVICES	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**	**Out-of-Network/Non-Preferred Provider (You Pay)**
Physician Office Visits Primary Care Physician Specialty Care Physician If an in-office surgery is rendered on the same day as an office visit, then one Copayment will apply.	$20 Copayment per visit $50 Copayment per visit	30% (after Deductible)

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Northern Counties Health Care, Inc.
PPO Plan
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PHYSICIAN'S SERVICES (continued)	In-Network/Preferred Provider Network/BlueCard® (You Pay)	Out-of-Network/Non-Preferred Provider (You Pay)
OB-GYN Office Visits	$50 Copayment per visit	30% (after Deductible)
Office Surgery Primary Care Physician Specialty Care Physician	$20 Copayment per visit $50 Copayment per visit	30% (after Deductible)
Nutritional Counseling Nutritional Counseling when not part of preventive services as required under the Affordable Care Act (ACA). Nutritional Counseling when part of ACA is covered as a Preventive Service benefit.	$50 Copayment per visit	Not covered
Routine Pediatric Vision Exam Limited to one exam per calendar year up to age 19.	No charge	Not covered
Pediatric Vision Hardware Limited to one pair of frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year up to age 19.	No charge	Not covered
Routine Pediatric Dental Exams Limited to two exams per calendar year up to age 19.	No charge	Not covered
EMERGENCY SERVICES	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**	**Out-of-Network/Non-Preferred Provider (You Pay)**
Emergency Services Includes facility, Physician, lab, and x-ray. Facility Services Physician Services Copayment waived if held for observation or admitted within 24 hours.	0% (after Deductible) $25 Copayment per visit	Same as In-Network benefits
Ambulance Services (ground or air ambulance transport)	0% (after Deductible)	Same as In-Network benefits
Urgent Care Facility Includes Provider and facility services.	0% (after Deductible)	Same as In-Network benefits
HOSPITAL SERVICES - OUTPATIENT	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**	**Out-of-Network/Non-Preferred Provider (You Pay)**
Outpatient Hospital Services Outpatient surgery, ambulatory surgery, anesthesia.	0% (after Deductible)	30% (after Deductible)

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HOSPITAL SERVICES – INPATIENT	In-Network/Preferred Provider Network/BlueCard® (You Pay)	Out-of-Network/Non-Preferred Provider (You Pay)
Inpatient Hospital Services	0% (after Deductible)	30% (after Deductible)
Inpatient Maternity Care Includes delivery and postnatal care.	0% (after Deductible)	30% (after Deductible)
MENTAL HEALTH/SUBSTANCE USE SERVICES	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**	**Out-of-Network/Non-Preferred Provider (You Pay)**
Inpatient Mental Health/Substance Use Disorder Treatment As many days as Medically Necessary.	0% (after Deductible)	30% (after Deductible)
Mental Health/Substance Use Disorder Treatment – Intensive Outpatient Care	0% (after Deductible)	30% (after Deductible)
Outpatient Mental Health/Substance Use Disorder Treatment – Office visits	$20 Copayment per visit	30% (after Deductible)
THERAPY SERVICES	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**	**Out-of-Network/Non-Preferred Provider (You Pay)**
Outpatient Cardiac and Pulmonary Services	0% (after Deductible)	30% (after Deductible)
Outpatient Physical, Speech and Occupational Therapy Limited to 30 combined visits per member per calendar year. The visit limit does not apply to Mental Health/Substance Use Disorder Treatment.	0% (after Deductible)	30% (after Deductible)
Chiropractic Services Services to treat a neuromusculoskeletal condition. Limited to 12 visits per member per calendar year.	$50 Copayment per visit	Not covered
OTHER COVERED SERVICES	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**	**Out-of-Network/Non-Preferred Provider (You Pay)**
Durable Medical Equipment Includes supplies.	0% (after Deductible)	30% (after Deductible)
Breastfeeding Equipment Limited to the rental or purchase of one non-hospital grade breast pump per pregnancy up to the purchase price, and includes related supplies, when pump is ordered or prescribed by a Physician.	No charge	30% (after Deductible)

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Northern Counties Health Care, Inc.
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OTHER COVERED SERVICES (continued)	In-Network/Preferred Provider Network/BlueCard® (You Pay)	Out-of-Network/Non-Preferred Provider (You Pay)
Outpatient Diagnostic X-Ray & Lab Diagnostic services.	0% (after Deductible)	30% (after Deductible)
Outpatient High Tech Radiology Includes MRI, PET, CAT Scan, and nuclear cardiac imaging test.	0% (after Deductible)	30% (after Deductible)
Hospice Care Inpatient or outpatient Hospice services for the terminally ill.	0% (after Deductible)	30% (after Deductible)
Skilled Nursing Facility/Rehabilitation Hospital/Convalescent Care/Extended Care Facility	0% (after Deductible)	Not covered
Home Health Care	0% (after Deductible)	30% (after Deductible)
Private Duty Nursing Covered up to 14 hours per member per calendar year.	0% (after Deductible)	30% (after Deductible)
Prosthetic Devices	0% (after Deductible)	30% (after Deductible)
Organ Transplant Care	Payable in accordance with the type of Expense incurred and the place where service is provided	30% (after Deductible)
CBA Blue Live Telemedicine	**CBA Blue Live Telemedicine Providers (You Pay)**	
	$40 per visit fee Fee will be applied to the in-network Out-of-Pocket Maximum.	
PRESCRIPTION DRUG BENEFITS	**Network/Participating Pharmacy**	**Non-Network/Non-Participating Pharmacy**
Retail (Up to 30 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	Prescription Deductible then; $5 Copayment $35 Copayment $75 Copayment	Not covered
Mail Order (Up to 90 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drugs	Prescription Deductible then; $10 Copayment $70 Copayment $150 Copayment	Not covered
Wellness Drugs	No charge, Deductible is waived	Not covered
Prescription Drug Calendar Year Deductible	$150 Per individual	Not covered

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard®® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by Non-Participating Providers will be subject to the Maximum Allowable Benefit, as defined in this Plan Document.
3. All other covered benefits not listed above will be subject to Deductible, then payable at 100% In-Network and 70% Out-of-Network.
4. All in and Out-of-Network benefit limits are combined.
5. All in and Out-of-Network Deductible and Out-of-Pocket amounts are not combined.
6. Medical and prescription drug Copayments are applied to the applicable Out-of-Pocket Maximum.
7. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
8. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.
9. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward in-network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

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Northern Counties Health Care, Inc.
Bronze Copay Plan
Schedule of Benefits

BENEFIT CATEGORY	In-Network/Preferred Provider Network/BlueCard®
Calendar Year Deductible The amount an individual or family must pay each calendar year before Payments begin for medical covered Expenses. Does not include prescription drug benefits. Prescription drugs are subject to a separate prescription drug Deductible. For 2-person or family coverage, the entire family Deductible must be met.	Single: $5,950 Family: $11,900
Medical Out-of-Pocket Maximum Limit The maximum amount of money that any individual or family will have to pay towards medical covered Expenses during any one calendar year. Includes the calendar year Deductible, prescription drug Deductible, Coinsurance, medical/prescription Copayments. Does not include premium Payments or amounts over the Maximum Allowable Benefit.	Single: $8,050 Family: $16,100
Plan Coinsurance	Plan pays 80% (unless otherwise stated), after the Deductible has been met
PREVENTIVE SERVICES	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**
Routine Preventive Care Examinations Includes certain immunizations, flu shots, pap tests, preventive laboratory, and x-rays	No charge
Routine Annual Gynecological Exam	No charge
Contraceptive Services and Supplies for Women FDA approved only; includes education and counseling, surgical services such as tubal ligation, contraceptive devices, and Physician services. Excludes reversals	No charge
Well-Child Care Includes certain immunizations and physical exams	No charge
Routine Prenatal and Postnatal Maternity Care Services	No charge
Routine Colorectal and Mammogram Screening	No charge
Routine Pediatric Vision Exam Limited to one exam per calendar year up to age 19.	No charge
Pediatric Vision Hardware Limited to one pair of frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year up to age 19.	No charge
Routine Pediatric Dental Exams Limited to two exams per calendar year up to age 19.	No charge

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PHYSICIAN'S SERVICES	In-Network/Preferred Provider Network/BlueCard® (You Pay)
Physician Office Visits Primary Care Provider Specialty Care Provider If an in-office surgery is rendered on the same day as an office visit, then one Copayment will apply.	$20 Copayment per visit $50 Copayment per visit
OB-GYN Office Visits	$50 Copayment per visit
Office Surgery Primary Care Provider Specialty Care Provider	$20 Copayment per visit $50 Copayment per visit
Nutritional Counseling Nutritional Counseling when not part of preventive services as required under the Affordable Care Act (ACA). Nutritional Counseling when part of ACA is covered as a Preventive Service benefit.	$50 Copayment per visit
EMERGENCY SERVICES	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**
Emergency Services Includes facility, Physician, lab, and x-ray.	20% (after Deductible)
Ambulance Services (ground or air ambulance transport)	20% (after Deductible)
Urgent Care Facility Includes Provider and facility services.	20% (after Deductible)
HOSPITAL SERVICES - OUTPATIENT	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**
Outpatient Hospital Services Outpatient surgery, ambulatory surgery, anesthesia.	20% (after Deductible)
HOSPITAL SERVICES – INPATIENT	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**
Inpatient Hospital Services	20% (after Deductible)
Inpatient Maternity Care Includes delivery and postnatal care.	20% (after Deductible)

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MENTAL HEALTH/SUBSTANCE USE SERVICES	In-Network/Preferred Provider Network/BlueCard® (You Pay)
Inpatient Mental Health/Substance Use Disorder Treatment As many days as Medically Necessary.	20% (after Deductible)
Mental Health/Substance Use Disorder Treatment – Intensive Outpatient Care	20% (after Deductible)
Outpatient Mental Health/Substance Use Disorder Treatment – Office visits	$20 Copayment per visit
THERAPY SERVICES	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**
Outpatient Cardiac and Pulmonary Services	20% (after Deductible)
Outpatient Physical, Speech and Occupational Therapy Limited to 30 combined visits per member per calendar year. The visit limit does not apply to Mental Health/Substance Use Disorder Treatment.	20% (after Deductible)
Chiropractic Services Services to treat a neuromusculoskeletal condition. Limited to 12 visits per member per calendar year.	$50 Copayment per visit
OTHER COVERED SERVICES	**In-Network/Preferred Provider Network/BlueCard® (You Pay)**
Durable Medical Equipment Includes supplies.	20% (after Deductible)
Breastfeeding Equipment Limited to the rental or purchase of one non-hospital grade breast pump per pregnancy up to the purchase price, and includes related supplies, when pump is ordered or prescribed by a Physician.	No charge
Outpatient Diagnostic X-Ray & Lab Diagnostic services.	20% (after Deductible)
Outpatient High Tech Radiology Includes MRI, PET, CAT Scan and nuclear cardiac imaging test.	20% (after Deductible)
Hospice Care Inpatient or outpatient Hospice services for the terminally ill.	20% (after Deductible)
Skilled Nursing Facility/Rehabilitation Hospital/Convalescent Care/Extended Care Facility	20% (after Deductible)

CBA Blue

Northern Counties Health Care, Inc.
Bronze Copay Plan
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OTHER COVERED SERVICES (continued)	In-Network/Preferred Provider Network/BlueCard® (You Pay)
Home Health Care	20% (after Deductible)
Private Duty Nursing Covered up to 14 hours per member per calendar year.	20% (after Deductible)
Prosthetic Devices	20% (after Deductible)
Organ Transplant Care	Payable in accordance with the type of Expense incurred and the place where service is provided
CBA Blue Live Telemedicine	**CBA Blue Live Telemedicine Providers (You Pay)**
	$40 per visit fee Fee will be applied to the in-network Out-of-Pocket Maximum.
PRESCRIPTION DRUG BENEFITS	**Network/Participating Pharmacy**
Retail (Up to 30 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	Prescription Deductible then; $5 Copayment $35 Copayment $75 Copayment
Mail Order (Up to 90 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drugs	Prescription Deductible then; $10 Copayment $70 Copayment $150 Copayment
Prescription Drug Calendar Year Deductible	$150 per member
Wellness Drugs	No charge, Deductible is waived

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont Preferred Provider Network as well as the BlueCard® Program. This document refers to Providers and facilities participating in that Preferred Provider Network as "preferred" or "In-Network" Providers and facilities. These Preferred Providers and facilities will bill the Contract Administrator directly and write off charges that exceed their contractual allowances. Charges for services rendered by Non-Preferred Providers are not covered under this Plan, except for Emergency Services, ambulance services from Non-Preferred Providers, urgent care from Non-Preferred Providers, and as otherwise required by applicable law.
2. All other covered benefits not listed above will be subject to Deductible, then payable at 80%.
3. Medical and prescription drug Copayments are applied to the applicable Out-of-Pocket Maximum.
4. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of Payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full Payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of Payment or to proactively prohibit assignment of Payment to anyone, including any Provider, at its discretion.
5. To receive benefit consideration, Covered Persons may need to submit claims for services provided by Out-of-Network Providers to the Contract Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.

6. If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum Limit will be calculated as if the Provider had been in-network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For out-of-network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward in-network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered out-of-network air ambulance services.

GENERAL PROVISIONS

PLAN ENROLLMENT

Eligibility: Only Employees who satisfy the eligibility requirements set forth in the "General Information" section are eligible for coverage under this Plan. The Dependent(s) of a covered Employee will become eligible for coverage on the date of the Employee's eligibility for coverage or on the date which the Employee acquires the Dependent.

If an Employee and spouse are both eligible for coverage as Employees under the Plan, only one (1) will be eligible to enroll Dependent(s). Also, an Employee cannot be covered as an Employee and a Dependent.

Plan Enrollment: To become covered under the Plan, an Employee must enroll themselves and/or their Dependents for coverage within thirty-one (31) days following the satisfaction of the eligibility requirements. The Employee and Dependents will be enrolled when a benefit enrollment form is completed, signed, and delivered to the Employer within the time limit. Should the enrollment occur more than thirty-one (31) days following the satisfaction of the eligibility requirements, the Employee and/or Dependents will only be eligible to enroll during the annual open enrollment period described below or, in certain circumstances, during a special enrollment period. Should multiple Plan options exist, an Employee may switch Plan options during an annual open enrollment period or special enrollment period.

Annual Open Enrollment Period: There will be an annual open enrollment period during the one (1) month period preceding the Plan's anniversary date. The Effective Date of Coverage will be the Plan's anniversary date.

Special Enrollment Periods: Individuals are eligible for special enrollment in the Plan for the following reasons:

1. If an Employee acquires a Dependent through marriage, Civil Union, Domestic Partnership, birth, adoption, or placement for adoption, the Dependent (and if not otherwise enrolled, the Employee and eligible Dependents) may be enrolled under this Plan. The request to enroll must be within thirty-one (31) days of the event. If enrollment is not requested **within thirty-one (31) days** following the event, the Dependents will only be eligible to enroll during the annual open enrollment period. The Effective Date of Coverage will be the date of the event. Newborn children of an eligible Employee will be covered from the moment of birth for the first sixty (60) days. To continue coverage beyond the first sixty (60) days, the Employee must complete an enrollment form and it must be received by the Contract Administrator.
2. If an Employee declines enrollment in the Plan for themselves or their Dependents because the Employee or Dependents have other health coverage, the Employee may in the future be able to enroll themselves and/or their Dependents in the Plan, provided they are otherwise eligible for coverage under the terms of the Plan, they meet certain conditions including any one of those set forth below and they request enrollment **within thirty-one (31) days** of that condition being satisfied:
    - when enrollment was declined under this Plan for Employee and/or Dependent Coverage, the Employee and/or Dependent had COBRA continuation coverage under another health plan, and COBRA continuation coverage under that other plan has since been exhausted; or

- if the other coverage that applied to the Employee and/or Dependent when coverage was declined was not COBRA continuation coverage, Employer contributions toward the other coverage have ceased, regardless of whether coverage under the other Employer's Plan has terminated; or
- if the other coverage that applied to the Employee and/or Dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
    a. loss of eligibility as a result of legal separation, dissolution of Domestic Partnership, termination of a Civil Union, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing; or
    b. the Employee and/or Dependent moving out of an HMO service area if HMO coverage terminates for that reason and, no other Plan options are available to the Employee/Dependent; or
    c. the other Plan ceasing to offer coverage to the group of similarly situated individuals that include the Employee and/or Dependent; or
    d. the Dependent losing Dependent status per Plan terms; or
    e. the other Plan terminating a benefit package option and no substitution is offered.

The Effective Date of Coverage will be the date following the date of the loss of the other coverage. The Plan's Waiting Period will not be applied.

3. If an Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, or if the Employee or Dependent becomes eligible for a state-granted premium subsidy towards Employer health coverage under either Medicaid or CHIP, the Employee may request to be enrolled in this Plan. The Employee's request to enroll must be made within sixty (60) days of the date on which the Employee or Dependent either (a) loses eligibility under Medicaid or CHIP or (b) becomes eligible for a state-granted premium subsidy towards Employer health coverage under either Medicaid or CHIP. The Effective Date of Coverage will be the first day of the month following the Employee's request to enroll in this Plan.

Qualified Medical Child Support Orders: If an Employee is required to provide benefits for his Dependent child under the direction of a court order and the Employee is not enrolled in the Plan, the Employee may enroll himself and his Dependent child provided enrollment is requested within thirty (30) days of issuance of the court order. The Plan's open enrollment provision will not apply. The Effective Date of Coverage will be the date of the court order. However, if the Employee has not yet satisfied the Plan's Waiting Period, coverage will become effective after satisfaction of such Waiting Period.

Disability Leave: An Employee will continue to be eligible for coverage under the Plan following the date of the disability leave of the Employee in accordance with the Northern Counties Health Care, Inc. Employee Handbook.

General Leave of Absence: An Employee will continue to be eligible for coverage under the Plan following the date of an approved leave of absence in accordance with the Northern Counties Health Care, Inc. Employee Handbook.

