TO OUR VALUED EMPLOYEES

Welcome to the Lakeside Industries, Inc. Group Medical and Dental Plan!

We are pleased to provide you with this comprehensive program of medical and prescription drug coverage.

With the exception of very large medical claims from which the Plan is protected by insurance, all Plan expenses are directly paid by the Lakeside Industries, Inc. Group Medical and Dental Plan. The major portion of the Plan cost is provided by Lakeside Industries, Inc. and is supplemented by the contributions you make to participate. This means that through careful use of the Plan, you, as a consumer of health care, can have a direct impact on the cost of our Plan which will benefit both you and the Company by allowing us to continue to provide this high-quality level of benefits.

Please read this booklet carefully and particularly note the special requirements you must follow prior to having surgery or being admitted to a medical facility - this is explained in the IMPORTANT INFORMATION section.

We have contracted for Care Management to help assure that you are receiving the best and most appropriate treatment when health care is needed. The Care Management team are your advocates to help improve the quality of your health care and to lower the cost of health care to you and the Plan.

If you have any questions regarding either your Plan's benefits or the procedures necessary to receive these benefits, please call the Plan Supervisor - Healthcare Management Administrators, Inc. (HMA) at 425/462-1000. When calling from outside of Seattle, you may call HMA toll free at 800/869-7093.

We wish you the best of health.

Lakeside Industries, Inc. Group Medical and Dental Plan

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This booklet is the Master Plan Document and has been prepared in accordance with Public Law 93-406, the Employee Retirement Income Security Act of 1974 (ERISA). This booklet and any amendments constitute the plan document for this benefit Plan. This Plan is maintained for the exclusive benefit of the Plan Employees and each Participant's rights under this Plan are legally enforceable.

The Plan Administrator has the right to amend this Plan at any time. The Plan Administrator will make a good faith effort to communicate to you all Plan amendments on a timely basis. For further information, see the section titled Amendment of Plan Document located in the General Provisions section of this Plan.

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

This Plan Document and Summary Plan Description, made by Lakeside Industries, Inc. (the "Company" or the "Plan Sponsor") as of January 1, 2024 hereby **amends and restates** the provisions of Lakeside Industries, Inc. Group Medical and Dental Plan (the "Plan"), which was originally adopted by the Company, effective January 1, 2006.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Lakeside Industries, Inc.

DocuSigned by:

By: Kari Shiflett

Name: Kari Shiflett

Date: 1/31/2024

Title: HR Director

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

INTRODUCTION AND PURPOSE

The Plan Sponsor has established the Plan for the benefit of eligible Employees, such as yourself, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from you and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. As a participant in the Plan, you may be required to contribute toward Plan benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for yourself, the economic effects arising from certain health expenses. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for medical and prescription drug charges. The Plan Document is maintained by Lakeside Industries, Inc. and may be inspected by you at any time during normal working hours.

GENERAL PLAN INFORMATION

NAME OF PLAN	Lakeside Industries, Inc. Group Medical and Dental Plan
NAME & ADDRESS OF EMPLOYER	Lakeside Industries, Inc. 6505 226th Place SE Suite 200 Issaquah, WA 98027 425/313-2600
EMPLOYER IDENTIFICATION NUMBER	91-0751657
PLAN NUMBER	501
TYPE OF PLAN	Employee Health Care Benefits Plan providing Medical and Prescription
HDHP QUALIFIED STATUS	This Plan is considered a qualified high deductible health plan.
TYPE OF PLAN ADMINISTRATION	Contract Administration
ACA PLAN STATUS	Non-Grandfathered
BUNDLED OR UNBUNDLED	Medical coverage is bundled with prescription drug coverage.
ORIGINAL PLAN EFFECTIVE DATE	January 1, 2006
LAST AMENDED DATE	January 1, 2024
PLAN YEAR	January 1st - December 31st

PLAN ADMINISTRATOR **PLAN SPONSOR** **NAMED FIDUCIARY** **DESIGNATED LEGAL AGENT**	Lakeside Industries, Inc. 6505 226th Place SE Suite 200 Issaquah, WA 98027 425/313-2600
EMPLOYEES	You will be considered an eligible employee of Lakeside Industries, Inc., when you meet the eligibility requirements described herein.
GROUP NUMBER	020465
CONTRIBUTION REQUIRED	Employee Coverage – No (full-time or part-time employees) Dependent Coverage – No (full-time employees) Yes (part-time employees)
PLAN SUPERVISOR	Healthcare Management Administrators, Inc. PO Box 85008 Bellevue, Washington 98015-5008 425/462-1000 Seattle Area 800/869-7093 All Other Areas
FUNDING MEDIUM	Benefits are paid through general assets.

The Plan shall take effect for each Participating Employer on the Effective Date unless a different date is set forth above opposite such Participating Employer's name.

LEGAL ENTITY; SERVICE OF PROCESS

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

NOT A CONTRACT

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between yourself and the Company or to be consideration for, or an inducement or condition of your employment. Nothing in this Plan Document shall be deemed to give you the right to be retained in the service of the Company or to interfere with the right of the Company to discharge you at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with bargaining representatives.

MENTAL HEALTH PARITY

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

APPLICABLE LAW

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with contributions made by your employer. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of

competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

DISCRETIONARY AUTHORITY

The Plan Administrator 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 regard to issues relating to eligibility for benefits; to decide disputes that may arise relative to your rights; and to determine all questions of fact and law arising under the Plan.

PLAN SUPERVISOR NOT A FIDUCIARY

The Plan Supervisor is not a fiduciary with respect to this engagement and shall not exercise any discretionary authority or control over the management or administration of the Plan, or the management or disposition of the Plan's Assets. The Plan Supervisor shall limit activities to carrying out ministerial acts of notifying Plan Participants, such as yourself, and making benefit payments as required by the Plan. Any matters for which discretion is required shall be referred by the Plan Supervisor to the Plan Administrator, and the Plan Supervisor shall take direction from Plan Administrator in all such matters. The Plan Supervisor shall not be responsible for advising the Company or Plan Administrator with respect to fiduciary responsibilities under the Plan nor for making any recommendations with respect to the investment of Plan Assets. The Plan Supervisor may rely on all information provided to it by the Company, Plan Administrator, and the Trustees, as well as the Plan's other vendors. The Plan Supervisor shall not be responsible for determining the existence of Plan Assets.

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

This Plan is a Qualified High Deductible Health Plan (QHDHP) as defined by the IRS, and can be paired with a tax-favored account such as a Health Savings Account (HSA). An HSA is an account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses, in accordance with IRS regulations. You can lower your overall health care costs by using these pre-tax dollars in your HSA to pay for deductibles, copayments, coinsurance, and other qualified expenses. You can contribute to an HSA only if you are enrolled in an HSA-eligible QHDHP and you have no disqualifying coverage. If you are enrolled on a qualified high deductible health plan and also have disqualifying coverage, which is any other coverage that is not a QHDHP, you (and your employer on your behalf) will not be able to make contributions to an HSA. If you have other insurance that is not a qualified high deductible health plan, you must notify your employer.

Lakeside Industries, Inc. of Issaquah, WA hereby establishes this Plan for the payment of certain expenses for your benefit to be known as Lakeside Industries, Inc. Group Medical and Dental Plan.

Lakeside Industries, Inc. assures you that during the continuance of the Plan, all benefits herein described shall be paid to you or on your behalf in the event you become eligible for benefits.

The Plan is subject to all the terms, provisions and conditions recited on the proceeding pages hereof.

This Plan is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

IMPORTANT INFORMATION - PLEASE READ

When contacting HMA's Customer Care Department, answers for benefits and eligibility will be provided to you and to providers of service. The benefits quoted by the Plan Supervisor (HMA) are not a guarantee of claim payment. Claim payment will be dependent upon eligibility at the time of service and all terms and conditions of the Plan. This disclaimer will be provided to you when benefits are quoted over the telephone.

For a written pre-estimate of benefits, a provider of service must submit to the Plan Supervisor the proposed course of treatment, including diagnosis, procedure codes, place of service, and proposed cost of treatment. In some cases, medical records or additional information may be necessary to complete the pre-estimate.

When the HMA Care Management Department pre-authorizes any confinement, procedure, service or supply, it is only for the purpose of reviewing whether the service is determined to be medically necessary for the care or the treatment of an illness. Pre-authorization does not guarantee payment of benefits. All charges submitted for payment are subject to all other terms and conditions of the Plan, regardless of authorization by the HMA Care Management Department whether by telephone or in writing.

NO SURPRISES ACT

The No Surprises Act is a federal law that establishes standards to protect you from balance billing if you receive emergency care at an Out-of-Network facility, if you receive treatment for certain ancillary services provided by an Out-of-Network provider but received them at a Preferred Network hospital or outpatient surgical facility, or if you receive Out-of-Network air ambulance services.

Under this Plan, you are responsible for certain cost-sharing amounts. This includes copayments, coinsurance and deductibles. You may have additional costs or be responsible for the entire bill if you see a provider or go to a facility that is not in your Plan's Preferred Provider Network.

Some providers and facilities have not signed a contract with your Preferred Provider Network. They are called Out-of-Network providers. Out-of-Network providers can bill you the difference between what this Plan pays and the amount your Out-of-Network provider bills. This is called balance billing.

The No Surprises Act will protect you from surprise medical bills in cases where you have limited control in choosing a Preferred Network or Out-of-Network provider. For Out-of-Network claims subject to the No Surprises Act, your cost-sharing will be the same amount as would be applied if the claim was provided by a Preferred 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 charge and the provider's billed charge for applicable services. This law does not apply if you choose or consent to receive services from an Out-of-Network provider.

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.

When you CANNOT be balance billed:

a) **Emergency Services**
The most you can be billed for emergency services is your plan's Preferred Network cost-sharing amount, even if you receive services at an Out-of-Network hospital or from an Out-of-Network provider that works at the hospital. This includes services provided in the emergency department of a hospital, a freestanding emergency room, and an urgent care facility when the state considers the facility as an independent freestanding emergency room and the services received are associated with an emergency. The amounts paid will be applied to your Preferred Network deductible and out-of-pocket maximum. The provider and facility cannot balance bill you for emergency services.

b) Certain services at an In-Network Health Care Facility
When you receive surgery, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeons, intensivists, or hospitalist services from an Out-of-Network provider while you are at a Preferred Network health care facility, the most you can be billed is your Preferred Network cost-sharing amount. The amounts paid will be applied to your Preferred Network deductible and out-of-pocket maximum. These providers cannot balance bill you.

c) Air Ambulance Services
When you receive air ambulance services, you are only required to pay the Preferred Network cost sharing amount even if the air ambulance company is Out-of-Network. The amounts paid will be applied to your Preferred Network deductible and out-of-pocket maximum. The air ambulance provider cannot balance bill you for the remaining amount. **Note:** This does not apply to ground ambulance services.

When you CAN still be balance billed:

If you receive services from an Out-of-Network provider, hospital or facility in any situation OTHER than those listed in paragraphs a), b), or c) above, you may still be balance billed, or you may be responsible for the entire bill. If you knowingly and voluntarily choose an Out-of-Network provider or sign a consent to receive services from an Out-of-Network provider, the Plan's Out-of-Network reimbursement rates will apply and you may be subject to balance billing.

In these instances, the Out-of-Network provider should notify you of their Out-of-Network status within 72 hours before services (or at the time of service if 72 hours advanced notice is not possible) are received. The notice should also include a good faith estimate of the cost for services and identify in-network options for obtaining services.

Independent Dispute Resolution (IDR)

The Plan has 30 days to make a benefit determination and either pay the Out-of-Network claim at the Out-of-Network rate directly to your provider or deny the claim. If your provider is not satisfied with our initial offering, they may request negotiation. If an agreement isn't reached during the negotiation period, your provider may initiate the Independent Dispute Resolution process. The Plan and your Out-of-Network provider will come to a negotiated agreement regarding full payment for services rendered within 30 days, starting on the day after your provider receives payment or the claim denial. If an agreement cannot be made, 4 days following the 30-day negotiation period, either the Plan or your provider may request arbitration, referred to as Independent Dispute Resolution (IDR). The IDR process will be administered by an independent, unbiased entity with no affiliation to the provider or the Plan. Once the IDR entity has made a determination, the arbitration process is final and binding.

PRE-AUTHORIZATION OF INPATIENT MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES

At the time that your doctor recommends surgery or an inpatient admission for you, you or your doctor should contact the HMA Care Management Department to request pre-authorization. All inpatient and outpatient non-emergency surgeries and all non-emergency admissions (excluding normal vaginal deliveries where the length of stay is 48 hours or less and cesarean section deliveries where the length of stay is 96 hours or less) must be pre-authorized in advance. You must call no later than 5 days prior to the medical facility admission or surgery. Surgeries performed in the doctor's own office do not need to be pre-authorized.

Pre-authorization is not required for services provided in an emergency room of a hospital. It is recommended that all emergency medical facility admissions and emergency surgeries be authorized within 48 hours after the medical facility admission or surgery, or by the next business day, if later.

Special Note Concerning Mothers and Newborns: Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time your provider recommends the extended stay.

Please see the Care Management provisions of this SPD for additional services which require pre-authorization. Failure to obtain pre-authorization from the HMA Care Management Department prior to the receipt of these services may result in the denial of your claim and the expenses will not apply towards the out-of-pocket maximum.

Pre-authorization does not guarantee payment of benefits. The Care Management Department should be contacted at the following numbers:

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
425/462-1000 - SEATTLE
800/869-7093 - OTHER AREAS NATIONWIDE

CERTIFICATION OF ADDITIONAL DAYS

If your physician/provider is considering lengthening a stay, you, your physician/provider, the hospital, or the medical facility must call HMA's Care Management Department to request certification for additional days. Call no later than the last day previously certified. If medically necessary, additional days of confinement may be certified at that time.

STEPS TO TAKE

When an inpatient admission or surgery is recommended, you, the physician/provider or a member of your family must call HMA's Care Management Department at least 5 days prior to the admission or surgery to obtain authorization. If an emergency admission or emergency surgery occurs, you or a member of your family should ask the attending physician/provider or the medical facility to contact HMA's Care Management Department within 48 hours of admission or surgery, or by the next business day, if later. Please be prepared to give HMA's Care Management Department the following information when you make the call for authorization:

- Your name and your age.
- Your subscriber identification number.
- Your group number (020465).
- Your medical facility name and address.
- The name and phone number of your admitting physician/provider.
- Your admission date.
- Your diagnosis.
- The procedure being performed.

The Care Management Department will send written confirmation of the approved admission to you once authorized.

CARE MANAGEMENT

Care Management services are provided for you if you are receiving acute or on-going care that is considered serious, high dollar or complex in nature. Acute or catastrophic events, high dollar claims and other unique or complex conditions will be monitored by Care Management. The following services may be reviewed for medical necessity and other conditions of the Plan; claims received without pre-authorization may be evaluated prior to payment to assess whether all benefit terms are met:

- Inpatient admissions and Outpatient surgeries.
- Home Health and Hospice Care.
- Radiation therapy (other than conformal).
- Durable Medical Equipment and Prosthetics that exceed $2,000.
- Infusions, Injections and Chemotherapy.
- Inpatient Acute Rehabilitation and Skilled Nursing Facility admissions.
- Residential, Partial Hospital Programs, and Intensive Outpatient Programs.
- Kidney Dialysis.
- Blood/Marrow and Solid Organ Transplants.
- Formula for PKU or other inborn errors of metabolism.
- Non-urgent ambulance or cabulance services.
- Gene therapy and adoptive cellular therapy.
- Genetic testing.

Assessment tools and evidenced based guidelines are used by Care Management for all case determinations. This SPD is the primary source for specific benefit language and is the default directive for any potential subsequent referenced guideline(s). Please see the Evidence Based Medicine provisions within the General Plan Provisions section of this SPD for information regarding guidelines and compendia used by this Plan for medical necessity and length of stay determinations.

Care Management will work with you to ensure that the right care at the right time is delivered and to lower the cost of health care to you and the Plan. The Care Manager shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of your care and when a higher level of care would be the reasonable outcome if lower level provisions of the Plan are not available. In order to qualify for alternative treatment, medical necessity criteria must be met for the higher cost service line that would be a reasonable expectation without access to the proposed lower cost alternative. Reasonable outcomes and expectations are determined by Care Management and/or Medical Director assessment.

Alternate care will be determined on the merits of each individual case and any care or treatment provided will not be considered setting any precedent or creating any future liability, with respect to you or any other covered participant.

CONTINUITY OF CARE

If you are receiving treatment for certain services, and your health care provider or facility was a contracted Preferred Network provider, but is no longer contracted, you may be able to continue to see that provider temporarily, on an in-network basis.

To qualify under this continuity of care provision, you must be:

- Undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Undergoing a course of institutional or inpatient care from the provider or facility;
- Scheduled to undergo non-elective surgery from the provider (including postoperative care following surgery);
- Pregnant and undergoing a course of treatment for pregnancy from the provider; or
- Determined to be terminally ill and is receiving treatment for such illness from the provider or facility.

If you qualify for continued benefits, the Plan will provide you 90 days of continued in-network coverage if your treating in-network provider leaves the network beginning on the date of the Plan's notice of termination is provided to you (or the date you are no longer receiving qualified continued treatment, whichever is earlier). This provision does not apply if the contract with the provider or facility was terminated due to a failure to meet quality standards or for fraud.

You must continue to be enrolled on this plan and you must elect continuation in writing (preferred) or verbally to be eligible for any continuity of care benefit. The Plan will notify you of the termination and that you have the right to receive continued transitional care from the provider or facility. You will also be given an opportunity to request a need for continued care. Coverage under this continuity of care provision will be provided on the same terms and conditions as any other in-network provider.

If you are receiving benefits under this continuity of care provision, your health care provider or facility must continue to adhere to all policies, procedures, and quality standards imposed by the network contract as if the termination had not occurred. During this continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue you for any amounts above the Plan's benefit amount.

When continuity of care ends, you may continue to receive services from this same provider, however, the plan will pay benefits at the out-of-network benefit level. Please see the Schedule of Benefits for more information. If we deny your request for continuity of care, you may appeal the denial. Please see Claim for Benefits and Appealing a Claim provisions for further information.

HOW TO FILE A CLAIM

All providers should send bills to the address listed on your medical identification card.

- You must provide the provider of service with the information listed on your medical identification card. Your provider must attach itemized bills to a claim form. An itemized bill is one that contains your provider's name, address, Federal Tax ID Number, and the nature of the accident or illness being treated.

- In the event that your provider does not submit the claim on your behalf, you may mail your claim form to the Plan Supervisor's address listed on the back of your identification card.

All claims for reimbursement must be submitted within one year of the date incurred.

PREFERRED NETWORK AND OUT-OF-NETWORK PROVIDER ARRANGEMENT

Your Plan contracts with provider networks to access discounted fees for your services. Hospitals, physicians and other providers who have contracted with the provider networks are called Preferred Network Providers or Participating Network Providers. Those who have not contracted with the networks are referred to in this Plan as Out-of-Network Providers. This arrangement results in the following benefits to you:

1. The Plan provides different levels of benefits based on whether you use a Preferred Network, Participating Network, or Out-of-Network-Network provider. If you elect to receive medical care from an Out-of-Network Provider, the benefits payable are generally lower than those payable when you use a Preferred Network provider, unless an exception applies as outlined in the Schedule of Benefits.
2. Except as outlined in the No Surprises Act provision above, if the charge billed by an Out-of-Network provider for any covered service is higher than the maximum allowable charge determined by the Plan, you are responsible for the excess unless the provider accepts assignment of benefits as consideration in full for services rendered. Since Preferred Network providers have agreed to accept a negotiated discounted fee as full payment for their services, you are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any provider, at its discretion.
3. To receive benefit consideration, you may need to submit claims for services provided by Out-of-Network Providers to the Plan Supervisor. Preferred Network providers have agreed to bill the Plan directly, so you do not have to submit claims yourself.
4. Benefits available to Preferred Network providers are limited such that if a Preferred Network provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a clean claim and review by the Plan Administrator, will be eligible for payment.

If you receive 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 a Preferred Network Provider and you receive such item or service in reliance on that information, your coinsurance, copayment, deductible, and out-of-pocket maximum will be calculated as if your provider had been Preferred Network despite that information proving inaccurate.

CONTINUATION OF COVERAGE PROVISIONS (COBRA)

Both you and your dependents should take the time to read the Continuation of Coverage Provisions. Under certain circumstances, you may be eligible for a temporary extension of health coverage, at group rates, where coverage under the Plan would otherwise end. The information in this section is intended to inform you, in a summary fashion, of your rights and obligations under the Continuation of Coverage provisions. To find out more about your Continuation of Coverage rights refer to the COBRA Section of this Summary Plan Description.

CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS

Healthcare Management Administrators, Inc. (HMA) is the Plan Supervisor. You are encouraged to contact HMA with questions you have regarding this Plan. HMA's Customer Care Department is available to answer questions about claims and how your benefits work. You may contact HMA's Customer Care Department at:

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
P.O. Box 85008, Bellevue, WA 98015-5008
425/462-1000 - Seattle
800/869-7093 - Other Areas Nationwide

SCHEDULE OF BENEFITS

This Plan does not require the designation of a primary care provider or to obtain a referral for services received from a specialist. You shall have the free choice to obtain services from any licensed physician/provider or surgeon, acting within the license's scope. The level of benefits received is based upon your decision at the time treatment is needed to access care through either Preferred or non-preferred providers. Benefits are payable at the Preferred level by accessing your care through a Preferred Provider, Preferred Medical Facility or from a Preferred Hospital. Out-of-Network charges will be paid at the Out-of-Network level of benefits.

If you are receiving treatment for certain services, and your health care provider or facility is no longer contracted as a Preferred Network provider, you may be able to continue to see that provider temporarily, on an in-network basis. Please see the Continuity of Care provision within the Important Information section for more information.

Important Out-of-Network Benefit Notice: The maximum allowable charge for Out-of-Network physician services is based upon 125% of Medicare allowable and all Out-of-Network facility fees is based upon 150% of Medicare allowable (including deductible, out-of-pocket maximum, and coinsurance as applicable), unless otherwise indicated under a specific benefit in the Schedule of Benefits.

Patients who utilize covered services received from Out-of-Network providers, may be subject to balance billing, even if the benefit shows Out-of-Network coverage at 100%. In this instance, the Plan will pay 100% of the maximum allowable amount, not 100% of the charges billed by the provider. Charges over the maximum allowable amount that are billed by the provider are not covered by this Plan and you may be billed for the balance of the charges.

For example, if you are charged $150 but the maximum allowable amount for that service is $100:

- ***With Out-of-Network coverage at 100%, the Plan will pay $100 (minus any applicable copayment or deductible). This is 100% of the maximum allowable amount. You may still be responsible for the amount billed by the Out-of-Network provider that is over the maximum allowable amount, in this example, $50. The Out-of-Network provider may balance bill you for the remaining $50.***
- ***With Out-of-Network coverage at 50%, the Plan will pay $50 (minus any applicable copayment or deductible). This is 50% of the maximum allowable amount. You may still be responsible for the amount billed by the Out-of-Network provider that is over the maximum allowable amount, in this example, $100. The Out-of-Network provider may balance bill you for the remaining $100.***

Your Preferred Provider Organization is:

If you live in Idaho/Oregon/Utah/Washington:
HMA Preferred Provider Network
800/869-7093
OR
Log in to the myHMA member portal at www.accesshma.com

If you live outside of WA, OR, ID, or UT:
PHCS Network
800/869-7093
OR
Log in to the myHMA member portal at www.accesshma.com

If you live in WA, OR, ID, or UT but are temporarily outside of your home state:
PHCS Network for Out-of-Area Access
800/869-7093
OR
Log in to the myHMA member portal at www.accesshma.com

You can access a directory of Preferred Network providers and facilities at any time on our online portal at www.accesshma.com. This directory is updated at least every 90 days. While we strive to provide accurate provider network status, the listings can change. We recommend you verify with your provider for the most up to date network contract status prior to receiving services.

Eligible expenses will be paid at the Preferred level (including the Preferred Network deductible and Out-of-Pocket Maximum) when (any of the following apply):

- The services are billed by a Preferred provider, hospital or medical facility.
- The services are for non-emergent care provided by a non-preferred Assistant Surgeon or Anesthesiologist, where the medical facility and the primary surgeon are both Preferred providers.
- You live outside the area serviced by the Preferred provider organization.
- You receive emergency services (includes Ambulance, Anesthesiologist, Assistant Surgeon, Emergency Room Services, Primary Surgeon, and Urgent Care) inside or outside the network area.
- The services are for Durable Medical Equipment (DME) distributed by a Preferred provider but the DME company is non-preferred.
- The services are for non-preferred diagnostic testing, lab and imaging services, where the physician/provider who ordered the services is a Preferred provider. Eligible services will be covered based upon 250% of the Medicare allowable charge.
- The services are for a non-preferred inpatient physician visit, where the hospital or medical facility where the services were rendered is a Preferred provider. Eligible services will be covered based upon 250% of the Medicare allowable charge.

If you do not reside within the HMA Preferred PPO Network service area but travel to it, you must use a HMA Preferred PPO Network provider in order to receive services covered at the Preferred Network level of benefit.

This Schedule of Benefits is a summary of the benefits provided under this Plan. **Please read the entire booklet for details on specific benefit limitations, benefit maximums, waiting periods and exclusions.**

MEDICAL BENEFITS

	Preferred/Participating Network	Out-of-Network
EMPLOYEE ONLY COVERAGE DEDUCTIBLE Per calendar year.	$2,000	$4,000
EMPLOYEE + DEPENDENTS COVERAGE DEDUCTIBLE Per calendar year.	$4,000	$8,000
EMPLOYEE ONLY COVERAGE OUT-OF-POCKET MAXIMUM Per calendar year.	$5,000	$10,000
EMPLOYEE + DEPENDENTS COVERAGE INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year.	$7,350	$20,000
EMPLOYEE + DEPENDENTS COVERAGE FAMILY OUT-OF-POCKET MAXIMUM Per calendar year.	$10,000	$20,000

Your individual and family out-of-pocket maximum includes eligible Medical and Prescription Drug expenses.

Your deductibles are combined. This means that the amounts credited to your Preferred and Participating Network deductibles are applied towards satisfying your Out-of-Network deductibles and the amounts credited to your Out-of-Network deductibles are applied towards satisfying your Preferred and Participating Network deductibles.

Your out-of-pocket maximums are combined. This means that the amounts credited to your Preferred and Participating Network out-of-pocket maximums are applied towards satisfying the Out-of-Network out-of-pocket maximums and the amounts credited to your Out-of-Network out-of-pocket maximums are applied towards satisfying your Preferred and Participating Network out-of-pocket maximums.

Your benefit maximums (calendar year and lifetime) are combined for Preferred, Participating, and Out-of-Network eligible expenses.

Once your out-of-pocket maximum is reached, your eligible expenses are paid at 100% of allowable charges for the remainder of the calendar year. Deductibles are included in the out-of-pocket maximum. There are some benefits that are not payable at the 100% coinsurance rate. The following expenses do not apply to the out-of-pocket maximum:

- Ineligible charges.

PRE-AUTHORIZATION FOR INPATIENT MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES is required for full benefits.

The deductible applies to all services unless noted as being waived in the Schedule below.