COORDINATION OF BENEFITS (COB)

Should a Covered Person be enrolled in this Plan while enrolled in any other Plan providing similar benefits, Coordination of Benefits (COB) rules control whether benefits are payable under this Plan before those of the other Plans. The benefits payable under this Plan will not be reduced where the COB rules provide that this Plan pays first. The benefits payable under this Plan may, however, be reduced where the COB rules provide that another Plan pays first. In any case, the total of all benefits payable under all Plans will not exceed 100% of the Maximum Allowable Benefit under this Plan, and this Plan will never pay more than it would otherwise pay in the absence of the COB rules. These COB rules apply separately to each Covered Person for each plan year. Please review the Miscellaneous Provisions section of this Plan Document for information about how this Plan coordinates with Medicare.

If a Plan does not have its own COB rules, it will be primary to this Plan (that is, it will pay benefits before this Plan does).

For all other Plans, the first of this Plan's following COB rules to apply will determine which of the Plans is primary:

1. Non-Dependent/Dependent – Any Plan under which the Covered Person is covered as an Employee, member, or subscriber (that is, other than as a Dependent) will pay first. Any Plan under which the Covered Person is covered as a Dependent of the Employee will pay second.

2. Dependent Child/Parents Not Separated or Divorced – If a Dependent child is covered under the Plans of both the child's parents, and the parents are not separated or divorced (regardless of whether they were ever married), the Plan of the parent whose birth date occurs earlier in the calendar year will pay first, and the Plan of the parent whose birth date occurs later in the calendar year will pay second. If the birth dates of the parents are the same, the Plan which has covered a parent for the longest period of time will pay benefits before the Plan of the other parent.

3. Dependent Child/Separated or Divorced Parents – Where a Dependent child is covered under the Plans of both parents, the parents are separated or divorced from one another, and there is otherwise no court decree setting forth the responsibility for the child's health care costs:

    a) the Plan under which the child is covered as a Dependent of the Custodial Parent will pay first;
    b) the Plan under which the child is covered as a Dependent of the Custodial Parent's spouse (i.e., stepparent of child) will pay second;
    c) the Plan under which the child is covered as a Dependent of the noncustodial parent will pay third; and
    d) if the specific terms of a court decree state that the parents share joint custody without stating that one parent is responsible for the child's health care costs, then the Plans shall follow the second rule above as if the parents are not separated or divorced.

4. Active/Inactive Employee – Any Plan under which the Covered Person is covered as an active Employee (or as that Employee's Dependent) will pay first. Any Plan under which the Covered Person is covered as a laid off or retired Employee (or as that Employee's Dependent) will pay second. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. Continuation Coverage – Any Plan under which the Covered Person is covered as an Employee (or as that Employee's Dependent) will pay first. Any Plan under which the Covered Person is covered under a right of continuation as provided under federal or state law (for example, under the Consolidated Omnibus Budget Reconciliation Act of 1985), will pay second. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determine the order of benefits, the Plan which has covered the Covered Person for the longest period of time will pay first; the Plan which has covered the Covered Person for the shortest period of time will pay last.

Right to Receive and Release Needed Information: The Plan may release or receive any information needed from another Plan or any other organization or person in order to enforce this provision. This information may be obtained without the consent of or notice to any other person. Any person claiming benefits under this Plan must furnish the Plan with any information requested by the Plan to enforce the COB provisions in accordance with the HIPAA Privacy Requirements.

Right to Make Payments: Should another Plan provide benefits which the Plan Administrator determines should have been paid by this Plan, the Plan has the right to make Payment to the other Plan directly. That Payment will satisfy the obligation of this Plan.

Right to Recovery: If the Plan pays benefits that should be paid by another Plan, the Plan has the right to recover from the other Plan or the Covered Person any overpayment made. If the Plan pays benefits that are later found to be greater than the Maximum Allowable Benefit, the Plan may recover the amount of the overpayment from the source to which it was paid. See the "Recovery of Payments" section herein for more information.

Coordination with Other Liability: This Plan will pay benefits secondary to the Covered Person's personal automobile insurance (including, but not limited to, no-fault insurance and uninsured motorist coverage) or other liability insurance policies through which medical Payments may be made for Expenses resulting from or in connection with an accidental Injury.

Coordination with Prescription Claims: There is no coordination of benefits with prescription drugs.

TERMINATION OF BENEFITS

An Employee's and/or a Dependent's Coverage under the Plan will terminate:

1. on the date the Plan terminates; or

2. on the date an Employee withdraws from the Plan by either not reenrolling during the Plan's annual open enrollment period, or revoking his election to participate in the Plan as permitted in the "General Information" section; or

3. on the date an Employee ceases to satisfy the Plan's eligibility requirements (determined as described in the "General Information" section); or

4. on the date an Employee is terminated, unless continuation of coverage, as provided herein, is elected; or

5. on the date a Dependent withdraws from the Plan or a Dependent ceases to meet the definition of a Dependent as defined herein or Dependent Coverage is discontinued under the Plan for any reason, unless continuation of coverage, as provided herein, is elected; or

6. at the end of the month in which a Dependent child turns age twenty-six (26); or

7. on the date an Employee or Dependent enters the military, naval, or air force of any country or international organization on a full-time, active-duty basis, other than scheduled drills or other training not exceeding one (1) month in any calendar year (see Military Leave section below); or

8. on the last date of the period for which contribution has been made if the Employee fails to make any required contribution.

The Plan Sponsor, in its sole discretion, may cause a Covered Person's coverage under the Plan to terminate if the Covered Person provides false information or makes misrepresentations in connection with a Claim for Benefits; permits a non-participant to use a membership or other identification card for the purpose of wrongfully obtaining benefits; obtains or attempts to obtain benefits by means of false, misleading or fraudulent information, acts or omissions; fails to make any Copayment, supplemental charge, or other amount due with respect to a benefit; behaves in a manner disruptive, unruly, abusive, or uncooperative to the extent that the Plan is unable to provide benefits to him or her; or threatens the life or well-being of personnel administering the Plan or of Providers of services or benefits.

MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") provides special continuation coverage to covered Employees who otherwise lose health insurance coverage under the Plan because they leave employment to serve in the uniformed services. Under USERRA, affected covered Employees and their Dependents must be offered the right to continue coverage for up to twenty-four (24) months. The Employer may charge 102% of the applicable premium, provided the length of the military leave is longer than thirty (30) days. However, on the date that the Employee completes his active duty and returns to full-time employment, the Employee and his eligible Dependents will be re-enrolled in the Plan and coverage will be provided immediately. However, any limitations on the Employee's or Dependent's Coverage which were in affect before the active military duty leave will continue to apply.

REINSTATEMENT OF COVERAGE

If coverage terminates due to termination of employment, there may be circumstances in which a former Employee's Coverage will be reinstated without imposition of a Waiting Period if the former Employee returns to work with the Plan Sponsor within 91 days after the date of termination. When the Employee returns to work, the Employee's Coverage (if any) will be on the same basis as that being provided on the date of the Employee's termination. Any limitations on the Employee's Coverage which were in effect before the Employee's termination will continue to apply for the reinstated coverage. If a former Employee's Coverage is not reinstated under this section pursuant to the Plan Sponsor's policies, then he or she will be treated as a new Employee for purposes of the Plan. Please contact the Plan Sponsor if you have any questions regarding reinstatement of coverage.

EXTENSION OF BENEFITS (COBRA)

Qualified beneficiaries may elect to continue coverage under the Plan when their coverage terminates due to a "qualifying event." These rights are protected under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.
(COBRA) of 1986.

Depending on the type of qualifying event, "qualified beneficiaries" can include the Employee covered under the Plan and the Employee's covered Dependents. A qualified beneficiary is an individual who, on the day before a qualifying event (as described below), is a beneficiary under the Plan as the spouse, Civil Union Partner, Domestic Partner, or Dependent child of the Employee. The Employee is a qualified beneficiary with respect to the termination and reduced employment qualifying events below.

A child who is born to or placed for adoption with the covered Employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Contract Administrator of the birth or adoption.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

The Employee has the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The Employee's termination of employment for reasons other than gross misconduct.

2. The Employee's retirement or reduction in hours of employment.

The Employee's spouse, Civil Union Partner, or Domestic Partner has the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The Employee's termination of employment for reasons other than gross misconduct.

2. The Employee's retirement or reduction in hours of employment.

3. The Employee's death.

4. The Employee's divorce, legal separation, termination of a Civil Union, or termination of a Domestic Partnership.

5. The Employee becomes entitled to Medicare benefits (Part A, Part B, or both).

The Employee's Dependent children have the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The Employee's termination of employment for reasons other than gross misconduct.

2. The Employee's retirement or reduction in hours of employment.

3. The Employee's death.

4. The Employee's divorce, legal separation, termination of a Civil Union, or termination of a Domestic Partnership.

5. The Employee becomes entitled to Medicare benefits (Part A, Part B, or both).

6. The Employee's Dependent child ceases to be an eligible Dependent as such term is defined in the Plan.

Similar rights may apply to certain retirees, spouses, and Dependent children if the Employer commences a bankruptcy proceeding and these individuals lose coverage.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Contract Administrator 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, or enrollment of the Employee in Medicare (Part A, Part B, or both), the Employer must notify the Contract Administrator of the qualifying event within thirty (30) days of any of these events on the form provided by the Contract Administrator to the Employer.

For the other qualifying events (divorce or legal separation of the Employee and spouse, termination of a Civil Union, termination of a Domestic Partnership, or a Dependent child's losing eligibility for coverage as a Dependent child), the qualified beneficiary must notify the Contract Administrator. The Contract Administrator must be notified in writing within sixty (60) days after the qualifying event occurs.

Once the Contract Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. The Contract Administrator must notify the qualified beneficiary in writing of their right to COBRA continuation of coverage within fourteen (14) days from the date the Contract Administrator is notified of a qualifying event.

The qualified beneficiary has sixty (60) days from the date of the written notice or qualifying event, whichever is later, to notify the Contract Administrator of their decision to elect COBRA continuation of coverage. To receive COBRA continuation of coverage, no evidence of insurability will be required, but a monthly premium will be charged. If continuation of coverage is not elected on a timely basis, group health insurance coverage will end.

If Medicare entitlement occurs prior to a qualifying event, then COBRA begins on the date of Medicare entitlement.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the day following the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's divorce or legal separation, termination of a Civil Union, termination of a Domestic Partnership, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to thirty-six (36) months.

If a qualifying event that is a termination of employment or reduction of hours occurs within eighteen (18) months after the covered Employee becomes entitled to Medicare, then the maximum coverage period for the spouse and Dependent children who are qualified beneficiaries receiving COBRA coverage will end thirty-six (36) months from the date the Employee became entitled to Medicare (but the covered Employees' maximum coverage period will be eighteen (18) months). This extension is available only if the covered Employee becomes entitled to Medicare within eighteen (18) months before the termination of employment or reduction of hours occurs.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage lasts for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and the Contract Administrator is notified in a timely fashion, the Employee and his covered Dependents can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The qualified beneficiary must make sure that the Contract Administrator is notified in writing of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, then the beneficiary must notify the Plan within thirty (30) days of determination by the Social Security Administration.

Second qualifying event extension of 18-month period of continuation coverage

If the Employee's family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and Dependent children if the former Employee dies, gets divorced, legally separated, terminates a Civil Union, or terminates a Domestic Partnership. This extension may be available to a spouse or Dependents if the former Employee enrolls in Medicare. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child. **In all of these cases, the qualified beneficiary must make sure that the Contract Administrator is notified in writing of the second qualifying event within sixty (60) days of the second qualifying event.**

In no event will COBRA coverage continue beyond thirty-six (36) months from the date of the original qualifying event.

Monthly Premium

1. The monthly premium will be 102% or, if applicable, 150% of the applicable premium (which for self-funded Plans, is based on reasonable actuarial estimates or on past costs). All premium Payments are due in advance and include the cost of the next month of COBRA continuation of coverage.

2. The initial premium Payment is due within forty-five (45) days of electing COBRA continuation of coverage. The Payment must cover all premiums due from the date of the qualifying event.

3. The maximum grace period for Payment of monthly COBRA coverage premiums will not exceed thirty (30) days from the due date established by the Plan Administrator or their authorized agent.

Termination of COBRA continuation coverage

COBRA continuation of coverage may be terminated prior to the expiration of the applicable time period as follows:

1. The Plan Administrator no longer provides group health coverage to any of its Employees.

2. The applicable monthly premium for COBRA coverage is not paid within thirty (30) days of the established due date.

3. The person who has elected COBRA coverage becomes entitled to Medicare benefits (Part A, Part B, or both). COBRA coverage will terminate on the first day of the person's birthday month. Should the person's birthday be on the first day of the month, then COBRA coverage will terminate on the first day of the month prior to the person's birthday.

4. The qualified beneficiary who has elected COBRA coverage becomes covered under another group health plan.

5. The unique disability extension period explained above will end as of the first day of month that begins more than thirty (30) days after the date of final determination under the Social Security Act that the qualified beneficiary is no longer disabled.

The covered Employee does not have to show that he or she is insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to the covered Employee's eligibility for coverage; the Plan Administrator reserves the right to terminate the covered Employee's Coverage retroactively if he or she is determined to be ineligible.

Note: Some of the changes under the Affordable Care Act (described below) may be Relevant to a covered Employee's decision to elect COBRA:

There may be other coverage options for a covered Employee and the Employee's family. Individuals are able to buy coverage through the Health Insurance Marketplace. In the Marketplace, the individual could be eligible for a new kind of tax credit that lowers his or her monthly premiums right away. Covered Employees will be able to see what the premiums, Deductibles, and out-of-pocket costs will be before making a decision to enroll in the Marketplace. Being eligible for COBRA does not limit a covered Employee's eligibility for coverage for a tax credit through the Marketplace.

Keep Plan Informed of Address Changes

In order to protect the participant's family's rights, the participant should keep the Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

PLAN DETAILS

Explanation of Preferred Provider Network, BlueCard®, and Out-of-Network Benefits:

To receive Preferred Provider Network / BlueCard® benefits as indicated on the Schedule of Benefits, you **must** choose Providers in the Blue Cross Blue Shield of Vermont's Preferred Provider Network or the BlueCard® Program for all care (with specific, limited exceptions as noted in this Plan Document, such as those explained in the No Surprises Act – Emergency Services and Surprise Bills language herein). **PPO Plan:** If you, instead, choose to obtain services from an Out-of-Network Provider or facility, then the Plan will pay for any covered services at the out-of-network benefit level indicated on the Schedule of Benefits, and you will be responsible for paying any additional amount to the Provider. **Bronze Copay Plan:** If you, instead, choose to obtain services from an Out-of-Network Provider or facility, no coverage will be provided with the exception of Emergency Services, ambulance services, and as otherwise required by applicable law.

As explained in the No Surprises Act – Emergency Services and Surprise Bills language herein, please note that Out-of-Network Providers and facilities are generally permitted to "balance bill" Covered Persons. This means that a Covered Person may be required to pay the difference between what the Provider charges for a service and what the Plan agreed to pay for that service (including amounts paid from the Plan and from Coinsurance and Copayments). In many situations, this difference could be significant.

You should not receive balance bills from Out-of-Network Providers and facilities (including Independent Freestanding Emergency Departments) for the provision of Emergency Services, air ambulance Providers, or certain Out-of-Network Providers rendering services in In-Network facilities. **In certain situations, an Out-of-Network Provider may ask for your consent to balance bill. You are never required to consent to balance billing in those situations. If you consent, you may receive a balance bill.**

The following provisions explain the Plan's Preferred Provider Network, including how to find a Preferred Provider and what happens if you use an Out-of-Network Provider instead. Note that the Plan's Preferred Provider Network benefits and Out-of-Network benefits refer to the "Maximum Allowable Benefit" under the Plan. The Maximum Allowable Benefit is important to understanding how much you and the Plan will pay for a covered service. Please refer to the definition of this term later in this Plan Document for more information.

Preferred Provider Network Program for In-Network Claims:
The Plan includes access to Blue Cross Blue Shield of Vermont's Preferred Provider Network and the BlueCard® Program in order to obtain discounts from Participating Providers for covered medical care. The Plan identification card identifies the selected Preferred Provider Network and a current list of the Participating Providers will be furnished to Covered Persons automatically by the Plan Sponsor or can be viewed by visiting www.cbabluevt.com. **Use of the network is voluntary; however, if you choose not to use In-Network Providers for a covered service, then the covered service will be paid at the out-of-network benefit level and you will be responsible for paying any additional amount to the Provider, except as prohibited by applicable law (see the No Surprises Act – Emergency Services and Surprise Bills language herein).** The benefits of utilizing Participating Providers include Provider fee discounts, direct billing to the Plan for covered services, and network Provider write-offs of any charges in excess of the discounted fee schedule.

EPO Plan only: The Covered Person must obtain services and supplies from Providers who participate in the Preferred Provider Network (as well as the BlueCard® Network). No coverage will be provided if the Covered Person chooses to obtain their services or supplies from a Provider who does not participate in the Preferred Provider Network, with the exception of Emergency Services, ambulance services, urgent care, and as otherwise required by applicable law.

If a Covered Person is referred by an In-Network Provider to a specialist and no Provider exists for that area of specialty within the Preferred Provider Network, as determined by the Contract Administrator, then the Covered Person may seek services of an Out-of-Network specialist and benefits for covered services will be paid as though they were furnished by an In-Network Provider.

Laboratory work for a sample that is drawn during a **visit** to an **In-Network** Physician or Hospital, and the sample is subsequently sent to an Out-of-Network lab or pathologist, then the laboratory fees and pathologist fees will be paid at the In-Network benefit level subject to the Maximum Allowable Benefit. **PPO Plan:** Should the Covered Person choose services from an Out-of-Network Provider or facility, then the services will be paid at the Out-of-Network benefit level. **Bronze Copay Plan:** Should the Covered Person choose services from an Out-of-Network Provider or facility, then the services will not be covered.

Continuity of Care

You may be eligible to continue care with a facility or Provider that leaves the Preferred Provider Network (or if there is a change in the contract with that facility or Provider that would terminate or result in a loss of your benefits with respect to the facility or Provider) if you are a "continuing care patient" of that facility or Provider at the time the facility or Provider leaves the network (or at the time the contract change is effective). This provision does not apply if the contract for the facility or Provider is terminated for failure to meet applicable quality standards or for fraud.

A "continuing care patient" is someone who, with respect to a specific facility or Provider, is: (i) undergoing a course of Treatment from that facility or Provider for a "serious and complex condition," (ii) undergoing a course of institutional or inpatient care from that facility or Provider, (iii) scheduled to undergo nonelective surgery from that facility or Provider (including the receipt of postoperative care with respect to such surgery), (iv) pregnant and undergoing a course of Treatment for the pregnancy from that facility or Provider, or (v) terminally ill (or was terminally ill) as determined under Section 1861(dd)(3)(A) of the Social Security Act, and is receiving Treatment for such Illness from that facility or Provider. A "serious and complex condition" is: (i) in the case of an acute Illness, a condition that is serious enough to require specialized medical Treatment to avoid the reasonable possibility of death or permanent harm, or (ii) in the case of a chronic Illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and that requires specialized medical care over a prolonged period of time.

If the Contract Administrator determines that you may be eligible for continued care pursuant to this section, then the Contract Administrator will notify you and provide you with an opportunity to elect to continue care. If you make such an election, then you may be able to continue care for up to 90 days from the date you receive the notice. Such continued transitional care would be provided under the same terms and conditions that would have applied and with respect to the items and services as would have been

covered under the Plan if the termination or contract change had not occurred, with respect to the course of Treatment relating to your status as a continuing care patient.
Please contact the Contract Administrator at (888) 222-9206 if you do not receive a notice, but you think you may be eligible for continued care under this section.

Out-of-Area Services

The Contract Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". Whenever you obtain health care services outside of the Vermont service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside of the Vermont service area, you will obtain care from Providers that have a contractual agreement (i.e. are "Preferred Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Non-Preferred Providers. Our Payment practices in both instances are described below.

The BlueCard® Program

Under the BlueCard® Program, when you access covered health care services within the geographic area served by a local Blue Cross Blue Shield Plan ("Host Blue"), the Contract Administrator will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Preferred Providers.

Whenever you access covered health care services outside of the Vermont service area and the claim is processed through the BlueCard® Program, the amount you pay for covered health care services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to the Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Provider or Provider group that may include types of settlements, incentive Payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under estimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Plan uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the calculation of the amount you pay for covered health care services. If any state laws mandate other liability calculation methods, including a surcharge, the Plan would then calculate your liability for any covered health care services according to applicable law.

When covered health care services are provided outside of the Vermont service area by Non-Preferred Providers, the amount you pay for such services will generally be based on either the Host Blue's Non-Preferred Provider local Payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the Non-Preferred Provider bills and the Payment the Plan will make for the covered services as set forth in this paragraph, except as prohibited by applicable law (see the No Surprises Act – Emergency Services and Surprise Bills language herein).

In certain situations (or as required by applicable law), the Plan may use other Payment bases, such as billed covered charges, the Payment the Plan would make if the health care services had been obtained within the Vermont service area, or a special negotiated Payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Plan will pay for services rendered by Non-Preferred Providers. **In these situations, you may be liable for the difference between the amount that the Non-Preferred Provider bills and the Payment we will make for the covered services as set forth in this paragraph,** except as prohibited by applicable law (see the No Surprises Act – Emergency Services and Surprise Bills language herein).

The Blue Cross Blue Shield Global Core Program

If you need Emergency Services when traveling outside the United States, the Blue Cross Blue Shield Global Core Program provides Hospital and professional coverage through an international network of health care Providers. With this program, the Covered Person is assured of receiving care from licensed Health Care Professionals. The program also assures that at least one staff member at the Hospital will speak English, or the program will provide translation assistance. Here's how to use the Blue Cross Blue Shield Global Core Program:

- Call the Blue Cross Blue Shield Global Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, 7 days a week, for the names of participating doctors and Hospitals. Outside the U.S., the Covered Person may use this number by dialing an AT&T Direct Access Number. The Covered Person can also visit the website at www.bcbsglobalcore.com.

- Show your Plan ID card at the Hospital. If the Covered Person is admitted, they will only have to pay for Expenses not covered by the Plan, such as Copayments, Coinsurance, Deductibles, and personal items. Remember to call the Contract Administrator within forty-eight (48) hours after receiving services or care, or as soon as reasonably possible.

- If you receive outpatient Hospital care or care from a doctor in the Blue Cross Blue Shield Global Core Program, pay the bill at the time of Treatment. When you return home, submit an international claim form, and attach the bill. This claim form is available from the health care Provider or by visiting the Blue Cross Blue Shield Global Core website at www.bcbsglobalcore.com. Mail the claim to the address on the form. You will receive reimbursement for any covered Expenses, less any Copayment, Coinsurance, and amount above the Maximum Allowable Benefit.

Physician's Office Visits: Charges for Physician's office visits when the Employee or their Dependent(s) incur Expenses as a result of an Illness or accidental Injury are covered Expenses.

PPO Plan: In-Network: Benefits for a primary care Physician's office visit will be subject to a $20 Copayment per visit, then payable at 100%. Benefits for Physician's office visit by a specialist will be subject to a $50 Copayment per visit, then payable at 100%. All other services provided at the time of the office visit will be subject to the calendar year Deductible and Coinsurance provisions. **Out-of-Network:** Benefits will be subject to the calendar year Deductible and Coinsurance provisions.

Bronze Copay Plan: Benefits for a primary care Physician's office visit will be subject to a $20 Copayment per visit, then payable at 100%. Benefits for Physician's office visit by a specialist will be subject to a $50 Copayment per visit, then payable at 100%. All other services provided at the time of the office visit will be subject to the calendar year Deductible and Coinsurance provisions.

Emergency Services: Charges for Emergency Services are covered Expenses. Charges may include facility fees, Physician fees, x-rays, laboratory tests, and other Medically Necessary services and supplies required in an emergency, unless otherwise specified herein. Benefits are subject to the In-Network calendar year Deductible and Coinsurance provisions. Physician services under the PPO Plan option are subject to a $25 Copayment per visit, then payable at 100%. The Copayment will be waived if the Covered Person is held for observation or admitted within twenty-four (24) hours.

Pre-Certification Requirement: The Plan requires that the following services and procedures be pre-certified by the Contract Administrator in advance, or reimbursement from the Plan may be reduced or denied:

- Non-emergency Hospital admissions;
- Dialysis;
- Chemotherapy;
- Radiation therapy;
- Durable medical equipment or prosthetics in excess of $3,500; and
- Non-emergency air ambulance transport.

Note that pre-certification is not required for Hospital stays in connection with childbirth for the mother or newborn child which are forty-eight (48) hours or less for vaginal deliveries, or ninety-six (96) hours or less for cesarean section deliveries. **It is the Covered Person's responsibility** to be sure that in the event of a Hospital admission for an **Emergency Medical Condition**, the Contract Administrator is notified within **forty-eight (48)** hours. Final determination as to whether a Hospital admission (or air ambulance transport) results from an Emergency Medical Condition will rest solely with the Plan.

When a doctor recommends that the Employee or Dependent receive one of the services or procedures listed above, **it is the Covered Person's responsibility** to notify the Plan and to obtain pre-certification for the services or procedures. In-Network Providers may pre-certify services for a Covered Person; however, the Covered Person is ultimately responsible for obtaining pre-certification and must ensure that the Provider complies with this provision.

If a Covered Person incurs Expenses for services or procedures which have not been pre-certified, a thorough review will be conducted of the services or procedures to determine Medical Necessity at the point of claim. If the review process identifies care which is not Medically Necessary, the services or procedures will not be covered under the Plan. The Plan Administrator retains sole and absolute discretion to determine whether a particular claim will be reduced partially or completely denied. A financial penalty may be deducted from any benefit Payment which may be due for a covered Expense.

In order for the Contract Administrator to pre-certify a non-emergency Hospital admission, the attending Physician must certify to the Contract Administrator that, in the Physician's professional opinion, the stay is necessary for the Covered Person's condition. The Plan reserves the right to request an independent medical opinion by a Physician of the Plan's choice.

Please note that pre-certification does not guarantee coverage of services or procedures. Coverage remains subject to all other requirements of this Plan, such as limitations and exclusions, Payment of required contributions, and eligibility at the time care and services are provided to the Covered Person.

Prescription Drug Program Benefits:

Preventive Drugs: The Plan includes coverage for preventive prescriptions (medications that CBA Blue, in conjunction with its Prescription Benefit Manager, has determined may prevent the occurrence of a disease or condition if the Covered Person has risk factors for that disease or condition, or to prevent the recurrence of a disease or condition if the Covered Person has recovered. Preventive medications may prevent conditions such as: high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, blood clotting, and prenatal nutrient deficiency. Please contact SmithRx for a list of these medications. Preventive medications on SmithRx's Preventive Medications List are payable at 100%. The prescription drug Deductible does not apply,

Retail Prescription Drug Program: The Plan includes a prescription drug program. Prescriptions filled at participating pharmacies are limited to a maximum thirty (30) day supply.

A list of participating pharmacies can be obtained by visiting www.smithrx.com.

All prescribed FDA approved generic contraceptives for women are covered at 100% when received from a participating pharmacy or In-Network Provider. The brand version will be covered at 100% only if Medically Necessary or a generic equivalent is not available.

When filling a prescription for which a generic drug is available and the Covered Person chooses the brand name drug, the Covered Person will be responsible for paying the brand name Copayment plus the difference in cost between the generic and the brand name drug.

Individual prescriptions are subject to the prescription drug calendar year Deductible and Copayments listed below.

Generic Copayment	Preferred Brand Copayment	Non-Preferred Brand Copayment
$5	$35	$75

Prescriptions purchased at non-participating pharmacies will not be covered.

Compound drugs that are not available from a participating pharmacy will be considered a covered Expense subject to the prescription drug calendar year Deductible and applicable participating pharmacy Copayment.

Mail Order Maintenance Prescription Drug Program: Maintenance drugs to treat Illnesses should be purchased through the mail order program. These Illnesses usually include: diabetes, epilepsy, anemia, chronic constipation, arthritis, high blood pressure, tuberculosis, various gastric disease, emphysema, menopause, mental and nervous disorders, thyroid disease, adrenal disease, ulcers, and any other condition that requires continuous medication. Mail order prescriptions are limited to a maximum ninety (90) day supply.

All prescribed FDA approved generic contraceptives for women are covered at 100% when received from a participating pharmacy or In-Network Provider. The brand version will be covered at 100% only if Medically Necessary or a generic equivalent is not available.

When filling a prescription for which a generic drug is available and the Covered Person chooses the brand name drug, the Covered Person will be responsible for paying the brand name Copayment plus the difference in cost between the generic and the brand name drug.

Mail order prescriptions are subject to the prescription drug calendar year Deductible and Copayments listed below.

Generic Copayment	Preferred Brand Copayment	Non-Preferred Brand Copayment
$10	$70	$150

Specialty Drugs: Specialty drugs are prescription medications that are used to treat complex or chronic medical conditions. They are often self-injected or self-administered. Specialty drugs usually require patient specific dosing, careful clinical monitoring, storage, and/or special handling. Specialty Pharmacy prescriptions are limited to a maximum thirty (30) day supply and must be purchased through the SmithRx Specialty Pharmacy.

Step Therapy Program: The Plan has implemented a Step Therapy program in order to assure the Covered Person's access to clinically appropriate medications to treat all conditions.

The Step Therapy program establishes an order of drug therapy options within select categories for Covered Persons to follow.

Maternity Perks Program: The Maternity Perks Program provides additional benefits to members during and after pregnancy. Additional benefits include reimbursement for:

- Car Seats: The Plan provides up to $150 for car seats purchased during pregnancy or up to three (3) months after delivery.
- Maternity Fitness Classes: The Plan provides up to $150 for maternity fitness classes taken during pregnancy and up to three (3) months after delivery.
- Homemaker Services: The Plan provides up to $225 for homemaker services received within the first three (3) months after delivery.
- Educational Classes: The Plan provides up to $125 for educational classes taken during pregnancy and up to three (3) months after delivery dealing with topics like childbirth, siblings, parenting and CPR.

To receive your Maternity Perks Program benefits, the member must file a claim and a paid receipt within six (6) months following delivery. Claim forms are available at your Human Resources office or by visiting our website at www.cbabluevt.com.

MEDICAL COVERED EXPENSES

Expenses incurred for the following medical, health care services, and supplies will be considered a covered Expense, provided the Expenses are (i) Medically Necessary to treat an Illness or Injury, or furnished in connection with participation of a Covered Person in a "Clinical Trial," as such term is defined in this Plan Document, (ii) prescribed or approved by an attending Physician, and (iii) incurred during a period that coverage was in effect in accordance with the applicable provisions of the Plan. Payment of such Expenses will be subject to all applicable Deductibles, Copayments, Coinsurance limits, the maximum benefit limit, and all other exclusions and limitations described in this Plan Document.

This Plan Document is intended to describe the covered Expenses provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in Treatment standards, it is impossible to describe all covered Expenses and/or exclusions with specificity. Please contact the Contract Administrator with questions about specific services, supplies, or Treatments.

1. Inpatient Hospital charges for room and board (including Birthing Centers), operating room, x-rays, physical therapy, radiation therapy, chemotherapy, prescription drugs, anesthesia, laboratory Expenses, Intensive Care Unit, and other Medically Necessary services and supplies during any one (1) period of Hospital Confinement, as shown below. Should the facility have no semi-private rooms or less expensive accommodations available, or the patient's condition requires the Employee or the Employee's covered Dependent to be isolated for their own health or the health of others, the private room rate will be allowed.

   Room and Board:

   semi-private room allowance.....semi-private room rate
   private room allowance.....semi-private room rate
   intensive care allowance.....actual charge (not to exceed the Maximum Allowable Benefit)

2. Outpatient Hospital charges for Medically Necessary services and supplies incurred as a result of an Illness, accident, or as a result of outpatient surgery performed (if performed on the same day), including charges for x-ray and laboratory Expenses, physical therapy, radiation therapy, and chemotherapy.

3. Inpatient Physician visits while the Employee or their Dependents are Hospital confined as a result of an Illness or an accidental Injury. No benefits will be paid for more than one (1) visit per day by any one (1) Physician or for the Treatment received in connection with, on, or after the date of an operation for which a surgical Expense benefit is payable under the Plan if such Treatment is given by the Physician who performed the operation.

4. All Treatment, services, or supplies of a professional anesthesiologist, radiologist, or pathologist.

5. Pre-admission testing, exams, x-ray, and laboratory examinations on an Outpatient Basis made prior to a scheduled Hospital admission and related to a condition previously diagnosed.

6. Local, Medically Necessary, professional air or ground ambulance service for inpatients or for outpatients receiving accident or Illness care to and from the Hospital or medical facility where Treatment is given. Ambulance services are covered only when a Covered Person is transported by a state or federally licensed vehicle that is designed, equipped, and used to transport the sick and injured, and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. Expenses for ambulance service will be covered only if the service is to the nearest Hospital or medical facility where necessary Treatment can be provided unless a longer trip is Medically Necessary.

   Air ambulance is considered a covered Expense only if it is Medically Necessary and the ground ambulance is not advisable. For example, if using a ground ambulance would endanger the patient's health and the patient's medical condition requires a more rapid transport than the ground ambulance can provide, this Plan may cover the air ambulance. Air ambulance is not covered if the patient is taken to a Hospital or medical facility that is not an acute care Hospital (such as a Skilled Nursing Facility), or if the patient is taken to a Physician's office or to the patient's home. If the Covered Person is being transported from one Hospital or medical facility to another, air ambulance will only be covered if using a ground ambulance would endanger the Covered Person's health and if the Hospital that first treats the Covered Person cannot give the Covered Person the medical services the Covered Person needs. For air ambulance services to be covered, the Covered Person must be taken to the closest Hospital or medical facility that can treat the Covered Person. All other non-emergency air ambulance services will not be covered, including but not limited to non-emergency air ambulance transfers made primarily because the Covered Person, the Covered Person's family, or the Covered Person's Physician prefers a specific Hospital or Physician.

   Failure to obtain pre-certification for non-emergency air ambulance services (i.e., not Medically Necessary for an Emergency Medical Condition) may result in a penalty, up to and including a complete denial of benefits for the services.

   A Covered Person must be taken to the nearest facility that can provide care for the Covered Person's condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility. No benefits are provided: for taxi or chair car service; or to transport you to or from your medical appointments. Ambulance services are subject to Medical Necessity reviews.

   Coverage includes Medically Necessary Treatment of an Illness or Injury by medical professionals from an ambulance service, even if you are not transported to a Hospital or medical facility. If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that an Emergency Medical Condition existed, even if you are not transported to a Hospital or medical facility.

7. Emergency room charges for Treatment of an Emergency Medical Condition.

8. Diagnostic x-rays and laboratory charges for Expenses incurred as a result of an Illness or Injury. No benefits are payable for Dental Services except as provided for in this Plan.

9. Treatment by a qualified physical therapist, occupational therapist, speech therapist, or respiratory therapist.

10. The following Dental Services rendered by a Physician, Dentist or oral surgeon:

    - Treatment for or in connection with an accidental Injury to jaws, sound natural teeth, mouth or face provided a continuous course of dental Treatment is started within six (6) months of the accident and covers a reasonable course of Treatment defined as not exceeding five (5) years from the beginning of Treatment.
    - Surgery to correct a gross deformity resulting from major disease or surgery within six (6) months of the onset of the disease or six (6) months after surgery and covers a reasonable course of Treatment defined as not exceeding five (5) years from the beginning of Treatment.
    - Surgery related to head and neck cancer where sound natural teeth may be affected primarily or as a result of the chemotherapy or radiation Treatment of that cancer.
    - Treatment of a congenital or genetic disorder, such as but not limited to the absence of one or more teeth, up to the first molar, or abnormal enamel (example lateral peg).
    - Facility and anesthesia charges for Covered Persons with phobias or a mental Illness documented by a licensed Physician or mental health professional; or with severe disabilities that preclude office-based dental care due to safety considerations; or who are developmentally unable to safely tolerate office-based dental care. Note: the professional charges for the dental services may not be covered.
    - Diagnostic imaging, including but not limited to plain film radiographs and Cone Beam CT (CBCT), performed as part of evaluation of an accidental Injury to the jaws, sound natural teeth, mouth or face, or as part of evaluation to correct gross deformity resulting from major disease or surgery.