	Preferred/Participating Network	Out-of-Network
ACUPUNCTURE Limited to 20 visits per calendar year.	80%	60%
ALLERGY INJECTIONS/TESTING	80%	60%
AMBULANCE (AIR AND GROUND) Out-of-Network services are payable at 250% of the Medicare allowable. Services received from an Out-of-Network provider will be applied to the Preferred Network deductible and out-of-pocket maximum.	80%	80%
ANESTHESIOLOGIST Out-of-Network services are payable at 250% of the Medicare allowable.	80%	60%
ASSISTANT SURGEON Paid based upon the primary surgeon's allowed amount, whether contracted or maximum allowable charge. Out-of-Network services are payable at 250% of the Medicare allowable.	80%	60%
BREAST PUMPS Eligible charges received from an Out-of-Network provider are covered based upon billed charges.	100% deductible waived	100% deductible waived
CHIROPRACTIC SERVICES AND X-RAYS Limited to 20 visits per calendar year.	80%	60%
CLINICAL TRIALS	Standard of care paid the same as any other condition	Standard of care paid the same as any other condition
CONTRACEPTIVE SERVICES	100% deductible waived	Not Covered
DENTAL ACCIDENT	Paid the same as any other condition	Paid the same as any other condition
DIABETIC EDUCATION	100% deductible waived	Not Covered
DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT TRAINING	80%	60%
DIAGNOSTIC X-RAY, IMAGING AND LABORATORY	80%	60%
DIETARY EDUCATION	100% deductible waived	Not Covered
DURABLE MEDICAL EQUIPMENT	80%	60%

	Preferred/Participating Network	Out-of-Network
EMERGENCY ROOM & SERVICES Out-of-Network services are payable at 250% of the Medicare allowable. Services received from an Out-of-Network provider will be applied to the Preferred Network deductible and out-of-pocket maximum.	80%	80%
FERTILITY PRESERVATION Limited to $10,000 lifetime maximum	80%	60%
FLU SHOTS	100% deductible waived	100% deductible waived
GENE AND ADOPTIVE CELLULAR THERAPY	80%	Not Covered
Travel, Meals, and Lodging Limited to $7,500 per course of treatment. Services received from an Out-of-Network provider will be applied to the Preferred Network deductible and out-of-pocket maximum.	80%	80%
GENETIC TESTING	80%	60%
HOME HEALTH CARE Limited to 130 visits per calendar year.	80%	60%
HOSPICE CARE Limited to 14 inpatient days. Limited to 240 respite hours every 6 months.	80%	60%
IMMUNIZATIONS	100% deductible waived	100% deductible waived
INFUSION THERAPY	80%	60%
INJECTIONS	80%	60%
KIDNEY DIALYSIS (OUTPATIENT SERVICES)	80%	60%
MEDICAL FACILITY SERVICES		
Inpatient	80%	60%
Outpatient Surgical Facility	80%	60%
Miscellaneous Services	80%	60%
MEDICAL SUPPLIES	80%	60%
MENTAL HEALTH SERVICES		
Inpatient	80%	60%
Outpatient	80%	60%
Applied Behavioral Analysis Services received from an Out-of-Network provider will be applied to the Preferred Network deductible and out-of-pocket maximum.	80%	80%
NATUROPATHIC SERVICES	80%	60%

	Preferred/Participating Network	Out-of-Network
OBESITY TREATMENT (NON-SURGICAL)	Paid the same as any other condition	Paid the same as any other condition
ORTHOTICS	80%	60%
PHYSICIAN SERVICES		
Inpatient Services	80%	60%
Office Visits	80%	60%
PRE-ADMISSION TESTING	80%	60%
PREVENTIVE CARE	100% deductible waived	Not Covered
PREVENTIVE COLONOSCOPY	100% deductible waived	Not Covered
Fecal DNA Testing With Cologuard® **Preventive** Eligible services from an Out-of-Network provider will be based upon billed charges.	100% deductible waived	100% deductible waived
Fecal DNA Testing With Cologuard® **Diagnostic And Medically Necessary** Services received from an Out-of-Network provider will be applied to the Preferred Network deductible and out-of-pocket maximum. Eligible services from an Out-of-Network provider will be based upon billed charges.	80%	80%
PREVENTIVE GYNECOLOGICAL SERVICES	100% deductible waived	Not Covered
PREVENTIVE MAMMOGRAPHY	100% deductible waived	Not Covered
PROSTHETICS	80%	60%
RADIATION AND CHEMOTHERAPY	80%	60%
REHABILITATION SERVICES		
Inpatient Limited to 30 days per calendar year, with an additional 30 days per calendar year for the treatment of spinal cord injury, head injury, or stroke.	80%	60%
Outpatient Limited to 45 visits per calendar year with an additional 80 visits per calendar year for the treatment of spinal cord injury, head injury, or stroke. Rehabilitation services for the treatment of autism are not applied towards the per calendar year limit.	80%	60%
SECOND SURGICAL OPINION	80%	60%

	Preferred/Participating Network	Out-of-Network
SKILLED NURSING FACILITY CARE Limited to 120 days per calendar year.	80%	60%
STERILIZATION (ELECTIVE)		
Females	100% deductible waived	60%
Males	100%	60%
SUBSTANCE USE DISORDER SERVICES		
Inpatient	80%	60%
Outpatient	80%	60%
SURGEON FEES	80%	60%
TELEMEDICINE	Paid the same as any other condition	Paid the same as any other condition
TEMPOROMANDIBULAR JOINT DISORDER	80%	60%
TOBACCO CESSATION	100% deductible waived	Not Covered
TRANSPLANTS		
Transplants	80%	60%
Donor Benefits	80%	60%
Transportation Expenses (Travel, Meals, Lodging) Limited to $7,500 per transplant. Limited to $125 maximum per day. Services received from an Out-of-Network provider will be applied to the Preferred Network deductible and out-of-pocket maximum.	80%	80%
URGENT CARE FACILITY Services received from an Out-of-Network provider will be applied to the Preferred Network deductible and out-of-pocket maximum. Out-of-Network services are payable at 250% of the Medicare allowable.	80%	80%
OTHER MISCELLANEOUS ELIGIBLE CHARGES	80%	60%

Benefit maximums described herein are combined for the Preferred Network, Participating Network, and Out-of-Network.

A 5-day grace period will be allowed in determining whether or not an annual or monthly benefit limitation has been satisfied.

PRESCRIPTION BENEFITS

EMPLOYEE ONLY COVERAGE OUT-OF-POCKET MAXIMUM Per calendar year.	$5,000
EMPLOYEE + DEPENDENTS COVERAGE INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year.	$7,350
EMPLOYEE + DEPENDENTS COVERAGE FAMILY OUT-OF-POCKET MAXIMUM Per calendar year.	$10,000

Your individual and family out-of-pocket maximum includes eligible Medical and Prescription Drug expenses.

Express-Scripts - Retail Pharmacies

Generic Drugs	20% Copay
Brand Name Drugs	
On Formulary Drug List	20% Copay
Not On Formulary Drug List	20% Copay
Dispensing limit	30 days

Express-Scripts - Mail Order Prescriptions

Generic Drugs	20% Copay
Brand Name Drugs	
On Formulary Drug List	20% Copay
Not On Formulary Drug List	20% Copay
Dispensing limit	90 days

Medical deductible applies. You must pay 100% of the prescription at the pharmacy until the deductible has been satisfied. The Express-Scripts pharmacy will submit the claim to the Plan and charges will be applied towards your deductible. Once your deductible is met, you will only be required to pay the applicable coinsurance at the pharmacy. The deductible is waived for preventive prescription drugs (as determined by Express-Scripts) in accordance with IRS guidelines.

This Plan requires your pharmacist to fill the prescription with a generic product whenever it is available, unless the prescription is written as "Dispense as Written." If the prescription is not specified as "Dispense as Written" and the prescription is filled with a name brand prescription at your request, then the copay **plus** the difference between the ingredient cost of the generic drug and the brand name drug will be charged.

Over the Counter COVID-19 Tests

Over the Counter (OTC) COVID-19 Tests can be purchased point-of-sale at retail pharmacy locations, and are eligible for coverage under the pharmacy benefits of this Plan with no up-front out-of-pocket cost to you. Coverage will be limited to 8 tests per person every 30 days, based upon the purchase date of the test. If you paid up front for an OTC Covid-19 test and need to submit for reimbursement you must contact the PBM for claim submission instructions.

ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Employee Eligibility

You are eligible for coverage under this Plan if:

Class 1 Employees:

- You are a non-union salaried or hourly Lakeside Industries, Inc. employee who is regularly scheduled to work at least 20 hours per week in the state of Washington; or
- You are the Lakeside Industries, Inc. Alaska Barge Manager or a salaried Lakeside Industries, Inc. Aviation or Marine employee who is expected to work 800 hours per calendar year; or
- You are member of the board who is a current or former Lakeside Industries, Inc. employee, up to the Medicare eligibility age.

Class 2 Employees:

- You are a non-union seasonal Lakeside Industries, Inc. employee who averages at least 30 hours per week during your initial and/or standard 12-month measurement period.

If you are an Active, non-union Class 2 employee who is not designated eligible for coverage at time of hire your employer may use a 12-month look-back measurement period to determine your eligibility. You must average or be expected to average the required minimum hours of service established by your employer each week during your initial 12-month measurement period to be eligible for coverage.

Your initial measurement period begins the first day of the month following your date of hire, with an initial stability period commencing the first day of the second full calendar month following your initial measurement period. If there is a gap between the end of your first stability period and the start of the standard stability period, you will remain eligible until the first day of the standard stability period as long as you are actively working.

The standard 12-month measurement period begins the first day of the payroll period that includes March 1st, with a standard stability period commencing each April 1st. Coverage is effective the first day of the stability period following the applicable measurement period. To remain eligible for coverage, you must average the required minimum hours of service each week during each subsequent standard measurement period.

You are ineligible if, regardless of the number of hours worked, you are: a part-time employee regularly scheduled to work less than the minimum required hours or a temporary employee.

Dependent Eligibility

The following dependents are eligible for coverage under this Plan:

- Your legally married spouse as defined in the definition section. Coverage may continue during a legal separation only if ordered by a court decree.

- Your domestic partner. Domestic Partners are defined as two adults, of the same or opposite gender engaged in a spouse-like relationship and who have lived together for a period of at least 6 consecutive months. To qualify for domestic partners coverage, both individuals must meet the following qualifications:

  1) You have shared the same household for at least 6 consecutive months and intend to continue to do so indefinitely.
  2) You are engaged in a committed relationship of mutual caring and support and intend to remain so indefinitely.
  3) You share responsibility for each other's common welfare and living expenses.
  4) You share financial interdependence.
  5) You consider themselves to be life partners.
  6) You are not married (as defined by federal tax law) to, in a committed relationship with, or legally separated without a dissolution of marriage from anyone else.
  7) You have not had another domestic partner or spouse enrolled in the plan within the prior 6 months.
  8) You are both age 18 or older and mentally competent to consent to a contract.
  9) You are not related by blood to a degree of closeness that would prohibit legal marriage.
  10) You are not in the relationship solely for the purpose of obtaining benefits coverage.
  11) You have not been previously legally married to each other.
  12) You have not been previously covered under this plan as the employee's domestic partner and experienced a break in coverage because the domestic partnership ended.
  13) You must sign a Declaration of Domestic Partnership certifying that your relationship exists, and provide sufficient documentation of a domestic partnership, as defined.

  Coverage is available to the children of your Domestic Partner provided that the child meets the eligibility requirements for dependent children provided herein.

  Upon termination of your domestic partner relationship, you must submit a signed Declaration of Termination of Domestic Partnership acknowledging that your relationship has ended. Coverage for your domestic partner and your domestic partners' dependent children will cease on the last day of the month in which your domestic partner relationship has ended.

  Please contact your Human Resources Department if there is any change of circumstances attested to in this Declaration within 30 days of the change, to obtain an official Declaration of Domestic Partnership or for more information on how to qualify for coverage under this provision.

- Your married or unmarried child, under the age of 26, regardless of whether or not your child is eligible for employer sponsored coverage through your child's own employer, whether or not a full-time student, whether or not claimed as a dependent on your federal income taxes, and whether or not dependent upon you for support.
- Your unmarried dependent child(ren) incapable of self-support because of intellectual disability, mental health condition or physical disability or developmental disability that began prior to the date on which your child's eligibility would have terminated due to age. Proof of incapacity must be received within 120 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required as often as is reasonably necessary to verify continued eligibility for benefits.
- Your unmarried dependent child(ren) whose coverage is required pursuant to a valid court, administrative order or Qualified Medical Child Support Order (QMCSO).

- Your adopted children are eligible under the same terms and conditions that apply to your dependent, natural children covered under this Plan.
- If you are covered as an employee, you cannot also be covered as a dependent. No dependent can be covered as a dependent of more than one employee.

The term "dependent children" means any of your natural children, legally adopted children, or children who have been placed for adoption with you prior to the age of 18, step-children, or children who have been placed under the legal guardianship of you or your spouse by a court decree or placement by a State agency. Placement for adoption is defined as the assumption and retention of an obligation for total or partial support of a child in anticipation of adoption irrespective of whether the adoption has become final. The child's eligibility terminates upon termination of the legal obligation.

A dependent is defined as an individual who is: (1) listed on your application as your dependent; (2) eligible for dependent coverage (based upon the criteria above); (3) whose application has been accepted by the Plan Administrator; and (4) for whom the applicable rate of coverage has been paid.

ENROLLMENT

Regular Enrollment

To apply for coverage under this Plan, you must complete and submit an enrollment form within 60 days of the date you first become eligible for coverage. The completed enrollment form should list all of your eligible dependents to be covered. If you are not enrolled during the enrollment eligibility period, you will be required to wait until the next open enrollment period unless you become eligible to enroll as a result of a special enrollment period.

When you acquire a new dependent (birth, marriage, adoption, etc.), your new dependent must be enrolled within the enrollment eligibility periods specified below.

Your domestic partner who is not enrolled when you are first eligible, will be eligible for Special Enrollment to the same extent as a spouse.

Newly acquired dependent: Your newly acquired dependent (except a newborn child or a child placed for adoption) must be enrolled within 60 days of the date of acquisition.

Newborn: Your newborn child may be covered from birth provided your child is enrolled within 60 days of the date of birth.

Adopted Child: Your child placed for adoption may be covered from the date of placement provided your child is enrolled within 60 days of the date of placement.

Newborn Enrollment

A newborn child of you or your spouse will be covered for 3 weeks following your child's birth. The Plan must be notified of the birth. To continue your newborn child's coverage beyond the first 3 weeks, your child must be eligible under the terms of the Plan and a completed enrollment application, listing your child as a dependent, must be received by the Plan Administrator within 60 days from the date of birth.

MID-YEAR ENROLLMENT CHANGES

You are given the opportunity to pay required contributions for participation in this group health plan through a Premium Only Plan sponsored by Lakeside Industries, Inc., in accordance with the Internal Revenue Code, Section 125. The Premium Only Plan allows for your contributions to be made on a pre-tax basis. Since this plan is provided pursuant to Section 125, certain rules apply regarding changes in enrollment under the Premium Only Plan and therefore impact enrollment under the medical plan. IRS rules state that

your enrollment decisions for the Premium Only Plan are irrevocable for the duration of the plan year, unless you experience an IRS qualifying status change.

Qualifying status changes are IRS-approved events to change your pre-tax benefit elections during the plan year. If you experience a qualifying status change, you may change your benefit election to adapt to that change.

IRS qualifying status change reasons include the following:

- Change in your legal marital status.
- Change in your number of dependents.
- Change in the employment status of you, your spouse or your child (includes termination or commencement of employment, strike or lockout; commencement of or return from an unpaid leave of absence; change in worksite; or other change in employment status that may affect eligibility).
- You, your spouse, or your child becomes eligible for COBRA continuation coverage.
- Change as required under a judgment, decree, or court order, including a Qualified Medical Child Support Order, resulting from your divorce, legal separation, annulment or change in legal custody of a child or foster child who is your dependent.
- You, your spouse, or your child's entitlement to Medicare or Medicaid or the loss of coverage under Medicare or Medicaid.
- Significant cost changes for a benefit package (increase or decrease).
- Significant curtailment of a benefit package with or without a loss of coverage.
- Addition or improvement of a benefit package option.
- Change in coverage under another employer plan (same employer or another employer).
- Loss of group health coverage sponsored by a governmental or educational institution, by you, your spouse, or your child.
- Changes due to you taking leave under the Family and Medical Leave Act.

To make a mid-year enrollment change, you must submit a written request to the Plan Administrator within 60 days after the status change occurs (within 60 days for a newly eligible dependent acquired through marriage, and within 60 days for newly eligible dependent acquired through birth, adoption, or placement for adoption.) Your request must describe the desired change and the status change reason. The requested change must be consistent with the status change event; otherwise, the request will be declined.

If you want to make a plan change, but one of the above events does not apply, you will need to wait until the Plan's next open enrollment period. For more information regarding mid-year plan changes, please contact your Human Resources Department.

Special Enrollment for Loss of Other Coverage

If you are a current employee, a special enrollment period is available for you and your dependents who lose coverage under another group health plan or had other health insurance coverage if the following conditions are met:

- You or your dependent is eligible for coverage under the terms of the Plan, but not enrolled.
- Enrollment in the Plan was previously offered to you.
- You declined coverage under the Plan because, at the time, you and/or your dependents were covered by another group health plan or other health insurance coverage.
- You have declared in writing that the reason for your declination was the other coverage.

You or your dependent may request the special enrollment within 31 days of the loss of your other health coverage under the following circumstances:

- If your other group coverage is not COBRA continuation coverage, special enrollment can only be requested after losing eligibility for the other coverage due to a COBRA qualifying event or after cessation of employer contributions for the other coverage. Loss of eligibility of other coverage does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause. You do not have to elect COBRA continuation in order to preserve the right to a special enrollment.
- If your other group coverage is COBRA continuation coverage, the special enrollment can only be requested after exhausting COBRA continuation coverage.
- If you no longer reside, live, or work in the service area and therefore your other individual or group coverage no longer provides benefits to you and in the case of group coverage, no other benefit packages are available.
- If your other plan no longer offers any benefits to your class of similarly situated individuals.

Your effective date of coverage will be the first of the month following the date your request is received by the Plan Administrator.

Special Enrollment for Loss of State Children's Health Insurance Program (SCHIP) or Medicaid

If you are a current employee, a special enrollment period is available for you and your dependents who are otherwise eligible for coverage under the Plan, if one of the following events occurs:

- You or your dependent's State Child Health Plan coverage or Medicaid coverage is terminated due to a loss of eligibility.
- You or your dependent become eligible for State Child Health Plan or Medicaid premium assistance.

You or your dependent may request the special enrollment within 60 days from the date your other coverage is lost or within 60 days from the date that your premium assistance eligibility is determined.

Your effective date of coverage will be the first of the month following the date your request is received by the Plan Administrator.

Special Enrollment for New Dependents

If you are a current employee, a special enrollment period is available for you if you acquire a new dependent by birth, marriage, domestic partnership, legal guardianship, adoption, or placement for adoption. This special enrollment applies to the following events:

- When you become married, a special enrollment period is available for you and your newly acquired dependents. As long as the proper enrollment material is received by the Plan Administrator within the 60-day enrollment period, the effective date of coverage will be the first of the month following your date of marriage/date of domestic partnership agreement.
- When you or your spouse acquires a child through birth, adoption, or placement for adoption, a special enrollment period is available for you, your spouse and the dependent. As long as the proper enrollment material is received by the Plan within the 60-day enrollment period, the effective date of coverage will be the date of the birth, adoption, or placement of adoption.
- For a legal guardianship, on the date on which such child is placed in your home pursuant to a court order appointing you as the legal guardian for the child.

When you acquire a new dependent as outlined above, any pre-existing dependent(s) who meets the eligibility requirements of the Plan but not previously enrolled, will be eligible to enroll for coverage during the special enrollment period.

Special Enrollment for New Dependents through Qualified Medical Child Support Order

Section 609(a) of ERISA requires medical benefit plans to honor the terms of a Qualified Medical Child Support Order (QMCSO). The order must be issued as a part of a judgment, order of decree or a divorce settlement agreement related to child support, alimony, or the division of marital property, issued pursuant to state law. Agreements made by you, but not formally approved by a court are not acceptable. If the child is enrolled within 60 days of the court or state agency order, the waiting period does not apply.

Open Enrollment

An open enrollment period is held once every 12 months to allow you to change your participation. The open enrollment period will be the month of November for an effective date of January 1st.

EFFECTIVE DATE OF COVERAGE

Employee Effective Date

Your effective date of coverage is the first of the month following the waiting period. The waiting period is the period that must pass before coverage for you or your dependent, that is otherwise eligible to enroll under the terms of the Plan, can become effective. Periods of employment in an ineligible classification are not part of your waiting period.

Class 1 Employees:
Your effective date of coverage is the first of the month coinciding with or following your date of hire.

Class 2 Employees:
Your effective date of coverage is the first day of the stability period following the applicable waiting period.

Dependent Effective Date

If you elect coverage for your dependents during the first 60 days of eligibility, your dependents' effective date will be the same as your effective date.

If you get married, you must add your newly acquired dependents within 60 days of your date of marriage and the effective date of coverage is the first of the month following your date of marriage/date of domestic partnership agreement.

If you acquire a child through birth, adoption, or placement for adoption, you must add the child within 60 days of the date of birth, adoption or placement for adoption and the effective date of coverage for the child is the date of birth, adoption, or placement for adoption.

TERMINATION OF COVERAGE

Except as provided in the Plan's Continuation of Coverage provisions, coverage will terminate on the earliest of the following occurrences:

Employee

- The date your Employer terminates the Plan and offers no other group health plan.
- The last day of the month in which you cease to meet the eligibility requirements of the Plan.
- The last day of the month in which your employment ends.
- The date you begin active duty military service in the armed forces of any country (coverage may continue in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994).

- The date you fail to make any required contribution when coverage is contributory.
- The first day you fail to return to work following an approved leave of absence.
- The last day of the month in which you retire.

Dependent(s)

- The date your Employer terminates the Plan and offers no other group health plan.
- The date your coverage terminates.
- The last day of the month in which such individual ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which you (the employee) die.
- The date your dependent becomes eligible and enrolled under this Plan as an employee.
- The last day of the month in which contributions have been made on your dependent's behalf.
- The date your dependent begins active duty military service in the armed forces of any country (coverage may continue in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994).
- The date the Plan discontinues dependent coverage.

Your employer has the right to rescind your or your dependents coverage for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under this Plan. Your employer may either void coverage for you and/or your covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide you at least 30 days advance written notice of such action. Your employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. Your employer reserves the right to collect additional monies if claims are paid in excess of your and/or your dependent's paid contributions.

If you or your dependent commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or you fail to notify the Plan Administrator that you have become ineligible for coverage, then your employer may either void coverage for you and your covered dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide you at least 30 days advance written notice of such action.

APPROVED FAMILY AND MEDICAL LEAVE

The Plan will at all times comply with the Family and Medical Leave Act (FMLA) or similar state law that applies to coverage under this group health plan. During any leave taken under FMLA (or applicable state law), you may maintain coverage under this Plan on the same conditions as if you had been continuously employed during the entire leave period.

Please contact your Human Resources Department for information on how to qualify for a Family/Medical Leave of Absence.

APPROVED LEAVE OF ABSENCE (OTHER THAN FEDERAL FAMILY AND MEDICAL LEAVE OF ABSENCE)

If you are granted an approved leave of absence (other than medical/family leave of absence) you, and your covered dependents, will be eligible to continue coverage until terminated by your Employer.You will be

responsible for paying all of the premiums during the leave of absence. If your leave extends more than what is allowed by your employer, you, and your covered dependents, will be eligible to continue coverage under the (COBRA) Continuation of Coverage Provisions of the Plan.

You and your dependents who are being reinstated to an active status after an approved leave of absence do not have to satisfy the initial waiting period again if it was satisfied prior to going out on the approved leave of absence. There will be no lapse in coverage for you and your dependents that have continued coverage while on the approved leave of absence. If you did not continue coverage while on the leave of absence, then coverage will be reinstated on the first day of the month following your return to active status.

You and any of your dependents who had not satisfied the waiting period prior to the approved leave of absence will receive credit for the portion of the initial waiting period that was satisfied prior to your leave of absence. Coverage will begin on the first of the month following your satisfaction of any remaining eligibility waiting period.
You, and your dependents, who are reinstated after an approved leave of absence, which extends beyond what is allowed by your employer, will be treated as a new enrollee.

Please contact your Human Resources Department for information on how to qualify for an Approved Leave of Absence.

LEAVE OF ABSENCE DUE TO FURLOUGH

If you are granted an approved leave of absence due to furlough as a result of state or federal order, you, and your covered dependents, will be eligible to continue coverage for up to 6 months as determined by your employer. If your leave extends beyond 6 months, you, and your covered dependents, will be eligible to continue coverage under the (COBRA) Continuation of Coverage Provisions of the Plan. You will be responsible for paying your standard contribution amounts (if any) for both you and your dependents during the furlough leave of absence. Contact your Human Resources Department to make contribution arrangements. Failure to return to work as of the first scheduled shift upon the conclusion of the furlough period shall be treated as a termination event due to failure to return from an approved leave.

You and your dependents who are being reinstated to an active status after an approved leave of absence due to furlough, do not have to satisfy the initial waiting period again if it was satisfied prior to going out on the approved leave of absence. There will be no lapse in coverage for you and your dependents that have continued coverage while on the approved leave of absence. If you did not continue coverage while on the leave of absence, then coverage will be reinstated on the first day of the month following your return to active status.

You and any of your dependents who had not satisfied the waiting period prior to the approved leave of absence will receive credit for the portion of the initial waiting period that was satisfied prior to your leave of absence. Coverage will begin on the first of the month following your satisfaction of any remaining eligibility waiting period.

You, and your dependents, who are reinstated after an approved leave of absence, which extends beyond 6 months, will be treated as a new enrollee.

Please contact your Human Resources Department for information regarding leave of absence due to furlough.

MILITARY LEAVE OF ABSENCE

If you are going into or returning from military service, you may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights apply only to you and your dependents covered under the Plan before leaving for military service.

The maximum period of coverage of a person under such an election shall be the lesser of:

a. If your election is made on or after December 10, 2004, the 24-month period beginning on the date that your Uniformed Service leave commences; or

b. The period beginning on the date that your Uniformed Service leave commences and ending on the day after the date on which you were required to apply for or return to a position of employment and you fail to do so.

If you elect to continue Plan coverage you may be required to pay up to 102% of the full contribution under the Plan, except if you are on active duty for 30 days or less, you cannot be required to pay more than your employee share, if any, for the coverage.

Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during your military service. If, while on active service, you obtain coverage through TRICARE, that coverage will be primary for any injury or illness that was caused by your active military service.

If you are enrolled on a qualified high deductible health plan and you elect coverage through TRICARE, you (and your employer on your behalf) will no longer be able to contribute to a Health Savings Account (HSA).

Please contact your Human Resources Department for information concerning your eligibility for USERRA and any requirements of the Plan.

REINSTATEMENT OF COVERAGE

If you or your dependent, who was covered under this Plan terminates employment or loses eligibility for coverage and is rehired or again becomes eligible for coverage within 13 weeks of the date of termination, the waiting period will be waived. If you are not reinstated on the Plan within 13 weeks, you must re-satisfy the waiting period before re-enrolling in the Plan; however, the deductibles, out-of-pocket maximums and benefit limitations previously applied/credited, will continue to apply once reinstated.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

Lakeside Industries, Inc. Group Medical and Dental Plan (the Plan)

The following information about your right to continue your health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your covered spouse and dependent children, upon loss of coverage under this Plan. **The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

In general, COBRA requires that a "qualified beneficiary" covered under this group health plan who experiences a "qualifying event" be allowed to elect to continue that health coverage for a period of time. **You and your dependents will be considered qualified beneficiaries if you were covered by the Plan on the day before the qualifying event occurred. Your domestic partner and your domestic partner's enrolled children will be considered a qualified beneficiary and eligible to continue coverage under the COBRA provisions to the same extent as your spouse or child.** Coverage is elected on the election form provided by the Plan Administrator. Both you and your dependents should take the time to read the Continuation of Coverage Rights provisions.

The Plan has multiple group health components and you may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan or by Lakeside Industries, Inc. (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires. Nothing in this SPD is intended to expand your rights beyond COBRAs requirements.

The Plan Administrator is:

Lakeside Industries, Inc.
6505 226th Place SE Suite 200
Issaquah, WA 98027
425/313-2600 (phone)

The party responsible for administering COBRA continuation coverage ("COBRA Administrator") is:

Everything Benefits
1253 Springfield Avenue, Suite 350
New Providence, NJ 07974
800/689-3568 (phone)
cobra@everythingbenefits.com

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?"