    A sound natural tooth is a tooth that is whole or properly restored using direct restorative dental materials (i.e. amalgams, composites, glass ionomers or resin ionomers); is without impairment, untreated periodontal conditions, or other conditions; and is not in need of Treatment provided for any reason other than accidental Injury. A tooth previously restored with a dental implant. crown, inlay, onlay, or treated by endodontics, is not a sound natural tooth.

11. Physician's surgical services for Treatment of an Injury or Illness, if performed in an inpatient or outpatient unit of a Hospital, a freestanding facility, a Physician's office, or a Dentist or an oral surgeon's services for the Treatment of an accidental Injury to sound natural teeth within six (6) months of such Injury will be considered a covered Expense.

12. X-ray, laboratory, and radium Expenses excluding dental x-rays, unless rendered for the Treatment of a fractured jaw, cysts, tumors or Injury to sound natural teeth as a result of an accident will be considered covered Expenses.

13. Professional services of a legally qualified Physician for the care of a covered Illness or accidental Injury.

14. Physician's home and office visits when the Employee or his Dependent incurs Expenses as a result of an Illness or accidental Injury.

15. Services of a surgeon and an assistant surgeon if two (2) or more procedures are performed during the course of a single operation through the same incision or in the same operative field. The fees will be limited to the Maximum Allowable Benefit. Benefits are payable for the professional services of a legally qualified Physician in rendering technical assistance to the operating surgeon when required in connection with a surgical procedure performed on an Inpatient Basis (benefits will not exceed twenty-five (25%) of the Maximum Allowable Benefit for the procedure performed when the assistant is a Physician and ten (10%) when the assistant is a PA). However, no benefits are payable for surgical assistance rendered in a Hospital where it is routinely available as a service provided by a Hospital intern, resident, or house officer.

16. Medically Necessary dressings and medicines, including prenatal vitamins, for which a Physician's prescription is required and dispensed by a licensed pharmacy.

17. Birth control methods. All prescribed Food and Drug Administration (FDA) approved contraceptive methods for women, and patient education and counseling for all women with reproductive capacity are covered at 100% at the In-Network benefit level or when received from a participating pharmacy. All prescribed brand contraceptives will be covered at 100% only if Medically Necessary or a generic equivalent is not available.

18. Diabetic supplies such as insulin, alcohol swabs, blood and urine test strips, lancets, needles and syringes necessary for the administration of prescription drugs and professional instructions, not including printed material for their use. Nutritional counseling and outpatient self-management training and education for people with diabetes is covered. Insulin injection devices are covered under the medical benefits of this Plan, but are not covered under the pharmacy benefits.

19. Medical supplies, such as, but not limited to dressings for cancer or burns, catheters, colostomy and ostomy bags and related supplies.

20. Rehabilitative Care, as defined herein.

21. Sterilizations for male or female. Sterilization procedures for a ***female*** will be covered at 100% at the In-Network benefit level as required under the Affordable Care Act (ACA).

22. Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetics. The Plan covers a device and related supplies only when the device is surgically implanted or worn as anatomic supplement to replace:

    - all or part of an absent body organ (including contiguous tissue and hair);
    - wigs (replacement of the original wig (cranial/scalp prosthesis) is limited to one wig every three (3) years) for hair loss due to chemotherapy and/or radiation therapy for the Treatment of cancer, third-degree burns, traumatic scalp Injury, congenital baldness present since birth, and medical conditions resulting in alopecia areata or alopecia totalis (excluding androgenic alopecia, alopecia barbae, postpartum alopecia, traction alopecia, or other hair loss due to natural or premature aging);
    - the lens of an eye; or
    - all or part of the function of a permanently inoperative, absent or malfunctioning body part.

Prosthetic devices that are attached to (or inserted into) prosthetic shoes and which replace a missing body part are covered.

The Plan will replace one lost, stolen, or destroyed prosthetic per calendar year if not covered by an alternative entity (including but not limited to homeowner's insurance and automobile insurance).

23. Dental prostheses only if required:

- to treat an accidental Injury (except Injury as a result of chewing or biting);
- to correct gross deformity resulting from major disease, congenital anomalies that result in impaired physical function or surgery;
- to treat obstructive sleep apnea; or
- to treat craniofacial disorders, including temporomandibular joint syndrome.

24. Eyeglasses or contact lenses to treat aphakia or keratoconus. The Plan covers only:

- one set of accompanying eyeglasses or contact lenses for the original prescription; and
- one set for each new prescription.

25. Molded, rigid or semi-rigid support devices that restrict or eliminate motion of a weak or diseased body part.

The Plan will replace one lost, stolen, or destroyed orthotic per calendar year if not covered by an alternative entity (including but not limited to homeowner's insurance and automobile insurance).

26. The rental or purchase of durable medical equipment that requires a prescription from the Covered Persons Provider:

- is primarily and customarily used only for a medical purpose;
- is appropriate for use in the home;
- is designed for prolonged and repeated use; and
- is not generally useful to a person who is not ill or injured.

Durable medical equipment includes wheelchairs (manual and electric), hospital-type beds, walkers, canes, crutches, kidney machines, ventilators, oxygen and equipment for its administration, monitors, pressure mattresses, nebulizers, traction equipment, bili blankets, bili lights, and respirators.

The Plan reserves the right to determine whether rental or purchase of the equipment is more appropriate.

Durable medical equipment does not include items such as air conditioners, chair lifts, bathroom equipment, dehumidifiers, whirlpool baths, exercise equipment, motorized scooters and other equipment that has both non-medical and medical uses.

The Plan will replace one lost, stolen, or destroyed durable medical equipment per calendar year if not covered by an alternative entity (including but not limited to homeowner's insurance and automobile insurance) if the durable medical equipment's absence would put the Covered Person at risk of death, disability or significant negative health consequences such as a Hospital admission.

27. Treatment, services, or supplies for or related to an abortion, when such items or services are not prohibited by applicable law.

28. Dialysis.

29. Administration of infusions and transfusions, including the cost of unreplaced blood and blood plasma or autologous blood and blood plasma. Expenses for blood storage fees or blood donor fees are not covered.

30. Maternity care including prenatal, delivery, and postpartum care as well as charges arising from complications that may occur during maternity and delivery. Comprehensive lactation support and counseling, by a trained Provider during pregnancy and/or in the postpartum period, and costs for renting or purchasing non-hospital grade breastfeeding equipment, limited to one breast pump per pregnancy are payable at 100% at the In-Network benefit level.

31. Newborn Care Charges are a covered Expense for an Employee's newborn Dependents. Care of newborn children to include Hospital charges for nursery room and board and miscellaneous Expenses, charges by a pediatrician for attendance at a cesarean section, Physician examination for a newborn while Hospital confined, and circumcisions.

32. Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility/Rehabilitation Hospital charges, but not in excess of a daily charge for room and board, services, and supplies equal to one-half (1/2) of the discharging Hospital's semi-private room rate. The Covered Person must be under the care of an attending Physician who determines the continuing need for the Hospital or facility stay.

33. **Chiropractic Care:** Charges for home, office, and nursing home visits as well as examinations, x-rays, consultations, spinal manipulations, electrical stimulation, and interpretation are covered Expenses.

34. Organ transplant benefits to include charges for organ transplants and peripheral stem cell transplants for the Treatment of cancer are considered a covered Expense when the transplant procedure is not considered Experimental/Investigative and the Covered Person is considered an eligible recipient.

    The Plan pays benefits for the following services related to transplants:
    - Search for a donor;
    - Surgical removal of an organ;
    - Storage and transportation costs for the organ, partial organ or bone marrow; and
    - Costs directly related to the solid organ or bone marrow donation, including costs resulting from complications of the donor's surgery.

    The Plan pays benefits for transplants as follows:
    - If the Plan covers both the recipient and the donor, each receives benefits under their own benefits;

- If the Plan covers the recipient, but not the donor, both receive benefits under the recipient's Plan (benefits available to the recipient will be paid first). The donor will only receive benefits for services that occur within 120 days from the date of the donor's surgery;
- No benefits are available if the Plan covers the donor, but not the recipient.

If the covered organ transplant procedure is not completed, the Plan provided benefits only if the covered organ transplant procedure was scheduled to occur within 24 hours of the donor's surgery.

The Plan does not cover the purchase price of any organ or bone marrow that is sold rather than donated. The Plan also does not cover voluntary transplants, such as uterine transplants as Treatment for infertility.

35. Hospice care charges, as defined herein. Benefits are payable for up to six (6) months of services. The following services are covered when provided by a Hospice Provider:

- skilled nursing visits;
- home health aide services for personal care services;
- homemaker services for house cleaning, cooking, etc.;
- continuous care services in your home;
- respite care services;
- Hospice services in a facility;
- social service visits before the patient's death;
- bereavement visits and counseling for family members up to one (1) year following the patient's death; and
- other Medically Necessary services.

36. **Preventive Care:** Routine physical examinations, well-baby care, and well-adult care are covered Expenses. Charges can include examinations (including breast and pelvic), immunizations, consultations, laboratory tests, pap smears (including laboratory fees), x-rays, mammograms, nutritional counseling (as required under the Affordable Care Act), sterilization procedures for women, and EKG's. The list of preventive care services covered under this benefit may change periodically based upon the recommendation of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. Information on the recommendations of these agencies can be found at: https://www.healthcare.gov/preventive-care-benefits/.

37. **Mental Health and Substance Use Disorder Treatment:** Inpatient mental health care and alcohol and/or drug addiction in a Hospital, public or licensed Mental Hospital, drug/alcohol abuse Treatment facility, or outpatient Mental Health Disorder services provided by a board-certified Physician, a licensed psychologist, clinical or certified social worker or certified alcohol counselor (C.A.C.) will be considered covered Expenses. Charges may include hospitalizations, inpatient rehabilitation, detoxification, short-term residential Treatment programs, psychological testing, individual and group outpatient psychotherapy, family and couples therapy, intensive outpatient programs, partial Hospital day Treatment, psychologist testing when integral to Treatment, and psychotherapeutic programs directed toward improving compliance with prescribed medical Treatment regimens for such chronic condition as diabetes, hypertension, ischemic heart disease and emphysema.

38. **Home Health Care:** The following services or supplies furnished to the Covered Person at home by a licensed Provider or Home Health Care Agency:

    A. Part-time intermittent nursing care by or under the supervision of a registered professional nurse (RN); and/or visits by persons who have completed a home health aide training course under the supervision of registered nurse for the purpose of giving personal care to the patient.

    B. Physician's home and office visits, physical therapy, occupational therapy, speech therapy and infusion therapy.

    C. Medical supplies, laboratory services, drugs, and equipment prescribed by a Physician to the extent such items would have been covered if you or your Dependent had been hospitalized.

    D. **Exclusions and Limitations:** In no event will home health care Expenses include charges for loss resulting from services solely for Custodial Care, transportation services, any period during which you or your Dependent are not under the continuing care of a Physician, Injury, or Illness arising out of or in the course of employment, declared or undeclared war or act of war.

39. Medically Necessary private duty nursing care up to fourteen (14) hours per Covered Person per calendar year rendered on an outpatient basis by a registered graduate nurse (RN) or, services of a licensed practical nurse (LPN) when certified by the attending Physician and a registered graduate nurse (RN) is not available, but only for nursing duties and excluding custodial care.

40. Any taxes and/or surcharges applied to a covered Expense are considered eligible Expenses when the tax or surcharge is mandated by state or federal government until such time that ERISA preemption is clearly established by law prohibiting the applicable tax and/or surcharge.

41. Any of the following services in connection with a mastectomy:

    a) all stages of reconstruction of the breast on which the mastectomy is performed;
    b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c) prostheses and Treatment of physical complications of the mastectomy, including lymphedema; and
    d) mastectomy bras.

    The Women's Health and Cancer Rights Act of 1998 requires the Plan Sponsor to notify you, as a covered participant or Dependent under this Plan, of your rights related to benefits provided through the Plan in connection with a mastectomy. You as a covered participant or Dependent under this Plan have rights for coverage to be provided in a manner determined in consultation with your attending Physician for the above referenced services.

42. The Plan will reimburse otherwise eligible medical covered Expenses for "Patient Care Services," as such term is defined in this Plan Document, furnished in connection with participation of a Covered Person in a "Clinical Trial," as such term is defined in this Plan Document, which is intended to treat cancer or other life-threatening condition in a patient who has been so diagnosed. A copy of the "Clinical Trial" protocol may be required in order to determine if benefits are available under this Plan. Nothing herein shall create a presumption that the Employer recommended, directed, endorsed, or required any Covered Person's participation in a Clinical Trial.

43. Smoking cessation Treatment will be covered at 100% when received from an In-Network Provider or participating pharmacy to a maximum of two (2) quit attempts per calendar year, consisting of:

- Four (4) sessions of telephone, individual or group counseling lasting at least ten (10) minutes per quit attempt; and,
- All FDA approved smoking cessation medications (prescription and over-the-counter) for a 90-day supply Treatment regimen when prescribed by a health care Provider.

44. Nutritional counseling (when not part of preventive services as required under ACA). Nutritional Counseling when part of ACA is covered as a Preventive Service benefit.

45. Medical foods or formulas and supplements administered through a feeding tube as determined to be Medically Necessary.

46. Allergy testing (percutaneous, intracutaneous, patch, and RAST testing).

47. Routine pediatric vision exams to a maximum of one (1) exam per Covered Person per calendar year up to age nineteen (19).

48. Pediatric vision hardware limited to one (1) pair of frames and lenses for prescription glasses or one pair of equivalent contact lenses per Covered Person per calendar year up to age nineteen (19).

49. Routine pediatric dental exams are limited to two (2) exams per Covered Person per calendar year up to age nineteen (19).

50. Acne medications, including Isotretinoin (Accutane).

51. Female libido enhancement drugs and male impotence medications.

52. Medically Necessary services related to Autism Spectrum Disorder (ASD), which includes Asperger's Syndrome, moderate or severe Intellectual Disorder, Rett Syndrome, Childhood Disintegrative Disorder (CDD) and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS).

53. Gender-affirming care services when Medically Necessary.

GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

Expenses incurred for the following items will be considered excluded or limited, as explained in this section. The Plan Administrator will resolve, in its sole discretion, any question that arises as to whether an item is excluded or limited under the Plan.

1. Confinement, Treatment, services, or supplies except to the extent herein provided which are:
    a) not furnished or ordered by a recognized Provider and not Medically Necessary to diagnose or treat an Illness or Injury;
    b) Experimental or Investigational in nature, except for certain off-label cancer drugs and drugs administered as part of certain clinical cancer trials.

2. Services for disease or Injury sustained as a result of war, declared or undeclared. For all purposes of this Plan, terrorism is considered an act of war.

3. Services for disease or Injury sustained as a result of participation in a riot or civil disobedience.

4. Services for disease or Injury sustained while committing or attempting to commit a criminal act or engage in an illegal activity. This exclusion does not apply if the Injury resulted from being the victim of an act of domestic violence or resulted from a documented medical condition (including both physical and mental health conditions), even if the condition if not diagnosed before the Injury.

5. Services, supplies, and/or Treatment a Covered Person incurs while confined and/or arising from confinement in a prison, jail, or other penal institution.

6. Any accidental bodily Injury or Illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion applies to all covered individuals, including but not limited to, self-employed individuals who choose not to provide themselves with insurance coverages, including, but not limited to, workers' compensation and occupational disease insurance, regardless of whether such coverage or coverages are required by law.

7. Services, supplies, and/or Treatment a Covered Person incurs while on full-time active duty in the armed forces of any country, combination of countries or international authority.

8. Dental Services, except to the extent expressly treated as a covered Expense in this Plan Document.

9. Vision therapy or orthoptics, except following surgery to the muscles controlling the eye or in Treatment of strabismus.

10. Eye refractions and any corrective Treatment or surgery to correct a refractive error (i.e. such as hyperopia, myopia, astigmatism, or radial keratotomy, etc.) or eye examinations for the purpose of prescribing corrective lenses (except eye examinations for children up to age 19 are covered as provided herein), or fitting or actual cost of corrective lenses except to the extent expressly treated as a covered Expense in this Plan Document (i.e. intra-ocular implant of lenses in the Treatment of cataracts and vision hardware for children up to age 19 as provided herein).

11. Hearing aids or examinations for the prescription or fitting of hearing aids.

12. Treatment, services, supplies, and facilities provided by or in a Hospital owned or operated by any government or agency thereof where such care is provided at government Expense under a Plan or program established pursuant to the laws or regulations of any government or under a Plan or program under which any government participates other than as an Employer. The term "any government" includes the federal, veteran, state, provincial, municipal, local government, or any political subdivision thereof, of the United States or any other country. The Plan will not exclude benefits for a Covered Person who receives billable medical care at any of the above facilities.

13. Treatment, services, or supplies provided by the Employee, spouse, parent, son, daughter, brother, or sister of a Covered Person or by a member of the Covered Person's household.

14. Treatment, services, or supplies for which there is no legal obligation to pay or for which no charges would be made if the person had no medical or dental coverage.

15. Treatment, services, or supplies for which the Covered Person recovers the cost by legal action or settlement.

16. Reverse sterilizations.

17. Cosmetic or reconstructive surgery, except for Medically Necessary Expenses:

    a) to repair or alleviate the damage from an accident; or
    b) incurred for reconstructive surgery following a mastectomy or for surgery and reconstruction of the other breast to produce symmetrical appearance; or
    c) incurred as a result of a birth defect.

18. Custodial Care.

19. Routine foot care, to include Treatment of corns, callouses, bunions (except capsular or bone surgery), flat feet, subluxations of the feet, toenails, fallen arches, weak feet, or chronic foot strain and symptomatic complaints of the feet. This exclusion does not apply to necessary foot care for Treatment of diabetes.