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to you and your dependents losing Plan coverage who are "qualified beneficiaries." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the Plan gives to other Participants or beneficiaries under the Plan who are not receiving COBRA coverage. If you elect COBRA, you will have the same rights under the Plan as other Participants or beneficiaries covered under the component or components of the Plan, including open enrollment and special enrollment rights. Under the Plan, if you elect COBRA you must pay for COBRA coverage.

Additional information about the components of the Plan is available in other portions of this SPD.

WHO IS ENTITLED TO ELECT COBRA?

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

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

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (Part A, Part B, or both, only in limited circumstances as this entitlement should not cause a loss of coverage); or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your parent-employee dies;
- Your parent-employee's hours of employment are reduced;
- Your parent-employee's employment ends for any reason other than gross misconduct;
- Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both, only in limited circumstances as this entitlement should not cause a loss of coverage);
- Your parents become divorced or legally separated; or
- You stop being eligible for coverage under the Plan as a "dependent child."

If you take FMLA leave and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will be entitled to elect COBRA if (1) you were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) you will lose Plan coverage within 18 months because of your failure to return to work at the end of the leave. (This means that you may be entitled to elect COBRA at the end of an FMLA leave even if you were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage.")

Special COBRA rights apply to you if you are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). If applicable, you are entitled to a second opportunity to elect COBRA for yourself and certain family members (that have not already elected COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which you become eligible for TAA or ATAA, but only if the election is made within the six months immediately after your group health plan coverage ended. If you qualify or may qualify for TAA or ATAA, contact the Plan Administrator using the Plan contact information provided below. **Contact the Plan Administrator promptly after qualifying for TAA or ATAA or you will lose the right to elect COBRA during a special second election period.**

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is your end of employment, reduction of hours of your employment or your death, the Plan will automatically offer COBRA coverage. You need not notify the Plan Administrator of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of you and your spouse or your dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan Administrator in writing within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which you, your spouse, or your child loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event (Form & Notice Procedures)," and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Qualifying Event." **If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.** (You may obtain a copy of the Notice of Qualifying Event (Form & Notice Procedures) from the Plan Administrator.)

ELECTING COBRA COVERAGE

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the COBRA Administrator (An election notice will be provided to you at the time of a qualifying event. You may also obtain a copy of the Election Form from the Plan Administrator.)

Under federal law, you must have 60 days from the date of the COBRA election notice provided to you at the time of your qualifying event to decide whether you want to elect COBRA under the Plan. Mail, fax, or e-mail the completed Election Form to:

Everything Benefits
1253 Springfield Avenue, Suite 350
New Providence, NJ 07974
800/689-3568 (phone)
cobra@everythingbenefits.com

You must complete the Election Form in writing and mail, fax, or e-mail to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about your COBRA coverage.

If mailed, your election must be postmarked (if faxed or e-mailed, your election must be electronically delivered) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event. IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

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

You do not have to send any payment with your Election Form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

You and your covered dependents will have an independent right to elect COBRA. For example, your spouse may elect COBRA even if you do not. COBRA may be elected for only one, several, or for all of your dependent children who are qualified beneficiaries. You and your spouse (if your spouse is a qualified beneficiary) may elect COBRA on behalf of you and your children, and parents or legal guardians may elect COBRA on behalf of children. **If you, your spouse, or your children do not elect COBRA within the 60-day election period specified in the Plan's COBRA election notice you WILL LOSE THE RIGHT TO ELECT COBRA COVERAGE.**

When you complete the Election Form, you must notify the COBRA Administrator if you have become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify the COBRA Administrator of the date of your Medicare entitlement at the address specified above for delivery of the Election Form.

As a qualified beneficiary, you may be enrolled in one or more group health components of the Plan at the time of a qualifying event. If you are entitled to a COBRA election as the result of a qualifying event, you may elect COBRA under any or all of the group health components of the Plan under which you were covered on the day before the qualifying event.

You are entitled to elect COBRA even if you have other group health plan coverage or are entitled to Medicare benefits on or before the date on which you elect COBRA. However, as discussed in more detail below, your COBRA coverage will terminate automatically if, after electing COBRA, you become entitled to Medicare benefits or become covered under other group health plan coverage. See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you receive COBRA coverage for the maximum time available to you. In addition, affordable coverage may be available for you and your family through the Health Insurance Marketplace. Health Insurance Marketplace coverage may cost less than COBRA continuation coverage. You should compare other coverage options with COBRA and choose the coverage that is best for you. Please be aware once you've made your choice, it can be difficult or impossible to switch to another coverage option.

LENGTH OF COBRA COVERAGE

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When Plan coverage is lost due to your death, your divorce or legal separation, or your dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When Plan coverage is lost due to the end of your employment or reduction of your hours of employment, and you become entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than yourself) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date of employment termination, COBRA coverage under the Plan's components for your spouse and children who lost coverage as a result of your termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if you become entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of your hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in your COBRA election was your termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if you are disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate your right to extend the period of COBRA coverage.

If you, as a qualified beneficiary are determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was your termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the later of your termination of employment or reduction of hours or the date coverage is lost due to the qualifying event and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if qualified.

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

- The date of the Social Security Administration's disability determination;
- The date of your termination of employment or reduction of hours; and
- The date on which you lose (or would lose) coverage under the terms of the Plan as a result of the termination of employment or reduction of hours.

Notwithstanding the above 60 day notification of disability period, notice of disability from the Social Security Administration must be delivered to the Plan Administrator during the initial 18 month qualifying event period for consideration of disability as a second qualifying event.

In providing this notice, you must use the Plan's form entitled "Notice of Disability (Form & Notice Procedures)," and you must follow the procedures specified in the section below entitled "Notice

Procedures for Notice of Disability." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period and within 18 months after your termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE. (You may obtain a copy of the Notice of Disability (Form & Notice Procedures) from the COBRA Administrator.)

An extension of coverage will be available to your spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following your termination of employment or reduction of hours.

The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include your death, divorce, legal separation or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if the event would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when you are a covered employee and become entitled to Medicare as Medicare entitlement does not cause a loss of coverage.)

This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which you would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while you were still covered under the Plan).

In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event (Form & Notice Procedures)," and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Second Qualifying Event." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT. (You may obtain a copy of the Notice of Second Qualifying Event (Form & Notice Procedures) from the COBRA Administrator.)

ENROLLING IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

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

- Any required premium is not paid in full and on time;
- You become covered, after electing COBRA, under another group health plan;
- You become entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- Your employer ceases to provide any group health plan for its employees; or
- During a disability extension period, you, as a disabled qualified beneficiary, are determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

COBRA coverage may also be terminated for any reason the Plan would terminate your coverage or for you not receiving COBRA coverage (such as fraud).

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, you become entitled to Medicare (Part A, Part B, or both) or you become covered under other group health plan coverage. You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)," and you must follow the procedures specified below in the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability." (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) from the COBRA Administrator.)

Your COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator of Medicare entitlement or other group health plan coverage.

If you are a disabled qualified beneficiary and it is determined by the Social Security Administration you are no longer disabled, you must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination. You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)," and you must follow the procedures specified below in the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability." (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) from the COBRA Administrator.)

If the Social Security Administration determines that you are no longer disabled during a disability extension period, COBRA coverage for you and your family will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that you are no longer disabled. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator that you are no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period.")

COST OF COBRA COVERAGE

You are required to pay the entire cost of COBRA coverage. The amount you may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including you and your employer's contributions) for coverage of a similarly situated Plan Participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check.

Your first payment and all monthly payments for COBRA coverage must be mailed to:

Everything Benefits
1253 Springfield Avenue, Suite 350
New Providence, NJ 07974
800/689-3568 (phone)

cobra@everythingbenefits.com

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed.) See the section above entitled "Electing COBRA Coverage."

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

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

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The COBRA Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for your COBRA coverage - it is your responsibility to pay your COBRA premiums on time).

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

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child born to, adopted by, or placed for adoption with you during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if you are a qualified beneficiary, you have elected COBRA coverage for yourself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it may last for the duration of the maximum COBRA coverage period based upon the initial qualifying event and any second qualifying events (as applicable). To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age). Other pre-existing eligible dependents who were not previously enrolled, may enroll at the same time however, they are not considered qualified beneficiaries for purposes of COBRA continuation coverage.

A child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Plan Administrator during your period of employment with Lakeside Industries, Inc. is entitled to the same rights to elect COBRA as an eligible dependent child of yours.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan and COBRA Administrators informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan and COBRA Administrators.

PLAN CONTACT INFORMATION

You may obtain information about the Plan and COBRA coverage on request from:

Lakeside Industries, Inc.
6505 226th Place SE Suite 200
Issaquah, WA 98027
425/313-2600 (phone)

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent SPD (if you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from Plan Administrators).

NOTICE PROCEDURES

Lakeside Industries, Inc. Group Medical and Dental Plan (the Plan)

Notice Procedures for Notice of Qualifying Event

The deadline for providing this notice is 60 days after the later of (1) the qualifying event (i.e., a divorce or legal separation or a child's loss of dependent status); and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the qualifying event.

You must mail, fax, or e-mail this notice to:

Lakeside Industries, Inc.
6505 226th Place SE Suite 200
Issaquah, WA 98027
425/313-2600 (phone)

Your notice must be in writing (using the Plan's form described below) and must be mailed, faxed, or e-mailed. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If faxed or e-mailed your notice must be electronically delivered no later than the deadline described above.

You must use the Plan's form entitled "Notice of Qualifying Event (Form & Notice Procedures)" to notify the Plan Administrator of a qualifying event (i.e., a divorce or legal separation or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Qualifying Event (Form & Notice Procedures) from the Plan Administrator).

Your notice must contain the following information:

- The name of the Plan (Lakeside Industries, Inc. Group Medical and Dental Plan);
- The name and address of the employee or former employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event (divorce, legal separation, or child's loss of dependent status);
- The qualifying event (divorce, legal separation, or child's loss of dependent status);
- The date that the divorce, legal separation, or child's loss of dependent status happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are notifying the Plan Administrator of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within 60 days of the divorce or legal separation in accordance with these Notice Procedures for Notice of Qualifying Event and must in addition provide evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

If you provide a written notice that does not contain all of the information and documentation required by these Notice Procedures for Notice of Qualifying Event, such a notice will nevertheless be considered timely if **all** of the following conditions are met:

- The notice is mailed, faxed, or e-mailed to the individual and address specified above;
- The notice is provided by the deadline described above;
- From the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan;
- From the written notice provided, the Plan Administrator is able to identify you and any qualified beneficiary(ies), the qualifying event (divorce, legal separation, or child's loss of dependent status), and the date on which the qualifying event occurred; and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Qualifying

Event) within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for the Notice of Qualifying Event described above).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

You, as the covered employee, a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

If your notice was regarding your child's loss of dependent status, you must, if the Plan Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the Plan Administrator (for example, a birth certificate to establish the date that a child reached the limiting age). This will allow the Plan Administrator to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Plan Administrator that your child ceased to be a dependent on the date specified in your Notice of Qualifying Event, your child's COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures for Notice of Disability

The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of your termination of employment or reduction of hours; and (3) the date on which you or your family member would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Notwithstanding the above 60 day notification of disability period, notice of disability from the Social Security Administration must be delivered to the Plan Administrator during the initial 18 month qualifying event period for consideration of disability as a second qualifying event.

You must mail, fax, or e-mail this notice to:

Lakeside Industries, Inc.
6505 226th Place SE Suite 200
Issaquah, WA 98027
425/313-2600 (phone)

Your notice must be in writing (using the Plan's form described below) and must be mailed, faxed, or e-mailed. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If faxed or e-mailed, your notice must be electronically delivered no later than the deadline described above.

You must use the Plan's form entitled "Notice of Disability (Form & Notice Procedures)" to notify the Plan Administrator of a qualified beneficiary's disability and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Disability (Form & Notice Procedures) from the Plan Administrator.)

Your notice must contain the following information:

- The name of the Plan (Lakeside Industries, Inc. Group Medical and Dental Plan);
- The name and address of the employee or former employee who is or was covered under the Plan;
- The initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours);

- The date that the covered employee's termination of employment or reduction of hours happened;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary became disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name, and contact information of the individual sending the notice.

Your Notice of Disability must include a copy of the Social Security Administration's determination of disability.

If you provide a written notice to the Plan Administrator that does not contain all of the information and documentation required by these Notice Procedures for Notice of Disability, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- The notice is mailed, faxed, or e-mailed to the individual and address specified above;
- The notice is provided by the deadline described above;
- From the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan and a qualified beneficiary's disability;
- From the written notice provided, the Plan Administrator is able to identify you and any qualified beneficiary(ies) and the date on which your termination of employment or reduction of hours occurred; and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Disability) within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for the Notice of Disability described above).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

You, as the covered employee, a qualified beneficiary who lost coverage due to your termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.

Notice Procedures for Notice of Second Qualifying Event

The deadline for providing this notice is 60 days after the later of (1) the date of the second qualifying event (i.e., a divorce or legal separation, the covered employee's death, or a child's loss of dependent status); and (2) the date on which your covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under the Plan).

You must mail, fax, or e-mail this notice to the COBRA Administrator at:

Everything Benefits
1253 Springfield Avenue, Suite 350
New Providence, NJ 07974
800/689-3568 (phone)
cobra@everythingbenefits.com

Your notice must be in writing (using the Plan's form described below) and must be mailed, faxed, or e-mailed. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If faxed or e-mailed, your notice must be electronically delivered no later than the deadline described above.

You must use the Plan's form entitled "Notice of Second Qualifying Event (Form & Notice Procedures)" to notify the COBRA Administrator of a second qualifying event (i.e., a divorce or legal separation, the covered employee's death, or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Second Qualifying Event (Form & Notice Procedures) from the COBRA Administrator).

Your notice must contain the following information:

- The name of the Plan (Lakeside Industries, Inc. Group Medical and Dental Plan);
- The name and address of the employee or former employee who is or was covered under the Plan;
- The initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours);
- The date that the covered employee's termination of employment or reduction of hours happened;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- The second qualifying event (a divorce or legal separation, the covered employee's death, or a child's loss of dependent status);
- The date that the divorce or legal separation, the covered employee's death, or a child's loss of dependent status happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are notifying the COBRA Administrator of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If you provide a written notice to the COBRA Administrator that does not contain all of the information and documentation required by these Notice Procedures for Notice Second Qualifying Event, such a notice will nevertheless be considered timely if **all** of the following conditions are met:

- The notice is mailed, faxed, or e-mailed to the individual and address specified above;
- The notice is provided by the deadline described above;
- From the written notice provided, the COBRA Administrator is able to determine that the notice relates to the Plan;
- From the written notice provided, the COBRA Administrator is able to identify you and any qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event, and the date on which the second qualifying event occurred; and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Second Qualifying Event) within 15 business days after a written or oral request from the COBRA

Administrator for more information (or, if later, by the deadline for this Notice of Second Qualifying Event described above).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

You, as the covered employee, a qualified beneficiary who lost coverage due to your termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the second qualifying event reported in the notice.

If your notice was regarding a child's loss of dependent status, you must, if the COBRA Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the COBRA Administrator (for example, a birth certificate to establish the date that a child reached the limiting age). This will allow the COBRA Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the COBRA Administrator that the child ceased to be a dependent on the date specified in your Notice of Second Qualifying Event, the child's COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to loss of dependent status. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

If your notice was regarding the death of the covered employee, you must, if the COBRA Administrator requests it, provide documentation of the date of death that is satisfactory to the COBRA Administrator (for example, a death certificate or published obituary). This will allow the COBRA Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the COBRA Administrator that the date of death was the date specified in your Notice of Second Qualifying Event, the COBRA coverage of all qualified beneficiaries receiving an extension of COBRA coverage as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered employee's death. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

If you are providing a Notice of Other Coverage (a notice that you, your spouse, or your child has become covered, after electing COBRA, under other group health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective.

If you are providing a Notice of Medicare Entitlement (a notice that you, your spouse, or your child has become entitled, after electing COBRA, to Medicare Part A, Part B, or both), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If you are providing a Notice of Cessation of Disability (a notice that you, your spouse, or your child whose disability resulted in an extended COBRA coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

You must mail, fax, or e-mail this notice to the COBRA Administrator at:

Everything Benefits
1253 Springfield Avenue, Suite 350
New Providence, NJ 07974
800/689-3568 (phone)
cobra@everythingbenefits.com

Your notice must be provided no later than the deadline described above.

You should use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)" to notify the COBRA Administrator of any of these events, and all of the applicable items on the form should be completed. (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) from the COBRA Administrator.)

Your notice should contain the following information:

- The name of the Plan (Lakeside Industries, Inc. Group Medical and Dental Plan);
- The name and address of the employee or former employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies);
- The qualifying event that started your COBRA coverage;
- The date that the qualifying event happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are providing a Notice of Other Coverage, your notice should include the name and address of the qualified beneficiary who obtained other coverage, the date that the other coverage became effective, and evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a Notice of Medicare Entitlement, your notice should include the name and address of the qualified beneficiary who became entitled to Medicare, the date that Medicare entitlement occurred, and a copy of the Medicare card showing the date of Medicare entitlement.

If you are providing a Notice of Cessation of Disability, your notice must include the name and address of the disabled qualified beneficiary, the date of the Social Security Administration's determination that the qualified beneficiary is no longer disabled, and a copy of the Social Security Administration's determination.

You, as the covered employee, a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

If you first become covered by another group health plan coverage after electing COBRA, your COBRA coverage will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a Notice of Other Coverage is provided.

If you first become entitled to Medicare Part A, Part B, or both after electing COBRA, your COBRA coverage will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a Notice of Medicare Entitlement is provided.

If you are determined by the Social Security Administration to be no longer disabled, COBRA coverage for you and your family members whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a Notice of Cessation of Disability is provided.

PLAN PAYMENT PROVISIONS

DEDUCTIBLES

Employee Only Coverage

The deductible is the amount of eligible medical expenses each calendar year that you must incur before any benefits are payable by the Plan. Your employee only coverage deductible amount is listed in the Schedule of Benefits.

Employee Plus Dependents Coverage

When the deductible amounts accumulated by all covered participants of your family reach the employee plus dependents deductible shown in the Schedule of Benefits during one calendar year, no further deductibles will apply to any family member for the rest of that calendar year.

AMOUNTS NOT CREDITED TOWARD THE DEDUCTIBLE

The following expenses will not be considered in satisfying the deductible requirement:

- Expenses incurred for non-compliance with Plan pre-authorization requirements.
- Expenses for services or supplies not covered by this Plan.
- Charges in excess of the maximum allowable charge.

COINSURANCE PERCENTAGE

The coinsurance is the percentage of the maximum allowable charge that the Plan will pay for non-participating providers, or the percentage of the negotiated rate for preferred providers and participating providers. Once your deductible is satisfied, the Plan shall pay benefits for covered expenses incurred during the remainder of the calendar year at the applicable coinsurance as specified in the Schedule of Benefits. You are responsible for paying the remaining percentage. Your portion of the coinsurance represents your out-of-pocket expense.

The non-participating provider of service may charge more than the maximum allowable charge. The portion of the non-participating provider's bill in excess of the maximum allowable charge is not a covered expense under this Plan and is your responsibility.

OUT-OF-POCKET MAXIMUM

The amount of the coinsurance which is your responsibility is applied toward your out-of-pocket maximum. When you or your family's out-of-pocket total reaches the out-of-pocket maximum as shown in the Schedule of Benefits during one calendar year, the Plan will pay 100% of allowable charges of your incurred eligible medical expenses for the remainder of that calendar year.

Some benefits will remain at a constant coinsurance level, not applying toward your out-of-pocket maximum, and not payable at 100% once your out-of-pocket maximum is reached.

The following expenses are not applied to the out-of-pocket maximum:

- Expenses not covered under this Plan.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

ELIGIBLE EXPENSES

When medically necessary for the diagnosis or treatment of an illness or an accident, the following services are eligible expenses for yourself covered under this Plan. Eligible expenses are payable as shown in the Schedule of Benefits and are limited by certain provisions listed in the General Exclusions. Major Medical expenses are subject to all Plan conditions, exclusions, and limitations.

ACUPUNCTURE

Acupuncture services when performed by a provider acting within the scope of their license are eligible for coverage by the Plan.

ALLERGY INJECTIONS/TESTING

Eligible charges for the injections, testing, syringes and medication will be payable as shown in the Schedule of Benefits.

AMBULANCE (AIR AND GROUND)

Services of a licensed ambulance company for transportation to the nearest medical facility where the required service is available, if other transportation would endanger your health and the purpose of the transportation is not for personal or convenience reasons.

Cabulance

The Plan will cover charges of a licensed ground cabulance service for non-emergent medical transport if you are a medically stable patient who cannot otherwise use private transportation without endangering your safety. You will be eligible for ground cabulance services when:

- You are medically stable and require a wheelchair with portable oxygen, a non-active IV, hep lock, Foley catheter or NG tube.
- You are medically stable, non-ambulatory and you require movement by wheelchair, or you are ambulatory but you require assistance to transfer.

To be eligible for coverage, cabulance services must be provided to you by a licensed cabulance company and must be pre-authorized by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in denial of your claim. Cabulance staff are ADA certified and the vehicle is ADA compliant.

BLOOD BANK

Eligible charges made by a blood bank for processing of blood and its derivatives, cross-matching and other blood bank services; charges made for whole blood, blood components, and blood derivatives to the extent not replaced by volunteer donors will be covered by the Plan. Storage of any blood and its derivatives are not covered under the Plan.

CHIROPRACTIC CARE

Covered chiropractic services include spinal manipulation, adjunctive therapy, vertebral alignment, subluxation, spinal column adjustments and other chiropractic treatment of the spinal column, neck, extremities or other joints, provided for as defined under the definition of physician/provider. Examinations

and x-rays in connection with chiropractic care are subject to the chiropractic limit shown in the Schedule of Benefits.

CONTRACEPTIVE SERVICES

Benefits will be provided for consultations, counseling, all contraceptive methods which require a prescription and have been approved by the United States Food and Drug Administration, and Participant education. Benefits are also provided for insertion and removal of intrauterine devices and implants.

This benefit does not cover contraceptives that can be purchased without a prescription, such as condoms, sponges, or contraceptive foam or jelly.

DENTAL SERVICES

Dental services provided by a dentist, oral surgeon, or physician/provider, including all related medical facility inpatient or outpatient charges, including an outpatient surgical center, for only the following:

- Treatment for accidental injuries to natural teeth. Treatment for up to 12 months from the date of the accident for accidental injuries is provided under this Plan. Injuries caused by biting or chewing are not covered under the medical plan.
- Treatment performed by an oral surgeon to excise and/or biopsy suspected lesions, excised confirmed tumors or malignancies of the oral cavity, tongue, or jaw; whether done in a dental office or hospital.
- Benefits for anesthesia for dental services are covered the same as relevant services listed on your Schedule of Benefits. Services must be prior authorized by the Plan and are only provided for Participants with complicating medical conditions. Examples of these conditions include, but are not limited to:
    - Mental handicaps.
    - Physical disabilities.
    - A combination of medical conditions or disabilities that cannot be managed safely and efficiently in a dental office.
    - Emotionally unstable, uncooperative, combative Participants where treatment is extensive and impossible to accomplish in the office.

All other dental services are excluded.

DIABETIC EDUCATION

Diabetic education is a covered benefit, if provided by a physician/provider as defined under this Plan. Benefit will be provided for diabetic self-management training and education, including nutritional therapy. The Plan will be the final authority on which education programs will meet the criteria of eligibility.

DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT TRAINING

Covered expenses include charges for the following services, supplies, equipment, and training for the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy based upon your medical needs:

Services and Supplies:

- Foot care to minimize the risk of infection including routine and preventive foot care;
- Dilated retinal examinations;

- Diabetic needles and syringes;
- Injection aids for the blind;
- Diabetic test agents; urine test strips, ketone test strips;
- Lancets/lancing devices;
- Alcohol swabs;
- Injectable glucagon's; and
- Glucagon emergency kits.

Durable Medical Equipment:

- External insulin pumps;
- Blood glucose monitors; and
- Foot care appliances for prevention of complications associated with diabetes.

Training:

- Diabetes outpatient self-management training and medical nutrition therapy services must be ordered by a physician and provided by appropriately licensed or registered healthcare professionals. Services deemed preventive under the Affordable Care Act will be covered under the Diabetic and/or Dietary Education benefit.

DIAGNOSTIC X-RAY AND LABORATORY

Benefits will be provided for medical services, administration, and interpretation of diagnostic X-ray, pathology, and laboratory tests. Dental x-rays are excluded. 3D mammograms are covered.

Screening for gestational diabetes, Human Papillomavirus (HPV) DNA testing, and Human Immune-deficiency Virus (HIV) for women will be covered under the Preventive Care benefits of the Plan.

DIETARY EDUCATION

Dietary education is a covered benefit, if provided by a physician/provider as defined under this Plan. Benefits will be provided for education, guidance, and nutritional therapy for individuals with illnesses or diseases that can be improved with diet, including, but not limited to diabetes, high blood pressure, and high cholesterol. The Plan will be the final authority on which education programs will meet the criteria of eligibility.

DURABLE MEDICAL EQUIPMENT

Benefits are provided for rental or purchase (if more economical in the judgment of the Plan Supervisor's Care Management Department) of medically necessary durable medical equipment. Durable medical equipment is equipment able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally used in the absence of illness or injury. The durable medical equipment must be prescribed by a physician/provider for therapeutic use, and include the length of time needed, the cost of rental and cost of purchase prior to any benefits being paid. Examples of durable medical equipment include: crutches; wheelchairs; kidney dialysis equipment; beds and mattresses; traction equipment; footwear (corrective shoes, diabetic shoes and orthopedic shoes); keyboard language or assistive communication devices; non-invasive positive pressure ventilation systems (CPAP, BiPAP) and equipment for administration of oxygen. Repairs or replacement of eligible equipment shall be covered when necessary to meet your medical needs and when necessary to make the equipment serviceable, but not where repairs suggest malicious damage or culpable neglect.

Benefits are not provided for certain equipment including, but not limited to, air conditioners, humidifiers, over-the-counter arch supports, orthopedic chairs, personal hygiene items, purifiers, heating pads, enuresis (bed-wetting) training equipment, exercise equipment, whirlpool baths, weights, or hot tubs. The fact that an item may serve a useful medical purpose will not ensure that benefits will be provided. Please see the sections covering Medical Supplies, Orthotics, and Prosthetics for further information.

Services for manual and electronic breastfeeding equipment or supplies will be covered under the Breast Pump benefit as outlined in the Schedule of Benefits. Hospital grade equipment is covered under the Durable Medical Equipment benefit and is subject to all applicable plan provisions.

Purchase or rental of durable medical equipment that is over $2,000 must be reviewed by Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim.

EMERGENCY ROOM & SERVICES

Benefits will be provided for emergency room treatment of an accidental injury or a medical emergency. Charges for emergency room facility fees and services provided by the attending emergency room physician are paid at the level shown in the Schedule of Benefits under the Emergency Room & Services benefit. All other eligible services provided in an emergency room (including, but not limited to, outpatient physician visits, diagnostic testing, laboratory, and x-ray) will be covered at the level shown in the Schedule of Benefits for the specific service received. For example if you receive an x-ray during an emergency room visit, the Diagnostic X-ray, Imaging, and Laboratory benefit will apply to x-ray, not the Emergency Room benefit.

If services are received from an Out-of-Network provider, the plan will use a reasonable method of calculating reimbursement so payment is in line with reimbursement of services if received from an In-Network provider. Please see the definition of Maximum Allowable Charge in the General Definitions section.

FERTILITY PRESERVATION

In the event medically necessary treatments, including but not limited to, chemotherapy and radiation therapy which may result in infertility are required, the Plan will cover expenses for the preservation of fertility, including storage costs. Charges for treatment in excess of this limit are a non-covered expense under this Plan.

All treatment must be performed on an outpatient basis. This benefit does not include coverage for any expense related to the diagnosis of infertility or treatment to restore fertility.