20. Home or automobile modifications like air conditioners, HEPA filters, humidifiers, stair glides, elevators, lifts, motorized scooters, whirlpools, furniture or "barrier-free" construction, even if prescribed by a Physician. This exclusion does not apply to manual hydraulic patient lifts, commonly known as "Hoyer" lifts.

21. Treatment of obesity, except surgical Treatment when determined Medically Necessary. Weight loss medications, including anti-obesity, anorexiants, and appetite suppressants are covered with prior authorization.

22. Telephone, radio, television, and beautification services or for the preparation of reports, evaluations, and forms, or for missed appointments or for time spent traveling or in connection therewith that may be incurred by the Physician or Dentist or other Health Care Professional in the course of rendering services.

23. Procedures which do not correct the condition of infertility but are used to induce pregnancy such as artificial insemination, in-vitro fertilization, embryo transplantation, hormone therapy or gamete intra-fallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or any variations of these procedures including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, or cryopreservation of donor sperm and eggs.

24. Routine or elective Expenses except to the extent expressly treated as a covered Expense in this Plan Document. This exclusion includes but is not limited to shoe inserts, ankle pads, special shoes not attached to a brace (except with a diagnosis of diabetes), printed material, arch supports, elastic stockings, fluoride (except as required under the Affordable Care Act (ACA), vitamins (except prenatal), over-the-counter vitamins, food supplements, and any "over-the-counter drug" which can be purchased with or without a prescription or when no Injury or Illness is involved.

25. Treatment, services, or supplies incurred prior to the Covered Person's Effective Date of Coverage under this Plan or following the termination date of coverage under this Plan.

26. A portion of a charge for Treatment, services, or supplies in excess of the Maximum Allowable Benefit, or otherwise in excess of any amount specified by the terms of the Plan, as determined by the Contract Administrator.

27. Treatment, services, or supplies required as a result of complications from a Treatment or service not covered under the Plan, except as specified herein or required by law.

28. Biofeedback training or equipment or other forms of self-care or self-help training.

29. Massage therapy or rolfing.

30. Acupuncture, acupressure, hypnotherapy, homeopathic or naturopathic remedies. This exclusion does not apply to Medically Necessary covered services when performed within the scope of a naturopathic Provider's license.

31. Surrogacy related pregnancy and related costs, including prenatal and delivery Expenses, and all medical costs associated with the pregnancy if the pregnancy originates from or is related to a surrogacy arrangement. This exclusion also applies to a gestational carrier arrangement.

32. Never Events.

33. Work-hardening programs.

34. Physical, psychiatric, and psychological exams or Treatments and related services that are required by third parties. Some examples of non-covered services are: exams and tests that are required for recreational activities, employment, insurance, school, and court-ordered exams and services.

35. Treatment, services, or supplies when the Covered Person chooses to stay in a Hospital or another health care facility beyond the discharge time that is determined by the Plan.

36. Education, educational evaluation or therapy (except for the diagnosis or Treatment of Mental Health or Substance Use Disorder), therapeutic boarding schools, services that should be covered as part of an evaluation for, or inclusion in, a child's individualized education plan (IEP) or other educational program. This exclusion does not apply to Treatment of diabetes, such as medical nutrition therapy.

37. Surgical removal of bony impacted teeth.

38. Blood storage fees and blood donor fees.

39. Any Treatment, durable medical equipment, supplies, or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience.

40. Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other than activities of daily living (e.g. knee braces for skiing, running, or hiking), weight loss or exercise programs; health club or fitness center memberships.

41. Food and nutritional formulas or supplements, except for "medical foods" or formulas and supplements administered through a feeding tube as determined to be Medically Necessary. This exclusion does not apply to 100% amino acid formula, which may be determined as Medically Necessary.

42. Support therapies, including pastoral counseling, assertiveness training, dream therapy, equine therapy, hippotherapy, music or art therapy, recreational therapy, stress management, wilderness programs, therapy camps, retreat centers, adventure therapy and bright light therapy.

43. Communication devices and communication augmentation devices. Computer technology or accessories and other equipment, supplies or Treatment intended primarily to enhance occupational, recreational, or vocational activities, hobbies, or academic performance.

44. Dynamic splinting, patient-actuated end-range motion stretching devices and programmable or variable motion resistance devices.

45. Pneumatic cervical traction devices, except when the Covered Person has a diagnosis of Temporomandibular Joint Syndrome (TMJ).

46. Automatic or manual home blood pressure cuffs.

47. Tinnitus masking devices.

48. Clinical ecology, environmental medicine, inpatient confinement for environmental change or similar Treatment.

49. Immunizations purchased in bulk, such as those provided to a group of people and billed collectively rather than individually.

50. Electrical stimulation devices used externally. This exclusion does not apply to bone growth stimulators, transcutaneous electrical nerve stimulation (TENS) devices, or neuromuscular stimulators.

51. Cognitive training or retraining or educational programs, including any program designed principally to improve academic performance, reading, or writing skills. This exclusion does not apply to the diagnosis or Treatment of Mental Health or Substance Use Disorder.

52. Specialized examinations, services or supplies required by your Employer or for sports/recreational activities (e.g. driver's certifications, pilot flight physicals, etc.).

53. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).

54. Services including long-term residential programs, adventure-based activities, wilderness programs and residential programs, that focus on education, socialization, or delinquency.

55. Treatment for hair loss due to androgenic alopecia, alopecia barbae, postpartum alopecia, traction alopecia, and/or natural or premature aging.

56. Replacement of or duplicates of durable medical equipment and supplies, orthotics and prosthetics.

CLAIM FILING PROCEDURES

Written notice of the Employee or the Employee's Dependent's claim (proof of claim) must be received by the Contract Administrator as soon as is reasonably possible, by the later of:

a. the six (6) months after the occurrence or commencement of any loss, benefit, or Expense covered by the Plan, except for any Blue Cross Blue Shield of Vermont Provider contracts that have billing submission limits of up to twelve (12) months.
b. the timely filing provision deadline defined in the Provider's contract with the Host Plan.

For the purposes of this section, a claim is considered "received" once it is both in possession by the Host Plan and capable of being processed by the Contract Administrator. An incomplete or incorrect claim is not considered "received."

Failure to furnish written proof of claim within the time required will invalidate the claim, except in the case of the Covered Person's legal incapacity. Coverage is based on the Plan's provisions at the time the loss is incurred. It is the Employee's responsibility to inform his Provider(s) of this claim submission time limit.

Filing an In-Network or Out-of-Network Medical Claim:

To obtain benefits under this Plan, a diagnostic bill must be submitted that provides sufficient information, including the Employee's name, Claimant's name, Claimant's address, and Contract Administrator Group Number to allow the Contract Administrator to properly adjudicate each claim. The Contract Administrator may require additional forms and information to assist them in this process. The Covered Person should instruct their medical care Providers, both In-Network and Out-of-Network, to mail claims to the applicable following address:

Vermont Providers send claims to:

CBA Blue
P.O. Box 2365
South Burlington, VT 05407-2365

Providers outside of Vermont: File claims with your local Blue Cross & Blue Shield Plan.

Note that the No Surprises Act requires the Plan to follow a specific process for paying Providers and facilities for Out-of-Network claims covered by the No Surprises Act, and that Payment process may include an independent dispute resolution process between the Plan and your Out-of-Network Provider. That separate Payment process is applicable to the Out-of-Network Provider -- not to you -- and is different from the claims review procedures explained in this document. You must follow the claims review procedures explained below to request benefits or address any benefit dispute under the Plan.

[Should the Employee have any questions, please feel free to call or write to the Contract Administrator.]

CLAIM REVIEW PROCEDURES

I. Failure to Follow Pre-Service Claim Procedures:

In the case of a failure by a Claimant or an authorized representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim, the Claimant or representative will be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of a failure to file a Claim involving Urgent Care) following the failure. This notification will be oral unless written certification is requested by the Claimant or authorized representative. This section shall only apply in the case of a failure that:

1. Is a communication by a Claimant or an authorized representative of a Claimant that is received by the Pre-Certification Administrator; and

2. Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific Treatment, service or product for which approval is requested.

II. Timing of Notice of Benefit Claim Determinations:

(a) Provisions Applicable to All Benefits Under the Plan.

(i) The various time periods set forth in this Section II within which benefit determinations must be made shall begin at the time a claim is filed in accordance with these Claim Review Procedures without regard to whether all the information necessary to make a benefit determination accompanies the filing.

(ii) If any period of time set forth in this Section II is extended because of a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant until the earlier of (a) the date on which the Claimant responds to the request for additional information, or (b) the last day of the period provided to the Claimant to respond to the request for additional information.

(b) Additional Provisions Applicable to Health (including Prescription Drug) Benefits.

(i) Urgent Care Claims: In the case of a Claim involving Urgent Care, the Contract Administrator will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical urgencies, but not later than seventy-two (72) hours after receipt of the claim by the Contract Administrator, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Contract Administrator will notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Contract Administrator, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information.

Notification of any Adverse Benefit Determination will be made in accordance with the requirements set forth in Section III, Written Denial Provisions, below. The Contract Administrator will notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

1. The Contract Administrator's receipt of the specified information, or

2. The end of the period afforded the Claimant to provide the specified additional information.

(ii) Concurrent Care Decisions: If an ongoing course of Treatment to be provided over a period of time or number of Treatments has been approved by the Plan, any reduction or termination by the Plan of such course of Treatment (other than by Plan amendment or termination) before the end of such period of time or number of Treatments shall constitute an Adverse Benefit Determination. The Contract Administrator will notify the Claimant, in a manner in accordance with the Written Denial provisions set forth below, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Claimant to extend the course of Treatment beyond the period of time or number of Treatments that is a Claim involving Urgent Care shall be decided as soon as possible, taking into account the medical urgencies, and the Contract Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Contract Administrator, provided that any such claim is made to the Contract Administrator at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of Treatments. Notification of any adverse determination concerning a request to extend the course of Treatment, whether involving Urgent Care or not, shall be made in accordance with the Written Denial provisions set forth below, as appropriate.

(iii) Pre-Service Claim: In the case of a Pre-Service Claim, the Contract Administrator shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Contract Administrator. The period may be extended one time by the Plan for up to fifteen (15) days, provided that the Contract Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the information, and the Claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with the Written Denial provisions set forth below.

(iv) Post-Service Claim: In the case of a Post-Service Claim, the Contract Administrator shall notify the Claimant, in accordance with the Written Denial provisions set forth below, of the Plan's Adverse Benefit Determination within a reasonable period of time, but not more than thirty (30) days after receipt of the claim. This period may be extended one time by the Contract Administrator for up to fifteen (15) days, provided that the Contract Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the information, and the Claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

III. Written Denial Provisions

(a) Provisions Applicable to All Benefits under the Plan. The Contract Administrator shall provide a Claimant with written or electronic notification of any determination of a claim. In the case of an Adverse Benefit Determination, the notification shall set forth in a manner calculated to be understood by the Claimant:

(i) The specific reason(s) for the denial;

(ii) Specific references to pertinent Plan provisions upon which the denial is based;

(iii) A description of any additional material or information necessary for the Claimant to perfect the claim, and an explanation of why such material or information is necessary;

(iv) An explanation of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

(b) Additional Provisions Applicable to Health (including Prescription Drug) Benefits. In the case of an Adverse Benefit Determination concerning health benefits, the notification shall also set forth in a culturally and linguistically appropriate manner calculated to be understood by the Claimant:

(i) The specific internal rule, guideline, protocol, or other similar criterion if such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

(ii) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(iii) In the case of an Adverse Benefit Determination concerning a Claim involving Urgent Care, a description of the expedited review process applicable to such claims;

(iv) In the case of an Adverse Benefit Determination concerning health benefits: (a) information sufficient to identify the claim involved (including the date of service, the Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the Treatment code and its corresponding meaning); and (b) the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim; and

(v) In the case of an Adverse Benefit Determination concerning health benefits, a description of available internal appeals and external review processes, including information regarding how to initiate an appeal, and the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above in this Section III may be provided to the Claimant orally, provided that a written or electronic notification is furnished to the Claimant not later than three (3) days after the oral notification.

IV. Appeal of Adverse Benefit Determinations

(a) Provisions Applicable to All Benefits under the Plan.

(i) Each Claimant shall be afforded a full and fair review of any Adverse Benefit Determination. In addition to complying with the other requirements described in these Claim Filing Procedures, the Contract Administrator will provide a Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Contract Administrator in connection with its review of a Claimant's appeal. Such information will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is to be provided to the Claimant so that the Claimant will have a reasonable opportunity to respond prior to that date. In addition, if the Contract Administrator intends to issue an Adverse Benefit Determination on a Claimant's appeal that is based on a new or additional rationale from the one on which the claim was originally decided, the Claimant shall be provided, free of charge, with the new or additional rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is to be provided to the Claimant so that the Claimant will have a reasonable opportunity to respond prior to that date.

(ii) Each Claimant may appeal an Adverse Benefit Determination within one hundred eighty (180) days following receipt of notification of the Adverse Benefit Determination.

(iii) In connection with such review, the Claimant shall have the opportunity to submit any written comments, documents, records, or other information the Claimant believes is Relevant.

(iv) In connection with such review, the Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's appeal.

(v) The review of the Adverse Benefit Determination shall take into account all comments, documents, records and other information submitted by the Claimant that relate to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(b) Additional Provisions Applicable to Health (including Prescription Drug) Benefits.

(i) The review shall not afford deference to the initial Adverse Benefit Determination.

(ii) The review shall be conducted by an appropriate named Fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the review, nor a subordinate of such individual.

(iii) In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular Treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the person conducting the review will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Health Care Professional engaged for purposes of consultation in accordance with the previous sentence shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual.

(iv) The identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided to the Claimant upon request.

(v) In the case of a Claim involving Urgent Care, an expedited review process will be provided, pursuant to which a request for an expedited appeal to an Adverse Benefit Determination may be submitted orally or in writing by the Claimant and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

V. Timing of Notice of Benefit Determination Following Review

(a) Provisions Applicable to All Benefits under the Plan.

(i) The various time periods set forth in this Section V within which the review of an Adverse Benefit Determination must be completed shall begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a determination on review accompanies the filing.

(ii) If the period set forth in this Section V is extended as permitted therein due to a Claimant's failure to submit information necessary to decide a claim, the period for making the determination on review shall be tolled from the date on which the notification of the extension is sent to the Claimant until the earlier of (a) the date on which the Claimant responds to the request for additional information, or (b) the last day of the period provided to the Claimant to respond to the request for additional information.

(b) Additional Provisions Applicable to Health (including Prescription Drug) Benefits.

(i) Urgent Care Claims: In the case of a Claim involving Urgent Care, the Contract Administrator shall notify the Claimant, in accordance with the Notification of Benefit Determination provisions below, of the Plan's benefit determination on review as soon as possible, taking into account the medical urgencies, but not later than seventy-two (72) hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Plan.

(ii) Pre-Service Claims: In the case of a Pre-Service Claim, the Contract Administrator shall notify the Claimant, in accordance with the Notification of Benefit Determination provisions below, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than thirty (30) days after receipt by the Plan of the Claimant's request for review of an Adverse Benefit Determination.

(iii) Post-Service Claims: In the case of a Post-Service Claim, the Contract Administrator shall notify the Claimant, in accordance with the Notification of Benefit Determination, of the Plan's benefit determination on review within a reasonable period of time. Such notification shall be provided not later than sixty (60) days after receipt by the Plan of the Claimant's request for review of an Adverse Benefit Determination.

VI. Notification of Benefit Determination

(a) Provisions Applicable to All Benefits under the Plan. The Contract Administrator shall provide a Claimant with a written or electronic notification of a Plan's benefit determination on review. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant:

(i) The specific reason(s) for the adverse determination;

(ii) Reference to the specific Plan provisions on which the benefit determination is based;

(iii) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim for Benefits;

(iv) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under Section 502(a) of ERISA; and

(v) A statement describing the Claimant’s right, if any, to request external review of a final internal Adverse Benefit Determination or Adverse Benefit Determination, as provided under the Patient Protection and Affordable Care Act of 2010.

(b) Provisions Applicable to Health (including Prescription Drug) Benefits. In the case of an Adverse Benefit Determination on review concerning health benefits, the notification shall also set forth, in a culturally and linguistically appropriate manner calculated to be understood by the Claimant:

(i) The specific internal rule, guideline, protocol, or other similar criterion if such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

(ii) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(iii) In the case of an Adverse Benefit Determination concerning health benefits: (a) information sufficient to identify the claim involved (including the date of service, the Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the Treatment code and its corresponding meaning); and (b) the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;

(iv) In the case of an Adverse Benefit Determination concerning health benefits, a description of available internal appeals and external review processes, including information regarding how to initiate an appeal, and the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes;

(v) In the case of an Adverse Benefit Determination concerning health benefits, the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."; and

(vi) A description of any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

VII. Two Levels of Appeal

This Plan requires two levels of appeal by a Claimant before the Plan's internal appeals are exhausted. To exhaust internal appeals as required under this Plan, a Claimant or its authorized representative must both file an appeal of an initial Adverse Benefit Determination, constituting the initial post-service internal appeal, and file an appeal of the Adverse Benefit Determination issued in response to the initial internal appeal. That second internal appeal will constitute the final required level of appeal, and if the Plan issues an Adverse Benefit Determination in response to that Final Post-Service Appeal, such Adverse Benefit Determination will constitute the Final Adverse Benefit Determination.

VIII. Deemed Exhaustion of Internal Claims Procedures and De Minimis

(a) Final Internal Adverse Benefit Determination

(i) Upon receipt, review, adjudication and conclusion of a Final Post-Service Appeal, if it is determined by the Plan Fiduciary – either the Plan Administrator, Plan Sponsor, and/or other named Fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE – that benefits and/or coverage is not available from the Plan as it relates to claims for benefits submitted to the Plan; when such a final Adverse Benefit Determination is made, by either the Plan Administrator, Plan Sponsor, and/or other named Fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE, the determination will be final and binding on all interested parties.

(b) Exception to the Deemed Exhaustion Rule

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

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

IX. External Review Process

(a) The federal external review process does not apply to a denial, reduction, termination, or a failure to provide Payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health Plan.

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

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

(ii) An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and Cost-Sharing protections set forth in the No Surprises Act.

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

Standard external review

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

(a) Request for external review. The Plan will allow a Claimant to file a request for an external review with the Contract Administrator if the request is filed **within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination**. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

(b) a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

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

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.

(ii) The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).

(iii) The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under applicable law.

(iv) The Claimant has provided all the information and forms required to process an external review.

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

(e) Referral to Independent Review Organization. If the claim is eligible for external review, the Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Contract Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(f) Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or Payment for the claim without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

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

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

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

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

X. Legal Action

You must exhaust the mandatory levels of appeal in this Plan before you request external review or seek other legal recourse. No legal action may be brought until the Plan's claims and appeals procedures have been exhausted. After completing the claims and appeals procedures, should you wish to bring any legal action against the Plan, the Employer, and/or the Contract Administrator, you must bring any such lawsuit within twelve (12) months after the date of notification of the final decision upon appeal. If you fail to bring any such lawsuit within that timeframe, or if you fail to exhaust the Plan's claims and appeals procedures (including failure to timely file any request for review), you will lose any right you have to further review/appeal or to file a lawsuit (as applicable), and the Plan Administrator's (or its delegate's) decision will be final and binding.

XI. Recovery of Payments

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

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

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

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

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

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

(i) In error.
(ii) Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
(iii) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
(iv) With respect to an ineligible person.
(v) In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Subrogation, Reimbursement & Third-Party Recovery provisions.
(vi) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (vi) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

(g) The deduction may be made against any Claim for Benefits under this Plan by a Claimant or by any of his covered Dependents if such Payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

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

MISCELLANEOUS PROVISIONS

No Assignment of Benefits: Rights and benefits under the Plan shall not be assignable to any third parties, including but not limited to medical Providers, at any time.

As explained in this provision, the Plan may make Payments directly to a Provider under an assignment of Payment in the interests of convenience to a Covered Person. However, an assignment of Payment is not considered an assignment of rights or benefits and such Payments do not make a Provider an assignee or otherwise confer on the Provider any rights under the Plan, including but not limited to any right to claim any breach of Fiduciary duty, to recover benefits under the Plan, to enforce rights due under the Plan, or to any other cause of action which the Covered Person may have against the Plan or its Fiduciaries. This provision does not prohibit a Covered Person from designating an individual to act on their behalf but will not confer or transfer to that person any rights or benefits. A Covered Person may not interpret or rely upon the direct Payment of a Provider by the Contract Administrator as constituting authority to assign any other rights or benefits under the Plan to any party.

A Covered Person may assign Payment under the Plan to a Provider from whom the Covered Person receives covered benefits. In the absence of a written agreement with a Provider, the Contract Administrator reserves the right to make benefit Payments to a Provider directly under this assignment of Payment or, alternatively, to make benefit Payments to the Covered Person, as the Contract Administrator elects in its sole discretion. When benefit Payments are made directly to the Covered Person, the Covered Person will be responsible for paying the Provider.

Where benefit Payments are allowable in accordance with the terms of this Plan, Payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Should the Claimant be deceased, Payment shall be made to the Claimant's heir, assign, agent, or estate (in accordance with written instructions), or, if there is no such arrangement and in the Contract Administrator's sole discretion, the institute and/or Provider who provided the care and/or supplies for which Payment is to be made - regardless of whether an assignment of Payment occurred.

For purposes of this provision, the term "assignment of Payment" is defined as an arrangement whereby a Covered Person of the Plan assigns their right to seek and receive Payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. The Plan may rely on any assignment of Payment presented by a Covered Person or Provider. The Covered Person may revoke an assignment of Payment in writing at any time, effective with respect to any Payments not yet made to the Provider. The Contract Administrator may, in its sole discretion, decide not to honor an assignment of Payment for any Provider at any time, regardless of whether it made direct Payments to the Provider in the past. If a Provider accepts this arrangement, the Provider's rights to receive Payments from the Plan are equal to those of the Covered Person and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an assignment of Payment and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for services or Treatment rendered and is bound by rules of this Plan. If benefits for medical Expenses are paid directly to the Covered Person, the Plan will be deemed to have fulfilled its obligation with respect to such benefits.

Discharge: All Plan benefits made in accordance with the terms and provisions contained herein will discharge the Plan Sponsor from all future liability to the extent of the Payments so made.

Discretionary Authority: The Plan is administered by the Plan Administrator (which may be the Plan Sponsor, or another entity appointed by the Plan Sponsor for this purpose) in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan Administrator (or the PACE insofar as it relates to Final Post-Service Appeals) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan. The Plan Administrator, Plan Sponsor, and/or any other Fiduciary appointed by the Plan Sponsor for this purpose, reserves the right to allocate certain discretionary authority as it applies to assessment and final determinative authority on and regarding Final Post-Service Appeal[s], to the "PACE."

Except for functions reserved by the Plan to the Employer or Board of Directors, the Plan Administrator will control and manage the operation and administration of the Plan. In accordance with Sec. 503 of Title I of ERISA, the Plan Administrator may delegate to one or more other named Fiduciaries under the Plan authority to review all denied claims for benefits under the Plan with respect to which it has been designated named Fiduciary (including, but not limited to, the denial of certification of Medical Necessity of Hospital or medical Treatment). In exercising its Fiduciary responsibilities, the named Fiduciary will have discretionary authority to determine whether and to what extent participants and beneficiaries are entitled to benefits and to construe disputed or doubtful Plan terms. The named Fiduciary will be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

The PACE's Fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator, Plan Sponsor and/or any other Fiduciary appointed to act on behalf of the Plan complies. An entity that may perform services as the PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator and/or Plan Sponsor, but not as the PACE, and the PACE shall only be deemed to be a Fiduciary when making final determinations regarding Plan coverage and claims examined via Final Post-Service Appeal. All other matters, including, but not limited to, other appeals that are "not" Final Post-Service Appeals, and matters the Plan Administrator, Plan Sponsor and/or any other Fiduciary appointed to act on behalf of the Plan is prohibited from referring to the PACE in accordance with applicable law and/or pre-existing contract.

The PACE shall at all times strictly abide by, and make determination(s) in accordance with, the terms of the Plan and applicable law. In instances where the Plan Administrator, Plan Sponsor, and/or any other Fiduciary appointed by the Plan Sponsor for this purpose, delegates Fiduciary authority to the PACE to make a determination regarding a Final Post-Service Appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or any other Fiduciary appointed by the Plan Sponsor for this purpose, in this limited scope only. In such instances, the PACE's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, Plan Sponsor and/or any other Fiduciary appointed to act on behalf of the Plan, shall absolve the PACE of any and all Fiduciary (and other) liability, responsibility, obligations, and/or duties.

Duties and Rights of the PACE: When the PACE is assigned by the Plan Administrator, Plan Sponsor and/or any other Fiduciary appointed to act on behalf of the Plan, the task of making a determination regarding a Final Post-Service Appeal, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or other named Fiduciary assigned authority and the duty to otherwise handle appeals, only insofar as it relates to said Final Post-Service Appeals. Assignment is achieved by and when the Plan Administrator, Plan Sponsor and/or any other Fiduciary appointed to act on behalf of the Plan advances a request for a Final Post-Service Appeal, received by the Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding the Final Post-Service Appeal.

Federal Guidelines for a Plan Subject to ERISA: This Plan will comply with all federal laws and guidelines relative to welfare benefit Plans as required with respect to this Plan under ERISA. These federal laws and guidelines will supersede any provisions and terminology contained herein which may be to the contrary.

Family and Medical Leave Policy: All eligible Employees have the right to take family and medical leave according to the provisions of the federal and state laws as amended from time to time, as well as applicable Northern Counties Health Care, Inc. policies and procedures.

Increases/Decreases in Coverage: Any amendments to the Plan providing an increase in the amount of a covered Employee's and/or Dependent's Coverage will become effective as of the effective date stated in such amendment, provided coverage is in effect on that date. Any amendment to the Plan providing a decrease in the amount of a covered Employee's and/or Dependent's Coverage will begin on the effective date stated in such amendment.

Invalidity of Certain Provisions: If any provisions of the Plan will be held invalid or unenforceable, such invalidity or enforceability will not affect any other provision herein and this Plan will be construed and enforced as if such provisions had not been included.

Medicare Program Provisions:
When you (or your covered spouse or Dependent) are eligible for Medicare and Medicare is allowed by federal law to be the primary payor, the coverage provided by this Plan will be reduced by the amount of benefits allowed under Medicare for the same covered services. This reduction will be made whether or not you (or your covered spouse or Dependent) actually receive the benefits from Medicare.

The following provisions explain when federal law requires that this Plan be the primary payor, meaning that this Plan will provide benefits before Medicare benefits:

Under Age 65 with End Stage Renal Disease (ESRD)
If you are under age 65 and are eligible for Medicare only because of ESRD (end stage renal disease), the benefits of this Plan will be provided before Medicare benefits (that is, this Plan will pay first, and Medicare will pay second). This is the case only during the first 30 months beginning on the date you are first eligible to enroll in Medicare due to your ESRD. After 30 months, Medicare will become the primary payor and the benefits that are provided by this Plan will be reduced by the amount that Medicare allows for the same covered services.

Under Age 65 with Other Disability

If the covered Employee's Employer group normally employed 100 or more Employees on a typical day in the previous calendar year and if you are under age 65 and you are eligible to enroll in Medicare only because of a disability other than ESRD, then this Plan will provide benefits before Medicare benefits. However, this rule applies **only** if you are an actively employed Employee or the enrolled spouse or Dependent of the actively employed Employee. If you are an inactive Employee or a retiree or the enrolled spouse or Dependent of the inactive Employee or retiree, then Medicare will be the primary payor and the benefits that are provided by this Plan will be reduced by the amount that Medicare allows for the same covered services. (In some cases, this provision also applies to certain smaller Employer groups. The Plan Sponsor can tell you if it applies to your group.)

Age 65 or Older

If you are age 65 or older and are eligible for Medicare only because of age, this Plan will provide benefits before Medicare benefits. However, this rule applies **only** if you are an actively employed Employee or the enrolled spouse of the actively employed Employee. If you are an inactive Employee or a retiree or the enrolled spouse or Dependent of the inactive Employee or retiree, then Medicare will be the primary payor and the benefits that are provided by this Plan will be reduced by the amount that Medicare allows for the same covered services. Please note that, even if you are an actively employed Employee age 65 or older, you and/or your spouse have the option of enrolling in Medicare and declining coverage under this Plan if you would prefer.

Dual Medicare Eligibility

If you are eligible for Medicare because of ESRD and also eligible for Medicare because of a disability or your age, please contact the Plan Administrator to determine if this Plan or Medicare is the primary payor based on your individual circumstances.

Qualified Medical Child Support Orders: Participants and beneficiaries may obtain upon request from the Contract Administrator, without charge, a copy of the Plan's procedures relating to qualified medical child support orders.

Right to Make Payments: The Plan Administrator has the right to pay any other organization as needed to properly deliver Plan benefits. These Payments that are made in good faith are considered benefits paid under this Plan. Also, they discharge the Plan and the Plan Administrator from further liability to the extent that Payments are made.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan, or any provision of similar purpose of another Plan, the Contract Administrator or Plan Administrator may release to or obtain from any insurance company or other organization or person any information with respect to any person which the Contract Administrator or Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish to the Contract Administrator or Plan Administrator such information as may be required to implement this provision in accordance with the HIPAA Privacy Requirements.

Right to Recovery: Whenever the Plan has allowed benefits to be paid which have been paid or should have been paid by any other Plan, or which were erroneously paid, the Plan will have the right to recover any such excess Payments from the appropriate party.

Right to Amend the Plan: The President, Vice President, Treasurer, Chief Financial Officer, Chief Executive Officer, Controller, Head of the Human Resource/Personnel Department, or Plan Administrator, as authorized in writing by the Plan Sponsor, has the authority to amend this Plan Document, modify any of the provisions herein, or terminate the Plan at any time without the consent of or notice to any Covered Person hereunder. The Plan may be amended, modified, or terminated to address Plan utilization, costs, market forces, federal legislation, or other general business concerns of the Plan Sponsor. When a Plan amendment, modification, or termination is executed, the Plan Sponsor will provide notice of such action, in writing, to all Covered Persons as required by applicable law.

Should the Plan be terminated, the Plan Administrator will provide for:

First: Payment of benefits to each Covered Person of all covered Expenses for services which were incurred while the Plan was in effect.

Second: Payment of Expenses incurred in the liquidation and distribution of the Plan and any Payments due to the Plan Administrator.

Third: Direct disposition of all assets, if applicable, held in the Plan to Covered Persons as determined by the Plan Administrator, subject to the limitations contained herein and any applicable requirements of law or regulation.

The Use and Disclosure of Protected Health Information:

A. Uses and Disclosure of Protected Health Information (PHI)

The Plan will use and/or disclose Protected Health Information (PHI) (as such term is defined in the Health Insurance Portability and Accountabiity Act of 1996 (HIPAA) and the Privacy and Security Rules promulgated thereunder at 45 C.F.R. Parts 160 and 164 (the HIPAA Privacy Requirements) to the extent of and in accordance with the uses and disclosures permitted or required by the HIPAA Privacy Requirements. Specifically, to the extent allowed by law, the Plan will use and disclose PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. To the extent not defined in this Plan Document, terms used in this Use and Disclosure of Protected Health Information section will be defined as stated in the HIPAA Privacy Requirements. The Plan Administrator will adopt policies and provide forms as it deems advisable to implement this section.

B. The Plan Will Use and Disclose PHI in accordance with and as Required by Law and as Permitted by Authorization of the Plan Participant or Beneficiary

The Plan will disclose PHI in accordance with and as permitted or required by law. For example, (i) the Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of obtaining premium bids for health insurance coverage under the Plan, or for modifying, amending or terminating the Plan; (ii) the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan; and (iii) to the extent allowed by law, the Plan may use and disclose PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Except for the uses and disclosures permitted or required by HIPAA, the Plan shall obtain a written authorization from the individual who is the

subject of the PHI prior to a disclosure. "Summary health information" means information that may be individually identifiable health information and that summarizes the claims history, claims Expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan; and from which identifying information has been deleted, except that geographic information may be aggregated at the level of a five digit zip code.

C. Plan Sponsor Certification

The Employer (as Plan Sponsor) has delivered a certification to the privacy official for the Plan (as identified by the Employer) stating that this section has been amended into this Plan Document, that the Employer agrees to the terms of this section (including D, below), and identifying the group of designated Employees in E, below, who can use or disclose PHI for Plan administration purposes.

D. With Respect to PHI, the Plan Sponsor Agrees to the Following Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI, including implementation of reasonable and appropriate security measures to protect the information;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual in accordance with HIPAA;
- not use or disclose PHI in connection with any other benefit or Employee Benefit Plan of the Plan Sponsor unless authorized by an individual in accordance with HIPAA;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for and any security incident of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements under 45 C.F.R. Section 164.524;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA under 45 C.F.R. Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with HIPAA under 45 C.F.R. Section 164.528;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);
- ensure there is adequate separation between the Plan Sponsor and the Plan, as described below, that is supported by reasonable and appropriate security measures; and

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, the following Employees, classes of Employees or other persons under the Plan Sponsor's control may have access to PHI including PHI relating to Payment under, Health Care Operations of, or other matters pertaining to the administration of the Plan in the ordinary course of business:

CFO

HR Director

Human Resources Generalist

Human Resources Business Partner

F. Limitations of PHI Access and Disclosure

The Plan may disclose PHI to the Plan Sponsor (via the persons described in section E), and the Plan Sponsor may use and further disclose such PHI, only when the Plan Sponsor is either: (i) performing Plan administration functions that the Plan Sponsor performs for the Plan or (ii) acting on behalf of the Plan; provided that the Plan Sponsor may only use or disclose PHI to the same extent as would be permitted by the Plan under the HIPAA regulations.

G. Noncompliance Issues

If Plan Sponsor personnel described in section E above do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving any privacy or security related issues of noncompliance, including but not limited to disciplinary sanctions.

H. Security Requirements

The security rule under the HIPAA Privacy Requirements requires Plans to comply with four (4) general requirements. The Plan must:

- ensure the confidentiality, integrity, and availability of all electronic Protected Health Information that it creates, receives, maintains, or transmits;
- protect against any reasonably anticipated threats or hazards to the security or integrity of the electronic Protected Health Information;
- protect against any reasonably anticipated uses or disclosures of electronic Protected Health Information that are not permitted or required under HIPAA; and
- ensure compliance with the security standards by its workforce.

I. Reproductive Health Information

Pursuant to federal law (29 FR 32976), unless required by law, the Plan will **not** use or disclose PHI which is requested to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for either purpose.

If the Plan receives a request for PHI which is potentially related to reproductive health care for one of these impermissible purposes, the Plan will not use or disclose PHI without first obtaining a signed attestation from the requesting party that the request is not for an impermissible purpose.

SUBROGATION, REIMBURSEMENT & THIRD-PARTY RECOVERY PROVISION

Payment Condition

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

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

3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include Payment for future Treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges incurred up to the date such coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all Expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges incurred after the date of settlement if such recovery provides for consideration of future medical Expenses.

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

Subrogation

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

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional Payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

4. If the Covered Person(s) fails to file a claim or pursue damages against:

    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical Payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Workers' compensation or other liability insurance company; or
    e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit Payments, and school insurance coverage;

Then the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all Expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits incurred, that have been paid and/or will be paid by the Plan, or were otherwise incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other

similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other Expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

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

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

Covered Person is a Trustee Over Plan Assets

1. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Covered Person understands that he/she is required to:

    a. notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

c. in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

1. The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) ("incurred") prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were incurred, not the date upon which the Payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

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

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical Payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit Payments, and school insurance coverage.