GENDER AFFIRMATION SERVICES

Medically necessary medical and surgical services for gender affirmation, including related mental health services and prescription drugs, are covered by the Plan. Services must be pre-authorized by the Plan Supervisor's Care Management Department. Surgeries or other treatments that are cosmetic in nature or are deemed experimental or investigative based upon current medical policy are not covered by the Plan. Such services and coverage determination shall be made using approved industry standard medical criteria and Evidence Based Compendia used by this Plan, which may be informed in part, but is not limited to guidelines and recommendations put forth by World Professional Association for Transgender Health (WPATH).

The Plan does not cover any related services which are not medically necessary nor does it cover travel expenses, unless the Plan includes a separate Medical Travel benefit.

GENE AND ADOPTIVE CELLULAR THERAPY

This Plan covers services for medically necessary inpatient and outpatient adoptive cellular therapy and gene therapy and associated services. Covered services will be determined based upon industry standard medical criteria and Evidence Based Compendia used by this Plan and the services are provided by a Center of Excellence or a designated provider approved by the Plan. Services must be pre-authorized in advance by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim. Services received from a non-designated provider will not be covered.

Travel expenses are eligible for reimbursement by the Plan when covered gene therapy services are provided by an approved designated provider who is not available locally. This benefit includes reimbursement for transportation, meals, and lodging, for you, the patient, and is limited as shown in the Schedule of Benefits. Covered transportation includes commercial airfare (coach class), commercial train fare, or documented auto mileage (calculated per IRS allowances) to the treatment area and local ground transportation to and from treatment within that area during the course of the treatment.

If services are for your covered dependent child under the age of 18 or a disabled adult in need of caregiver assistance, round trip coach airfare will be paid for one accompanying parent, guardian, or caregiver for each trip, up to the limit shown in the Schedule of Benefits.

GENETIC TESTING

This Plan covers charges for medically necessary genetic testing and genetic counseling when received by a provider acting within the scope of their license.

Charges are covered for the examination of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or to provide information to guide the selection of treatment of certain diseases, including cancer.

Covered services includes genetic counseling when provided in conjunction with medically necessary genetic testing and when performed by a provider with specialized education in genetics (including genetic counselors, physician geneticists, and physicians with advanced training in genetics).

Genetic counseling includes counseling about the benefits and risk of potential genetic testing and interpretation of genetic testing results to guide further health care decisions.

Charges for genetic testing must be pre-authorized in advance by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim.

Services deemed preventive by the United States Preventive Services Task Force (USPSTF) will be paid under the Plan's Preventive Care benefit.

This Plan will comply with the Genetic Information Nondiscrimination Act of 2008 (GINA) at all times. GINA protects you against discrimination based on your genetic information in health coverage and in employment. GINA prohibits employers and other entities covered by GINA, from requesting or requiring genetic information from you or your family members. In order to comply with this law, you will not be required to provide any genetic information to the Plan, except as allowed under the law. Genetic information, as defined by GINA, includes your family medical history, the results of your or your family member's genetic tests, the fact that you or your family member sought or received genetic services, and genetic information of a fetus carried by you or your family member or an embryo lawfully held by you or your family member receiving assistive reproductive services.

HOME HEALTH CARE

Services for Home Health Care must be ordered by a physician/provider, include a treatment plan, and must be pre-authorized by the Care Management Department prior to services being rendered. Failure to pre-authorize services may result in the denial of the claim.

Charges made by a home health care agency (approved by Medicare or state certified) for the following services and supplies furnished to you in your home for care in accordance with a home health care treatment plan are included as covered medical expenses. Charges for home health care services described below will be applied to the home health care benefit and subject to the home health care maximum as shown in the Schedule of Benefits. Outpatient rehabilitation provided in a home setting are covered under the Rehabilitation Services benefit when medically appropriate for the patient. This benefit is not intended to provide custodial care but is provided for care in lieu of inpatient hospital, medical facility or skilled nursing facility care for you if you are homebound.

The following services will be considered eligible expenses:

- Part-time or intermittent nursing care by a registered nurse, a licensed vocational nurse, or by a licensed practical nurse.
- Physical therapy by a licensed, registered, or certified physical therapist.
- Speech therapy services by a licensed, registered, or certified speech therapist.
- Occupational therapy services by a registered, certified, or licensed occupational therapist.
- Nutritional guidance by a registered dietitian.
- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.
- Respiratory therapy services by a certified inhalation therapist.
- Home health aide services by an aide who is providing intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records.
- Medical supplies, drugs and medicines prescribed by a physician/provider, and laboratory services normally used by you in a skilled nursing facility, medical facility or hospital, but only to the extent that they would have been covered under this Plan if you had remained in the hospital or medical facility.
- Assessment by a Masters of Social Work (M.S.W.).

Exclusions to Home Health Care

- Non-medical or custodial services except as specifically included as an eligible expense.
- Meals on Wheels or similar home delivered food services.
- Services performed by a member of your family or household.
- Services not included in the approved treatment plan.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.

HOSPICE CARE

Services for Hospice Care must be ordered by a physician/provider, include a treatment plan, and must be pre-authorized by the Plan Supervisor's Care Management Department prior to services being rendered. Failure to pre-authorize services may result in the denial of the claim.

If you are terminally ill, the services of an approved hospice will be covered for medically necessary treatment or palliative care (medical relief of pain and other symptoms), subject to the conditions and limitations specified below. Services and supplies furnished by a licensed hospice (Medicare approved or state certified) for necessary treatment will be eligible for payment as shown in the Schedule of Benefits. The following services will be considered eligible expenses:

- Confinement in a hospice facility or at home.
- Ancillary charges furnished by the hospice while you are confined.
- Medical supplies and drugs prescribed by your attending physician/provider, but only to the extent such items are necessary for pain control and management of the terminal condition.
- Physician/provider services and/or nursing care by a registered nurse, licensed practical nurse, master in social work, or a licensed vocational nurse.
- Home health aide services and home health care.
- Nutritional advice by a registered dietitian, nutritional supplements, such as diet substitutes, administered intravenously or through hyperalimentation.
- Physical therapy, speech therapy, occupational therapy, respiratory therapy.
- Respite care up to a maximum of 240 hours in each six-month period of hospice care, to relieve anyone who lives with and cares for you if you are terminally ill. The first six-month respite care period begins on your first day of covered hospice care.

With respect to hospice care, a treatment plan must include:

- A description of the medically necessary care to be provided to you if terminally ill for palliative care or medically necessary treatment of an illness or injury but not for curative care.
- A provision that care will be reviewed and approved by your physician/provider at least every 60 days.
- A prognosis of six months or less to live.

Exclusions to Hospice Care

- Non-medical or custodial services except as specifically included as an eligible expense.
- Meals on Wheels or similar home delivered food services.
- Services performed by a member of your family or household.
- Services not included in your approved treatment plan.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.
- Hospice bereavement services.

IMMUNIZATIONS

Immunizations for routine use in children, adolescents, and adults if ordered by your physician/provider and are medically necessary or are recommended by the Federal Drug Administration (FDA) or Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and listed on the Immunization Schedules of the CDC for children and adults are covered as shown in the Schedule of Benefits. Covered services do not include immunizations for the purpose of travel, occupation or residence in a foreign country.

INFERTILITY TESTING

The Plan covers charges incurred for outpatient evaluation and testing of infertility. Charges for procedures to restore fertility or to induce pregnancy are not covered under this Plan.

INFUSION THERAPY BENEFIT

Inpatient and outpatient services and supplies for infusion therapy are provided at the coinsurance level shown in the Schedule of Benefits. Your attending physician/provider must submit, and periodically review, a written treatment plan that specifically describes the infusion therapy services and supplies to be provided. The treatment plan must be approved in advance by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim. Drugs and supplies used in conjunction with infusion therapy will be provided only under this benefit.

To ensure clinically appropriate delivery of treatment, lower overall cost of care and increase patient satisfaction and quality of life, the Plan has partnered with the Plan Supervisor's Care Management Department to offer an infusion/specialty drug program. This Plan requires utilization of an optimal site of care for infusion administration. Optimal sites of care include a physician's office, a pharmacy, an outpatient infusion center, or a home-based setting. The Care Management Department will work with you and your treating provider to ensure that the infusion services and any high cost specialty oral drugs are delivered through the most cost effective and medically appropriate channels. Site of care review criteria will be waived for payment of the first dose of a medication, to allow for adequate transition time to an approved site of care for subsequent infusions. The Plan reserves the right to require use of a specialty drug vendor who has contracted with the Plan or with the Plan Supervisor to manage this benefit. If an approved site of care is available under the infusion site of care program, the coverage of administering an infusion in an unapproved site of care may be denied.

KIDNEY DIALYSIS (OUTPATIENT SERVICES)

Charges for professional treatment, supplies, medications, labs, and facility fees related to outpatient kidney dialysis are covered services under the Plan. When kidney dialysis is recommended, your provider must first contact the Plan Supervisor's Care Management Department to pre-authorize the treatment. Failure to pre-authorize services may result in the denial of the claim. Eligible services will be covered as shown in the Schedule of Benefits and will be paid in accordance with the applicable provider network agreements, or in accordance with other Out-of-Network payment methodologies.

Eligible services include, but are not limited to, hemodialysis, peritoneal dialysis, and hemofiltration. Coverage is subject to your annual deductible and coinsurance up to the Out-of-Pocket Maximum amount offered under the Plan for Preferred Network, Participating Network, or Out-of-Network coverage. You may elect to enroll in Medicare coverage as a secondary insurance and the Plan will coordinate benefits as primary payer during the applicable Medicare coordination period.

The Plan Supervisor's assigned Care Manager will work with you to understand how the benefit works.

Notwithstanding the above, upon the conclusion of the coordination period as required under Federal Medicare regulations, this Plan will take a secondary position to Medicare as permitted pursuant to Medicare Secondary Payer regulations.

Please note: if you have secondary coverage through Medicare you will not be eligible to make or receive contributions to your Health Savings Account.

MATERNITY SERVICES

Pregnancy and complications of pregnancy will be covered as any other medical condition. Medical facility, surgical and medical benefits are available on an inpatient or outpatient basis for the following maternity services:

- Normal delivery.
- Cesarean delivery.
- Routine prenatal and postnatal care.
- Treatment for complications of pregnancy.
- Doula support services.

Breastfeeding support and services will be covered under the Preventive Care benefits of the Plan.

Newborns' and Mothers' Health Protection Act

The Plan will at all times comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for you or your newborn child to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section, or require that your provider obtain authorization from the Plan for prescribing a length of stay for you or your newborn child not in excess of the above periods.

MEDICAL FACILITY SERVICES

Inpatient Care

The following benefits will be provided for inpatient care in an accredited hospital or medical facility when you are under the care of a physician/provider:

- Room and board in a semi-private room.
- Intensive care, cardiac care, isolation or other special care unit.
- Private room accommodations, if medically necessary.
- Nursing care services.
- Prescribed drugs and medications administered in the hospital or the medical facility.
- Anesthesia and its administration.
- Oxygen and its administration.
- Dressings, supplies, casts, and splints.
- Diagnostic services, including but not limited to x-ray, laboratory, and radiological services.
- The use of durable medical equipment.

Outpatient Care

Benefits will be provided for minor surgery, including x-ray, laboratory, and radiological services, and for emergency room treatment of an accidental injury or a medical emergency.

Miscellaneous

All other charges made by a hospital or the medical facility during an inpatient confinement are eligible, exclusive of: personal items; services not necessary for the treatment of an illness or injury; or services specifically excluded by the plan.

MEDICAL SUPPLIES

When prescribed by your physician/provider, and medically necessary, the following medical supplies are covered; including but not limited to: braces; surgical and orthopedic appliances; colostomy bags and supplies required for use; catheters; syringes and needles necessary for diabetes or allergic conditions; dressings for surgical wounds, cancer, burns, or diabetic ulcers; oxygen; back brace; and cervical collars.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Benefits are available for inpatient or outpatient care for mental health and substance use disorder conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the diagnosis when rendered by a covered provider. Covered services also include neurobiological disorders as **defined in General Definitions**, and treatment of eating disorders (such as anorexia nervosa, bulimia, or any similar condition) when medically necessary. Medical services associated with Medication Assisted Treatment (MAT) for substance use disorder is covered under this benefit. Applied Behavioral Analysis is covered as outlined in the Schedule of Benefits.

Benefits are available for residential treatment facility, partial hospitalization, and intensive outpatient services.

Mental Health and Substance Use Disorder Services benefits include those received by you on an inpatient or intermediate care basis in a hospital or an alternate facility, and those received on an outpatient basis in your provider's office, alternate facility or home setting.

When inpatient or intermediate treatment (including Residential Treatment, Partial Hospital Program or Intensive Outpatient Program) for Mental Health Services, including neurobiological disorders, are recommended, you or your provider must first contact the Plan Supervisor's Care Management Department to pre-authorize the requested services.

Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorders that are both of the following are covered:

- Provided by or under the direction of a psychiatrist and/or a licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing a danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a covered condition under the Plan and is paid under the applicable benefit for the service being provided.

NEWBORN NURSERY CARE BENEFIT

Medical facility charges incurred by your well newborn during the initial period of confinement will be covered as charges of your baby. In addition, a circumcision performed in an outpatient setting within 31 days of the birth of your baby will be covered under this benefit.

- Medical facility nursery expenses for your healthy newborn, including circumcision.

- Routine pediatric care for your healthy newborn child while confined in a hospital or medical facility immediately following birth.
- Phenylketonuria (PKU) testing within the first seven days of life.

If your baby is ill, suffers an injury, premature birth, congenital abnormality, or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided coverage is in effect.

Charges for preventive care (routine immunizations and examinations) will be considered eligible expenses only to the extent specifically shown in the Schedule of Benefits.

OBESITY TREATMENT (NON-SURGICAL)

If you are obese, the Plan covers doctor's office visits and related laboratory tests for the treatment of obesity. Treatment must be provided by your doctor on an outpatient basis according to a written treatment plan. The benefit is limited to one course of treatment. A course of treatment begins and ends as specified in your treatment plan, or sooner if you discontinue treatment. Obesity is defined as BMI $\geq$ 30. This must be documented by objective evidence provided by your physician/provider who is treating you. The Plan does not pay for anything not included in your written treatment plan. In addition, the Plan does not pay for appetite or weight control drugs, dietary supplements, special foods or food supplements, health and weight control centers or resorts, health club memberships or exercise equipment.