Separation of Funds

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

Wrongful Death

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

Obligations

1. It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after Payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
    b. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other Payment is received.
    f. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been incurred) and/or reimbursement request submitted by or on behalf of the Plan.
    g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
    h. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage.
    i. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    j. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
    k. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, incurred, or that will be incurred, prior to the date of the release of liability from the Relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all Expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

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

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse Payment of any future medical benefits and any funds or Payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

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

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

Language Interpretation

The Plan Administrator retains sole, full, and final discretionary authority to construe and interpret the language of this Plan Document, to determine all questions of fact and law arising under this Plan Document, and to administer the Plan's rights with respect to this Plan Document. The words "herein" and "hereunder" used in this Plan Document shall mean this Plan Document. Whenever a noun or pronoun is used in this Plan Document in plural form and there is only one person within the scope of the word so used, or in singular form and there be more than one person within the scope of the word so used, such word or pronoun shall have a plural or singular meaning as the case may be. Headings are given to the sections only for the purpose of convenience and to make the document easier to read. Headings, numbering, and paragraphing shall not in any case be deemed material or Relevant to the interpretation of this Plan Document.

Severability

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

ERISA STATEMENT OF RIGHTS

As a participant in this Plan, the Employee is entitled to certain rights and protection under ERISA. ERISA provides that all Plan Participants will be entitled to:

Receive Information About the Plan and Benefits

1. 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.

2. Obtain 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, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

3. 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 Group Health Plan Coverage

4. Continue health care coverage for the Employee, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Covered individuals may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

5. 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 the Plan, called "Fiduciaries of the Plan, have a duty to do so prudently and in the interest of Plan Participants and beneficiaries. No one, including the Employer, a union, or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforce Your Rights

6. If a covered individual's claim for a welfare benefit is denied or ignored, in whole or in part, he or she has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a covered individual can take to enforce the above rights. For instance, if an Employee requests a copy of Plan Documents or the latest annual report from the Plan and does not receive them within 30 days, the Employee may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Employee up to $110 per day until the Employee receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if a covered individual is discriminated against for asserting his or her rights, the individual may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. Should the Employee be successful, the court may require the other party to pay the Employee's legal costs and fees. Should the Employee lose, the court may order the Employee to pay these costs and fees, for example, if the claim is frivolous.

Hospital Length of Stay Coverage

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

Assistance with Questions

Should the Employee have any questions about the Plan, the Employee should contact the Plan Administrator. Should the Employee have any questions about this statement or about the Employee's rights under ERISA, or if the Employee needs assistance in obtaining documents from the Plan Administrator, the Employee should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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. Employees may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan with respect to any such condition, service, facility, or person.

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

Ambulatory Surgical Center: A facility which is not physically attached to a health care facility, which provides surgical Treatment to patients not requiring hospitalization and does not include the offices of private Physicians or Dentists whether in an individual or group practice.

Birthing Center: A public or private facility, other than private offices or clinics of Physicians, which meets the freestanding Birthing Center requirements of the State Department of Health in the state where the Covered Person receives the services.

The Birthing Center must provide: a facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a Physician or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to Physicians who practice obstetrics and gynecology in an area Hospital; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified nurse midwife; arrangements for diagnostic x-ray and lab services; and the capacity to administer local anesthetic or to perform minor surgery.

In addition, the facility must only accept patients with low-risk pregnancies, have a written agreement with a Hospital for emergency transfers and maintain medical records on each patient and child.

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

Civil Union Partner: A Civil Union Partner must meet the following qualifications:

1. Employee and partner who are the same sex, are not related to one another, and are not already a party to another Civil Union or marriage.

2. Who have an intimate and exclusive committed relationship.

3. Who are both at least eighteen (18) years of age.

4. Who are mentally competent to consent to contract.

5. Who share responsibility for each other's welfare and the common necessities of life, including financial obligations.

6. Who can provide documentation that their Civil Union was certified by an authorized person in the state where the Civil Union was recognized.

Tax Considerations – Enrollment of Civil Union Partner (and Related Children): If you enroll an individual in the Plan for whom there is no exclusion from income under federal or state tax law – such as your Civil Union Partner (or such partner's child) who is not your tax Dependent – you will be required to pay your portion of the cost of such individual's coverage on an after-tax basis and have imputed income reported by your Employer to the applicable tax authorities. The value reported is based on the value of coverage that is not paid by you. You are responsible for determining the tax status of each person you enroll under the Plan, and for paying any applicable taxes.

No one associated with the Plan can give tax advice. This means that your Employer, the Plan Sponsor, the Plan Administrator, and the Contract Administrator cannot make the determination as to whether your Civil Union Partner, or any other individual qualifies as a Dependent under the Internal Revenue Code. You should consult with your personal tax advisor to discuss your individual circumstances before enrolling your Civil Union Partner, a partner's child, or anyone else who may not be considered your tax Dependent in the Plan.

Claimant: A participant of the Plan, or entity acting on the participant's behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

Claim for Benefits: A request for a Plan benefit or benefits made by a Claimant in accordance with the Plan's procedure for filing benefit claims. This includes any Pre-Service Claims and any Post-Service Claims.

Claim involving Urgent Care: Any claim for medical care or Treatment with respect to which the application of the time periods for making non-urgent care determinations:

(i) Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or

(ii) In the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or Treatment that is the subject of the claim.

Except as set forth in the next paragraph, whether a claim is a Claim involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Any claim that a Physician with knowledge of the Claimant's medical condition determines is a Claim involving Urgent Care shall be treated as Claim involving Urgent Care.

Clinical Trial: A Phase I, II, III or IV Clinical Trial that meets the following conditions:

1. The Clinical Trial is intended to treat cancer or other life-threatening condition in a patient who has been diagnosed; and
2. The Clinical Trial has been peer reviewed and is approved or funded by at least one of the following:
    a. The National Institutes of Health,
    b. The Centers for Disease Control and Prevention,
    c. The Agency for Health Care Research and Quality,
    d. The Centers for Medicare and Medicaid Services,
    e. A cooperative group or center of the entities described in a.-d. above,
    f. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants,
    g. The United States Food and Drug Administration pursuant to an Investigational new drug exemption,
    h. Under certain conditions, the United States Department of Defense of Veterans Affairs, Department of Defense, or Department of Energy,
    i. Or, with respect to Phase II, III and IV Clinical Trials, a qualified institutional review board.
3. The facility and personnel conducting the Clinical Trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the Clinical Trial, and
5. The patient has provided informed consent for participation in the Clinical Trial in a manner that is consistent with current legal and ethical standards, and
6. The available clinical or pre-clinical data provide a reasonable expectation that the patient’s participation in the Clinical Trial will provide a medical benefit that is commensurate with the risks of participation in the Clinical Trial, and
7. The Clinical Trial must have a preventive, diagnostic, or therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

Coinsurance: Coinsurance percentages represent the portions of covered Expenses paid by the Covered Person and by the Plan after satisfaction of any applicable Deductible. These percentages apply only to the portion of the covered Expenses which do not exceed the Maximum Allowable Benefit. The Covered Person is responsible for all non-covered Expenses and any amount which exceeds the Maximum Allowable Benefit for covered Expenses, except to the extent prohibited by applicable law.

Contract Administrator: Comprehensive Benefits Administrator, LLC dba CBA Blue**,** an independent licensee of the Blue Cross and Blue Shield Association, which is a third party claims administrator hired by the Plan Sponsor to handle the day-to-day administration of the Plan, including:

1. reviewing and processing claims for proper benefit Payments and providing explanation of benefits to covered Employees and/or Providers;

2. remitting benefit Payments for covered Expenses under the Plan to covered Employees and/or Providers;

3. reviewing all claims appeals.

Contributory Coverage: Plan benefits for which an Employee enrolls and agrees to make any required contributions toward the cost of coverage.

Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility: An institution which is licensed pursuant to state and/or local laws and is operated primarily for the purpose of providing Treatment for individuals convalescing from Injury or Illness, including that part or unit of a Hospital, which is similarly constituted and operated, and:

1. Has organized facilities for medical Treatment and provides for twenty-four (24) hour nursing service under the full-time supervision of a Physician or a registered nurse. Full-time supervision means a Physician or a registered nurse is regularly on the premises at least forty (40) hours per week;

2. Maintains daily clinical records concerning each patient and has a written agreement or arrangement with a Physician to provide services and emergency care for its patients;

3. Provides appropriate methods for dispensing and administering drugs and medicines;

4. Has transfer agreements with one (1) or more Hospitals, a utilization review procedures in effect, and operational policies developed with the advice of and reviewed by a professional group including at least one (1) Physician. A Convalescent Hospital/Extended Care Facility will not include any institution which is a rest home for the aged, or a place for the Treatment of mental disease, drug addiction or alcoholism, or a nursing home.

5. Qualifies as an "Extended Care Facility" under the health insurance provided by Title XVIII of the Social Security Act, at the time.

Copayment: A fixed amount of money that is paid each time a particular service is used. There may be Copayments on some services and not on other services.

Cost-Sharing: The amount a Covered Person is responsible for paying for a covered Expense under the terms of the Plan. Cost-Sharing generally includes Copayments, Coinsurance, and amounts paid towards Deductibles, but does not include amounts paid towards premiums, balance billing by Out-of-Network Providers, or the cost of items or services that are not covered under the Plan.

Covered Person: A covered Employee or a covered Dependent as determined under the applicable Plan provision.

Custodial Care: Care which is designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical personnel. Custodial Care includes services that could be performed by a relative or friend with minimal instruction or supervision.

Custodial Parent: The parent awarded custody by court decree. If there is no court decree, the Custodial Parent is the one with whom the child resides for more than half the year.

Day of Confinement: Any period of twenty-four (24) hours or any part thereof for which a full charge for room and board is made by a Hospital.

Deductible: The dollar amount of covered Expenses the covered Employee must pay during each calendar year before the Plan will begin paying for covered Expenses. The individual Deductible applies separately to each Covered Person. The family Deductible is the maximum Deductible applied to each family. When the family Deductible is satisfied, no further Deductible will be applied for any covered family member during the remainder of that calendar year. **Bronze Copay Plan:** For two-person or family coverage, the entire family Deductible amount must be met before Payments begin for services. When the family Deductible is satisfied, no further Deductible will be applied for any covered family member during the remainder of that calendar year.

Dental Services: Procedures involving the teeth, gums, or supporting structures.

Dentist: A duly licensed doctor of dentistry and a dental professional or practitioner who is duly licensed under appropriate state licensing authorities, provided a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of dentistry, and under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a doctor of dentistry.

Dependent:

1. The lawful spouse of an eligible Employee or a partner of a Civil Union; or

2. the married or unmarried child of an eligible Employee who has not attained their twenty-sixth (26th) birthday; or

3. an unmarried same or opposite sex Domestic Partner of an Employee, provided that the Employee and the partner complete a Statement of Domestic Partnership upon application for coverage.

The term "lawful spouse," as used above, means an eligible Employee's same- or opposite-sex spouse, provided that such individual is legally recognized as the eligible Employee's spouse in any jurisdiction (such as a State or foreign country), and even if the individual is not recognized as the eligible Employee's spouse in the Employee's State of residence.

The word "child", as used above, will include an eligible Employee's natural child, a legally adopted child (including a child in the custody of the Employee under an interim court order of adoption, whether or not a final adoption order is ever issued), a stepchild, a foster child, a child of a Domestic Partner, a child of a Civil Union Partner or a child for whom legal guardianship has been granted. If an eligible Employee's child is also his or herself an eligible Employee under this Plan, the child cannot receive duplicate coverage under the Plan. This means that the child must choose to either be covered as an eligible Employee or as a Dependent and cannot be covered as both.

Should an Employee have a child covered under the Plan who reaches the age at which the child would otherwise cease to be a Covered Person and if such child is under the care of a Provider who determines him/her to be mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider such child as a Dependent beyond such age, while such child remains in such condition, subject to all of the terms of the Plan, provided the Employee has, within thirty-one (31) days of the date on which the child attained such age, submitted proof of the child's incapacity, as described in the following paragraph.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child's incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the "Termination of Benefits" section of this Plan except as modified herein.

Dependent Coverage: Plan benefits extended to the Dependent(s) of a covered Employee.

Domestic Partner (Same and Opposite Sex): A Domestic Partner who has satisfied (and will provide satisfactory proof of such to the Plan Administrator) the following status requirements.

1. each party is the sole Domestic Partner of the other;
2. each party is at least 18 years of age and competent to enter into a contract in the state in which he or she resides;
3. the parties currently share a common legal residence and have shared the residence for at least six (6) months prior to applying for Domestic Partnership coverage;
4. neither party is legally married;
5. the partners are not related by adoption or blood to a degree of closeness that would bar marriage in the state in which they legally reside;
6. the parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future;
7. the parties are jointly responsible for basic living Expenses such as the cost of basic food, shelter, and any other Expenses of the common household (the partners need not contribute equally or jointly to the payment of these Expenses as long as they agree that both are responsible for them); and
8. neither party filed a Termination of Domestic Partnership within the preceding nine (9) months.

Tax Considerations – Enrollment of Domestic Partner (and related children): If you enroll an individual in the Plan for whom there is no exclusion from income under federal or state tax law – such as your Domestic Partner (or such partner's child) who is not your tax Dependent – you will be required to pay your portion of the cost of such individual's coverage on an after-tax basis and have imputed income reported by your Employer to the applicable tax authorities. The value reported is based on the value of coverage that is not paid by you. You are responsible for determining the tax status of each person you enroll under the Plan, and for paying any applicable taxes.

No one associated with the Plan can give tax advice. This means that your Employer, the Plan Sponsor, the Plan Administrator, and the Contract Administrator cannot make the determination as to whether your Domestic Partner, or any other individual qualifies as a Dependent under the Internal Revenue Code. You should consult with your personal tax advisor to discuss your individual circumstances before enrolling your Domestic Partner, a partner's child, or anyone else who may not be considered your tax Dependent in the Plan.

Effective Date of Coverage: The date an Employee and/or their Dependent(s) become eligible to enroll in the Plan.

Emergency Medical Condition: A medical condition, including a Mental Health Disorder condition or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act. In that section, such clauses refer to (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in the serious jeopardy, (ii) serious impairment to body functions, or (iii) serious dysfunction of any body organ or part.

Final determination as to whether services were rendered in connection with an emergency will rest solely with the Plan. The Plan will not limit what constitutes an Emergency Medical Condition solely on the basis of diagnosis codes, as required by the No Surprises Act.

Emergency Services: With respect to an Emergency Medical Condition, (i) an appropriate medical screening examination (as required under Section 1867 of the Social Security Act or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and (ii) within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, such further medical examination and Treatment as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or Treatment is furnished). In addition, Emergency Services include certain items and services (known as "post-stabilization services") (i) for which benefits are provided or covered under the Plan, and (ii) that are furnished by an Out-of-Network Provider or emergency facility (regardless of the department of the Hospital in which such items or services are furnished) after the Covered Person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services described in the preceding sentence are furnished; provided, however, that such items and services are **not** included as Emergency Services if all of the conditions in 45 CFR 149.410(b) are met.

For purposes of this definition, "to stabilize" has the meaning given in section 1867(e)(3) of the Social Security Act; "emergency department of a Hospital" includes a Hospital outpatient department that provides Emergency Services; and "Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable state law and provides Emergency Services.

Employee: Any common law Employees who are eligible for Employee Coverage under the eligibility requirements set forth in the "General Information" section contained herein. The definition of an Employee does not include independent contractors, contingent workers, or leased Employees. Any person the Plan Administrator determines is not an Employee shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters. If any such person is later determined by the Plan Administrator or by a court or governmental agency to be an Employee or to have been an Employee, he or she will only be eligible for Plan participation prospectively following such determination and after the satisfaction of all other eligibility requirements.

Employee Coverage: Group medical benefits provided under the Plan on behalf of a covered Employee.

Employer: Northern Counties Health Care, Inc. and any affiliate permitted by Northern Counties Health Care, Inc. to provide coverage to its Employees under this Plan.

Expense: A charge a Covered Person is legally obligated to pay. An Expense is deemed to be incurred on the date the service or supply is furnished.

Experimental/Investigative: A drug, device, medical Treatment or procedure that is not the subject of, or in some manner related to, the conduct of a Clinical Trial, as such term is defined herein, is Experimental or Investigative:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. if the drug, device, medical Treatment or procedure, or the patient informed consent document utilized with the drug, device, Treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. if reliable evidence shows that the drug, device, medical Treatment, or procedures is the subject of on-going phase I or phase II Clinical Trials, is the research, Experimental, study or Investigational arm of on-going phase III Clinical Trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of Treatment or diagnosis; or
4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical Treatment, or procedure is that further studies or Clinical Trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of Treatment or diagnosis.

For purposes of this definition, reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical Treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical Treatment or procedure.

Fiduciary: A Fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets; or has discretionary authority or responsibility in the administration of the Plan.

Final Post-Service Appeal: A post-service appeal, which constitutes the second and final internal appeal available to the Claimant, to be filed with the Plan Administrator, Plan Sponsor, and/or other named Fiduciary assigned authority and the duty to otherwise handle appeals. The term "Final Post-Service Appeal" shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication and conclusion of this appeal, external review becomes available to the Claimant in accordance with applicable terms found within the Plan Document and applicable law. The Plan Administrator, Plan Sponsor, and/or other named Fiduciary assigned authority and the duty to otherwise handle appeals, reserves the right to delegate certain discretionary authority as it applies to adjudication of Final Post-Service Appeals to the Plan Appointed Claim Evaluator or "PACE."

Health Care Operations: include, but are not limited to the following activities, in accordance with the HIPAA Privacy Requirements:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care Providers and patients with information about Treatment alternatives and related functions;
- rating Provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- 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, including formulary development and administration, development, or improvement of Payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
    a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
    b) customer service, including the provision of data analyses for policyholders, Plan Sponsors or other customers;
- resolution of internal grievances;
- the sale, transfer, merger, or consolidation of all or part of the "covered entity" within the meaning of HIPAA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

- consistent with the applicable requirements of the regulations issued under HIPAA, creating de-identified health information or a limited data set, and fundraising for the benefit of the "covered entity" within the meaning of HIPAA.

Health Care Professional: A Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with state law.

Home Health Care Agency: A licensed and state approved home health care facility possessing a valid certificate of approval issued in accordance with Title XVIII of the Social Security Act and licensed and approved by the appropriate state authorities which specializes in providing health care and therapeutic services to a person in such person's home.

Home Health Care Plan: A program for care and Treatment of a Covered Person established and approved, in writing, by such Covered Person's attending Physician, together with such Physician's certification that the proper Treatment of the Injury or Illness would require confinement as a resident inpatient in a Hospital or confinement in a Skilled Nursing Facility as defined in Title XVIII of the Social Security Act, at the time, in the absence of services and supplies provided as part of the Home Health Care Plan.

Hospice: An agency that provides counseling and incidental medical services for a terminally ill individual. Room and board may be provided. The agency must meet all of the following tests: (i) approved under any required state or governmental Certificate of Need; (ii) provides twenty-four (24) hour a day, seven (7) day a week service; (iii) it is under the full-time supervision of at least one (1) duly qualified Physician; (iv) has a nurse coordinator who is a registered graduate nurse with at least four (4) years of full-time clinical experience. Two (2) of these years must involve caring for terminally ill patients; (v) has a social service coordinator who is licensed in the area in which it is located; (vi) the main purpose of the agency is to provide Hospice services; (vii) has a full-time administrator; (viii) maintains written records of services given to each patient; (ix) its Employees are bonded; (x) it provides malpractice and malplacement insurance; (xi) is established and operated in accordance with any applicable state laws.

Hospital: A duly licensed, if required, and legally-constituted and operated institution which is primarily engaged in providing diagnostic services, therapeutic services for diagnosis, care and Treatment of sick or injured persons on an inpatient and/or Outpatient Basis, and which provides such care and Treatment: (i) under the supervision of one (1) or more Physicians, (ii) with twenty-four (24) hour nursing service under the supervision of one (1) or more Physicians licensed to practice medicine; and (iii) which has organized facilities for laboratory and diagnostic work and major surgery. The term "Hospital" will not include, other than incidentally, an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an Extended Care Facility, a place (primarily) for the Treatment of tuberculosis, mental, emotional, drug or alcoholic disorders, or a home for the aged. Services rendered in the infirmary or clinic of a college, university, or private boarding school will be eligible Expenses. In such instances, if a Covered Person is confined in a school facility that does not meet the definition of a Hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the Maximum Allowable Benefit for the Illness or Injury involved.

Hospital Confinement: Being registered as a bed-patient in a Hospital upon the recommendation of a Physician, or as a result of a surgical operation, or by reason of receiving emergency medical care.

Illness: Sickness or disease which results in Expenses for medical care, services, and supplies covered by the Plan. Such Expense must be incurred while the Covered Person, whose Illness is the basis of the claim, is covered under the Plan. Medical Expenses incurred by a Covered Person because of pregnancy will be covered to the same extent as any other Illness.

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

Injury: Accidental bodily harm resulting from an accident, which results in Expenses for medical care, services, and supplies covered by the Plan. Such Expense must be incurred while the Covered Person, whose Injury is the basis of the claim, is covered under the Plan.

Inpatient Basis: Hospital Confinement including one (1) or more days of confinement for which a room and board charge is made by a Hospital.

Intensive Care Unit: An accommodation in or part of a Hospital, other than a post-operative recovery room, which, in addition to providing room and board:

1. Is established by the Hospital for the purpose of providing formal intensive care;

2. Is exclusively reserved for critically ill patients requiring constant audio/visual observation prescribed by a Physician and performed by a Physician or by a specifically trained registered nurse; and

3. Provides all necessary lifesaving equipment, drugs, and supplies in the immediate vicinity on a standby basis.

Maximum Allowable Benefit: The Maximum Allowable Benefit shall mean the maximum amount of benefits the Plan will pay for a specific covered Expense or benefit under this Plan, as determined by the Contract Administrator in its sole and absolute discretion. The Contract Administrator has the sole and absolute discretion to determine the Maximum Allowable Benefit for a covered Expense or benefit, and expressly disavows use of usual, customary, and reasonable standards.

Preferred Provider Network Program (including BlueCard® Program) for In-Network Providers
For the Blue Cross Blue Shield of Vermont's Preferred Provider network, the Inter-Plan Programs, the BlueCard® Program, and the Blue Cross Blue Shield Global Core Program, the Maximum Allowable Benefit for a covered Expense or benefit will be calculated by the Blue Card Host, the BlueCard® Program, or Blue Cross Blue Shield Global Core for In-Network Providers.

Out-of-Network Provider
For an Out-of-Network Provider, the Maximum Allowable Benefit for a covered Expense or benefit will be a negotiated rate, if one exists.

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

If none of the above factors is applicable, the Contract Administrator will exercise its discretion to determine the Maximum Allowable Benefit based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP), or Fair Health benchmarking tables, or the "Host Allowed Amount" (when provided by the Blue Cross Plan of the state where a service was rendered). "Host Allowed Amount" is a reimbursement amount that is a proxy for what an In-Network Provider would be reimbursed for the same service in the same region of the country in which the Out-of-Network service was rendered. These ancillary factors will take into account generally-accepted billing standards and practices.

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

Subject to the No Surprises Act rules explained herein, the Contract Administrator will generally calculate the Maximum Allowable Benefit for Out-of-Network Emergency Services as the greater of:

- The negotiated amount for In-Network Providers for the Emergency Service furnished, excluding any In-Network Copayments or Coinsurance (the median amount if more than one amount applies to In-Network Providers).
- The amount for the Emergency Service calculated using the same method the Plan generally uses to determine Payments for Out-of-Network services, excluding any In-Network Copayments and Coinsurance and without reduction for Out-of-Network Cost-Sharing that generally applies under the Plan for Out-of-Network services).
- The amount that Medicare parts A and B would pay for the Emergency Service (excluding any Copayments and Coinsurance).

Medical Intervention: Any medical Treatment, service procedure, facility, equipment, drug, device, or supply.

Medically Necessary: Health care services, supplies, or Treatment will be considered Medically Necessary if the Contract Administrator determines such service, supply, or Treatment to be:

a) Appropriate and necessary for, and consistent with, the diagnosis or Treatment of the Illness or Injury;
b) Provided for the diagnosis or direct care and Treatment of the Illness or Injury;
c) Within generally accepted standards of good medical practice within the organized medical community;
d) Not primarily for the convenience of the Covered Person, the Physician or other Provider, or the Hospital or other facility;
e) Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or Treatment of the Covered Person's Illness or Injury;

f) The most appropriate service, supply, or Treatment which can safely be provided. The most appropriate service, supply, or Treatment must satisfy the following requirements:

- there must be valid scientific evidence demonstrating that the expected health benefit from the service, supply, or Treatment are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the Covered Person with the particular Illness or Injury being treated than other possible alternatives; and
- generally accepted forms of service, supply, or Treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
- for Hospital stays, acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition, and safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The Contract Administrator shall determine, in their sole and absolute discretion, whether a service, supplies, or Treatment is Medically Necessary under the Plan. Even though a Physician or other Provider may have prescribed a service, supplies, or Treatment, such service, supplies, or Treatment may not be Medically Necessary within this definition.

Mental Hospital: An institution (other than a Hospital as defined) which specializes in the diagnosis and Treatment of Mental Health Disorders or functional nervous disorders and which is operated pursuant to law and meets all of the following requirements:

1. Is licensed to give medical Treatment and is operated under the supervision of a Physician;

2. Offers nursing services by registered graduate nurses (RN) or licensed practical nurses (LPN) and provides, on the premises, all the necessary facilities for medical Treatment;

3. Is not, other than incidentally, a place of rest or a place for the aged, drug addicts, or alcoholics; or a place for convalescent, custodial, or educational care.

Mental Health Disorder: Any Illness or condition, regardless of whether the cause is organic, that is classified as a Mental Health Disorder, as defined in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, or other relevant state guideline or applicable sources.

Never Events: These events, as defined by The National Quality Forum, a private organization whose members include the American Medical Association (AMA), are "errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility." Never Events include, but are not limited to, procedures performed on the wrong side, wrong body part, wrong procedure, or wrong person. Never Events are not Medically Necessary as they are not required to diagnose or treat an Illness, Injury, disease or its symptoms and are not consistent with generally accepted standards of medical practice.

Newborn Care Charges: Charges for care of newborn children as more specifically defined herein.

No Surprises Act: The "No Surprises Act", which was enacted in Title I of Division BB of the Consolidated Appropriations Act of 2021, including the regulations and binding guidance issued thereunder, which generally governs patient Cost-Sharing, balance billing, and Payments to Providers for Emergency Services rendered in Out-of-Network facilities, services rendered by Out-of-Network Providers in In-Network facilities, and services rendered by air ambulance Providers. (For more details, see the No Surprises Act – Emergency Services and Surprise Bills language herein.)

Out-of-Pocket Maximum Limit: Under the terms of this Plan, the maximum dollar amount of medical covered Expenses or prescription drug benefits, as applicable, that any individual covered under the Plan would be required to pay toward covered Expenses during a **calendar** year. Whether a Covered Person has met the applicable Out-of-Pocket Maximum limit for the **calendar** year will be determined by adding the Deductible, Employee Copayments, and Employee share of Coinsurance amounts paid by the Employee as set forth by this Plan.

Outpatient Basis: Any Hospital Expenses incurred for which no room and board charge is made.

Outpatient Mental Health Treatment Facility: A comprehensive, health service organization, a licensed or accredited Hospital, or community mental health center or other mental health clinic or day care center which furnished Mental Health Disorder services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the diagnosis, evaluation, service or Treatment of mental health or emotional disorder.

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

Patient Care Services: Medical covered services, as described in this Plan, that are furnished to an individual enrolled in a Clinical Trial, as such term is defined here, which are consistent with the customary standard of care for someone with the patient's diagnosis and, are consistent with the study protocol for the Clinical Trial. Notwithstanding the foregoing, Patient Care Services do not include any of the following:

1. The Investigational item, device, drug, or service which is the subject of the Clinical Trial;
2. Any other FDA approved drug or device which is used during the course of the Clinical Trial and is paid for by the manufacturer, the distributor or the Provider of the drug or device;
3. non-health care services that a patient may be required to receive as a result of being enrolled in the Clinical Trial;
4. costs associated with managing the research related to the Clinical Trial (including items and services that are provided solely to satisfy date collection and analysis needs and are not used in the direct clinical management of the patient;
5. costs that would not be covered under the Plan for non-investigational/Experimental Treatments;

6. any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Clinical Trial;
7. the cost of services which are not provided as part of the Clinical Trial's stated protocol or other similar guidelines; or
8. any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Payment: Includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for the coverage and provision of Plan benefits or to obtain or provide reimbursement for the provision of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following, in accordance with the HIPAA Privacy Requirements:

- determination of eligibility, coverage, and Cost-Sharing amounts (for example, cost of a benefit, Plan maximums 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;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- 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 pre-certification, prior authorization, concurrent review and retrospective review; and
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for Payment purposes: name and address, date of birth, Social Security number, Payment history, account number and name and address of the Provider and/or health Plan).

Physician: A duly licensed doctor of medicine, a medical professional, or a practitioner who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of medicine, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a medical doctor.

Plan: The Northern Counties Health Care, Inc. Employee Benefit Plan, as described in this Plan Document.

Plan Administrator: Northern Counties Health Care, Inc.

Plan Anniversary Date: The date occurring in each calendar year which is an anniversary of the effective date of the Plan.

Plan Appointed Claim Evaluator or "PACE": An entity appointed by the Plan Administrator, Plan Sponsor, and/or other named Fiduciary assigned authority and the duty to otherwise handle appeals, with authority to make final, binding (insofar and to the same extent as a decision by the Plan Administrator, Plan Sponsor, and/or other named Fiduciary assigned authority and the duty to otherwise handle appeals, would be deemed to be binding), claims processing decisions in response to Final Post-Service Appeals. In instances where the Plan Administrator, Plan Sponsor, and/or other named Fiduciary assigned authority and the duty to otherwise handle appeals, delegates Fiduciary authority to the PACE, the PACE may exercise the same level of discretionary authority as that which the Plan Administrator, Plan Sponsor, and/or other named Fiduciary assigned authority and the duty to otherwise handle appeals, may otherwise exercise. The PACE's Fiduciary duties extend only to those determinations actually made by the PACE. The PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator, Plan Sponsor, and/or other named Fiduciary assigned authority and the duty to otherwise handle appeals, but the PACE shall only be deemed to be a Fiduciary when making final determinations regarding Plan coverage and claims examined via Final Post-Service Appeal. The PACE shall at all times strictly abide by, and make determination in accordance with, the terms of the Plan and applicable law, in light of the facts, law, medical records, and all other information submitted to the PACE.

Plan Document: This document.

Plan Effective Date: The date the Plan becomes liable to provide coverage under the terms of the Plan.

Plan Participant: Any Employee or Dependent that is eligible for, properly enrolled in, and covered by this Plan.

Plan Sponsor: Northern Counties Health Care, Inc.

Post-Service Claim: Any claim for a benefit under the Plan that is not a Pre-Service Claim.

Pre-Service Claim: Any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Prior Plan: The prior group medical Plan, if any, offered by the Plan Sponsor.

Protected Health Information: Health information, including demographic information, which is collected from an individual, and which;

- is created or received by the Plan;
- relates to the past, present, or future physical or Mental Health Disorder condition of an individual; or the past, present, or future Payment for the provision of health care to an individual; and
    a) that identifies the individual; or

    b) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual; and

- is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium by a covered entity under the HIPAA Privacy Requirements. Protected Heath Information excludes information in education records covered by the Family Educational Right and Privacy Act, records described at 20 U.S.C. 1232(g)(a)(4)(B)(iv), and employment records held by the Plan Sponsor in its role as Employer.

Provider: A Hospital, Physician, Ambulatory Surgical Center, Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility, Dentist, Health Care Professional, Home Health Care Agency, Hospice, Mental Institution, Outpatient Mental Health Treatment Facility, Rehabilitation Hospital, Residential Treatment Facility, Substance Use Treatment Facility, or other health care Provider~~s~~ or facility, duly licensed and/or operated under appropriate state law authorities where required~~,~~ and performing services within the scope of such license or state law requirements, as determined by the Contract Administrator in its sole discretion.

In-Network Provider (also referred to as a Preferred Provider): A member of a network of Providers (as defined above) which provides medical services to Covered Persons under this Plan on the basis of a contractual rate under an agreement with the Blue Cross Blue Shield of Vermont's Preferred Provider network (including the BlueCard Program); Covered Persons receiving covered services from an In-Network Provider are not responsible for any charges other than the Cost-Sharing requirements (Deductibles, Coinsurance and/or Copayments) and charges in excess of any specific benefit limits shown in the Schedule of Benefits or otherwise noted in this Plan.

Out-of-Network Provider (also referred to as a Non-Preferred Provider): Any Provider (as defined above) that is not an In-Network Provider (as defined above); Covered Persons receiving covered services from an Out-of-Network Provider are responsible for any applicable Deductibles, Coinsurance and/or Copayments, amounts in excess of any specific benefit limits shown in the Schedule of Benefits or otherwise noted in this Plan for Out-of-Network Providers, and may be responsible for any amounts in excess of the Maximum Allowable Benefit for the services received, unless specifically stated otherwise in this Plan.

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

Recognized Amount: Shall mean, except for Out-of-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Out-of-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

Rehabilitation Hospital: A facility which meets all requirements of a Hospital (as defined herein) other than the "surgical facilities" requirements and, in addition, meets the following criteria:

1. It must be accredited by the Joint Commission of Accreditation of Hospitals and be approved for Federal Medicare Benefits as a qualified Hospital;
2. It must maintain transfer agreements with acute care facilities to handle surgical and/or medical emergencies;
3. It must maintain a utilization review committee.

Rehabilitative Care: Medically Necessary inpatient medical care (as prescribed by a Physician) rendered in a Rehabilitation Hospital (as defined herein) excluding Custodial Care or occupational training.

Relevant: In the context of whether a document, record or other information shall be considered "Relevant," means the following: a document, record, or other information:

(i) relied upon in making the benefit determination;

(ii) 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;

(iii) demonstrating compliance with the administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the governing Plan Documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated Claimants in making the benefit determination; or

(iv) constituting a statement of policy of guidance with respect to the Plan concerning the denied Treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In no event should the provisions of this Claim Review Procedures section be interpreted to require any Claimant to file more than two (2) appeals of an Adverse Benefit Determination prior to bringing a civil action under Section 502(a) of ERISA.

Residential Treatment Facility: A facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the Treatment and care of Covered Persons diagnosed with alcohol, drug or Substance Use Disorders or Mental Health Disorders.

Substance Use Disorder: Any disease or condition that is classified as a Substance Use Disorder, as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, or other relevant state guideline or applicable sources.

Substance Use Treatment Facility:

1. A public or private facility providing services especially for detoxification or rehabilitation of substance use and which is licensed to provide such services;

2. A comprehensive health service organization, community mental health clinic or day care center which furnishes Mental Health Disorder services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the rehabilitation of substance use and which is licensed to provide such services.

Totally Disabled: A covered Employee shall be considered Totally Disabled if, as a result of a non-occupational Illness or a non-occupational accidental Injury, the Employee is unable to perform the full duties of his/her occupation or is unable to engage in any gainful occupation.

Treatment: The provision, coordination, or management of health care and related services by one or more health care Providers, including the coordination or management of health care by a health care Provider with a third party; consultation between health care Providers relating to a patient; and the referral of a patient for health care from one health care Provider to another.

Waiting Period: The period of time between the Employee's satisfaction of the Plan's eligibility requirements and the Effective Date of Coverage under the Plan.

PLAN DOCUMENT ACCEPTANCE PAGE

APPROVED AND ACCEPTED

This Plan Document, known as the Northern Counties Health Care, Inc. Employee Benefit Plan, is hereby executed at:

_____, _____ on 01/21/2025 | 9:39 PM EST _____

(City) (State) (Date)

BY: Signed by: _____ 20D2678F2D1F49C...

TITLE: Chief Executive Officer