OBESITY SURGERY (BARIATRIC SURGERY)

The Plan does not cover any form of surgical treatment to address obesity. Medically necessary treatment of complications (including but not limited to a hernia repair or treatment of iron deficiency), to a previous bariatric surgery are covered. The need for a removal, replacement, or revision surgery is not considered a complication. Treatment of complications resulting from a medical error are not covered nor are complications of a bariatric surgery performed outside of the United States. Cosmetic related procedures are not covered.

In addition, procedures/surgeries performed only to ensure the success of a non-covered obesity service, or as a result of a non-covered obesity service will not be covered under the Plan. The Plan does not pay for cosmetic surgery, including body sculpting desired as a result of significant weight loss.

ORTHOTICS

Medically necessary orthotic foot devices prescribed by a physician/provider to restore or improve function are covered at the coinsurance level indicated in the Schedule of Benefits.

Benefits are provided for medically necessary non-foot orthoses as follows: rigid and semi-rigid custom fabricated orthoses; semi-rigid prefabricated and flexible orthoses; rigid prefabricated orthoses.

Custom foot orthoses are only covered for you if you have impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease); when the foot orthosis is an integral part of a brace and is necessary for the proper functioning of the brace; when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of injury, sickness, or congenital defect; or if you have a neurological or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, misalignment, or pathological positioning of the foot and there is a reasonable expectation of improvement.

OUTPATIENT SURGICAL FACILITY

An outpatient surgical facility refers to a lawfully operated facility that is established, equipped, and operated to perform surgical procedures. Services rendered by an outpatient surgical facility are covered when performed in connection with a covered surgery.

PALLIATIVE CARE

Palliative care is covered if you have a serious illness and your provider has assessed that you are in need of palliative services. Covered services include counseling, symptom management, and treatment within scope of palliation concurrently with disease-directed therapies.

Palliative Care focuses on providing you with relief from the symptoms, pain and stress of a serious illness, regardless of the diagnosis. The goal is to improve quality of life for both you and your family. It is appropriate at any age and at any stage of a serious illness and can be provided along with curative treatment. Typically, the palliative care interdisciplinary team is composed of a physician board-certified in hospice and palliative medicine, an advanced practice nurse, a social worker and a chaplain. This benefit is available in conjunction with or without hospice benefits.

PHENYLKETONURIA (PKU) DIETARY FORMULA

This Plan covers tube feeding or orally administered formula which is medically necessary for the treatment of phenylketonuria (PKU) and other inborn errors of metabolism, based on medical evaluation and under the supervision of a Physician. Services must be pre-authorized by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in denial of your claim. This benefit does not cover foods related to dietary restrictions or gluten free diets.

PHYSICIAN SERVICES

Physician's fees for medical and surgical services are covered.

Services for well-women visits, sexually transmitted infection counseling for women, Human-Immune-deficiency virus (HIV) counseling for women, and screening and counseling for interpersonal and domestic violence for women will be covered under the Preventive Care benefits of the Plan.

PRE-ADMISSION TESTING

Charges for laboratory and x-ray examinations to determine if you are suitable for surgery prior to admission are covered as shown in the Schedule of Benefits.

PRESCRIPTION DRUGS

Inpatient drugs are covered when administered to you for the treatment of a covered illness or accident, while confined. Inpatient prescription drugs will be paid as shown in the Schedule of Benefits and are subject to the deductible.

Outpatient prescription drugs are reimbursable through your prescription drug card plan.

PREVENTIVE CARE

This benefit covers routine physician/provider services and related diagnostic tests that are regularly performed without the presence of symptoms, including school or sports examinations and examinations required by the Department of Transportation. Benefits will be covered under this Preventive Care benefit if services are in accordance with age and frequency guidelines according to, and as recommended by, the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices or the Health Resources and Services Administration (HRSA). In the event any of these bodies

adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. Services are payable as shown in the Schedule of Benefits.

PREVENTIVE COLONOSCOPY OR FECAL DNA TESTING WITH COLOGUARD®

Preventive routine screening colonoscopies are covered for all Plan participants. Services are payable as shown in the Schedule of Benefits. Additionally, fecal DNA testing with Cologuard®, may be considered medically necessary in lieu of colonoscopy. Any positive test must be followed up by colonoscopy.

PREVENTIVE MAMMOGRAPHY

Preventive routine screening mammograms, including 3D mammograms, are covered by the Plan. Services are payable as shown in the Schedule of Benefits. Mammograms, other than routine screening mammograms, are covered when medically necessary if prescribed by your physician/provider and payable at the Diagnostic, X-Ray and Laboratory Benefit as shown in the Schedule of Benefits.

PROSTHETIC APPLIANCES

Benefits are provided for artificial devices which are medically necessary to replace a missing or defective body part, including (but not limited to) artificial limbs, eyes, breasts, cochlear implant, BAHA, and artificial shoulder, knee, or hip. Benefits will also be payable for an external and permanent internal breast prosthesis following a mastectomy and as required by the Women's Health and Cancer Rights Act. Benefits are available for a testicular prosthesis if related to a medically necessary orchiectomy. A prosthesis ordered before your effective date of coverage will not be covered. A prosthesis ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be covered. Repair or replacement of prostheses due to normal use or growth of your child will be covered. Benefits are not provided for cosmetic prostheses except as stated in the Women's Health and Cancer Rights Act. Additional services may be authorized based upon medical necessity review by Care Management services.

Purchase of a prosthetic that is over $2,000 must be reviewed by Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim.

RADIATION THERAPY AND CHEMOTHERAPY

X-ray, radium, radioactive isotope therapy, and chemotherapy are covered expenses under this Plan. Services must be pre-authorized by the Care Management Department prior to services being rendered. Failure to pre-authorize services may result in the denial of the claim.

REHABILITATION BENEFIT

The Plan covers charges for you on an inpatient or outpatient basis in a rehabilitation center. Services for inpatient rehabilitation must be ordered by a physician, include a treatment plan and must be pre-authorized by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim. All services specified below will be provided if continued measurable progress is demonstrated at regular intervals.

Rehabilitative services are provided when medically necessary to restore and improve bodily function previously normal, but lost due to illness or injury, including function lost as a result of congenital anomalies. Rehabilitation services for the treatment of autism are covered under this benefit.

Occupational, physical, respiratory, speech therapy, pulmonary rehabilitation, neurodevelopmental therapy, and cardiac rehabilitation in the office, medical facility, or hospital will be paid under the rehabilitation benefit as shown in the Schedule of Benefits. Services may be provided in the home setting when medically appropriate for the patient.

Cardiac Rehabilitation Therapy - Benefits for an approved hospital-based cardiac rehabilitation program will be provided, when necessary to restore a bodily function lost or impeded due to illness or injury and such services are recommended by provider.

Massage Therapy - Charges of a registered, certified, or licensed physical therapist or massage therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury.

Neurodevelopmental Therapy - Benefits will be provided for medically necessary neurodevelopmental therapy treatment to restore and improve bodily function. This benefit includes maintenance services where significant deterioration of your condition would result without the service. Neurodevelopmental therapy means therapy designed to treat structural or functional abnormalities of the central or peripheral nervous system. Its purpose is to restore, maintain, or develop age appropriate functions. Covered therapy includes, but is not limited to, occupational therapy, physical therapy, speech therapy, and feeding therapy (the goal of feeding therapy is to help patients develop normal, effective feeding patterns and behaviors). This neurodevelopmental therapy benefit is not intended to cover enteral feeding, please see the Home Health Care benefit for additional information.

Occupational Therapy - Charges of a registered, certified, or licensed occupational therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury.

Physical Therapy - Charges of a registered, certified, or licensed physical therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury. Covered services include aquatic/swim therapy if medically necessary and included as part of a treatment plan.

If you are 65 years of age or older, physical therapy prescribed for the prevention of falls will be covered under the Preventive Care benefits of the Plan. Services are not applied towards the Rehabilitation Services per calendar year benefit limits.

Pulmonary Rehabilitation Therapy - Benefits for an approved hospital-based pulmonary rehabilitation program will be provided, when necessary to restore a bodily function lost or impeded due to illness or injury and such services are recommended by your provider.

Respiratory Therapy - Charges of a registered, certified, or licensed respiratory therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury.

Speech Therapy - Charges are covered when prescribed by your physician/provider and when necessary to restore a bodily function lost or impeded due to illness or injury. Excluded are speech therapy services that are educational in nature or due to: tongue thrust; stuttering; lisping; abnormal speech development; changing an accent; dyslexia; and hearing loss which is not medically documented.

Inpatient Treatment

The eligible expenses for inpatient rehabilitation are payable as shown in the Schedule of Benefits for the following services and supplies furnished while you require 24-hour care and are under continuous care of your attending physician/provider:

- Room, board and other services and supplies furnished by the facility for necessary care (other than personal items and professional services).
- Use of special treatment rooms.
- X-ray and laboratory examinations.
- Cardiac, occupational, physical, pulmonary, respiratory, and speech therapy.
- Oxygen and other gas therapy.

No benefits will be provided for the following inpatient or outpatient services:

- Custodial care.
- Maintenance, non-medical self-help, recreational, educational, or vocational therapy.
- Psychiatric care (see the Mental Health and Substance Use Disorder Services benefit for coverage).
- Learning disabilities or developmental delay, except as may be provided under coverage for neurodevelopmental therapy.
- Chemical dependency/substance use rehabilitative treatment (see the Mental Health and Substance Use Disorder Services benefit for coverage).
- Gym therapy.

SECOND SURGICAL OPINION

A second surgical opinion is not normally required but may be requested by you or by the Plan Supervisor's Care Management Department. This benefit is paid as shown in the Schedule of Benefits.

Please note that all non-emergency surgery other than surgery done in your doctor's own office must be pre-authorized by the Plan Supervisor's Care Management Department. When requested, the Plan will pay the maximum allowable fee for a second surgical opinion, and for a third and final opinion in case of conflict between the first two opinions.

Second or Third Opinion: Must be an opinion of an independent second or third surgeon acting on a consulting basis. A surgeon in association or practice with a prior surgical consultant will not be accepted.

SELF-ADMINISTERED MEDICATION BENEFIT

Coverage for self-administered medications are exclusively provided through the pharmacy benefits of the Plan. Please see the Prescription Drug Card Program provisions of this SPD for information regarding the Pharmacy Benefit Manager (PBM). Pre-authorization from the PBM may be required. (See the Infusion Therapy Benefit for infusion services provided under the medical benefits of the Plan.)

Please contact your PBM to determine if your medication can be self-administered and how it will be covered.

If you are unable or unwilling to self-administer an injectable medication, or the prescription drug plan does not carry the medication on its formulary, your attending physician must submit a written pre-authorization request to administer the injectable medication under the medical benefits of the Plan. Drugs must meet the Plan's Off Label Drug Use and Medical Necessity language criteria to be considered for pre-authorization. The request must be pre-authorized in advance by the Plan Supervisor's Care Management Department. Failure to pre-authorize the administration or purchase of the injectable medication may result in the denial of your claim. Self-administered benefit criteria may be waived for reimbursement purposes for the initial dose of the medication when multiple administrations are required and allow coverage under the major medical benefit if all terms and conditions are met, to allow for adequate transitioning of the prescription to your pharmacy benefit manager.

SKILLED NURSING FACILITY CARE

Services for Skilled Nursing Facility Care must be ordered by your physician/provider, include a treatment plan, and must be pre-authorized by the Care Management Department prior to services being rendered. Failure to pre-authorize services may result in the denial of the claim.

This Plan will pay benefits for confinement in a Skilled Nursing Facility, as specified in the Schedule of Benefits, provided such confinement is not for Custodial Care.

Charges for medically necessary services and supplies furnished by a licensed Skilled Nursing Facility will be applied to the Skilled Nursing Facility benefit and subject to the Skilled Nursing Facility maximum as shown in the Schedule of Benefits.

STERILIZATION - ELECTIVE

The Plan pays for elective sterilization procedures such as tubal ligations and vasectomies. These procedures shall be paid under the Major Medical benefits for you and your spouse.

Eligible expenses under this Plan shall not include reversal or attempted reversal of these procedures.

SURGERY AND RELATED SERVICES

Benefits are provided for the following inpatient or outpatient services:

- Surgeon's charges.
- Assistant surgeon's charges.
- Anesthesia.

If two or more surgical procedures are performed through the same incision during an operation, full benefits are only provided for the primary procedure and one half for the lesser procedure.

TELEMEDICINE

This telemedicine benefit covers medically necessary healthcare services between you and your physician to consult, treat, and prescribe for medical conditions. This benefit includes audio and video communication services, such as video conferencing and scheduled telephone visits. Telemedicine visits must be initiated at the request of you or your authorized provider and replace the need for an in-person office visit. Scheduling and record-keeping standards that apply to in-person visits also apply to telemedicine visits.

TEMPOROMANDIBULAR JOINT DISORDER (TMJ)

This Plan covers medically necessary surgical and non-surgical treatment of Temporomandibular Joint Disorders (TMJ) when provided by your physician/provider, approved medical facilities, licensed physical therapist or licensed oral surgeon. Oral surgeons will be covered only for the surgical treatment of TMJ disorders under this benefit.

TOBACCO CESSATION

The services of a provider listed under the definition of physician/provider, operating within the scope of their license, will be covered for a completed tobacco cessation program. Acupuncture for tobacco cessation will be covered under this benefit. Benefits are payable as shown in the Schedule of Benefits.

For medications to aid with nicotine withdrawal, please contact your Pharmacy Benefit Manager for further information.

TRANSPLANTS

Benefits are payable for charges for organ or tissue transplant services which are incurred while you are covered by this Plan. Such covered charges must be due to an accidental injury or sickness covered by this Plan.

You must contact the Plan Supervisor's Care Management Department prior to any testing that may occur to determine whether you are a transplant candidate. A written treatment plan must be submitted in order to obtain pre-authorization.

Also remember that pre-authorization is required before any medical facility admission. See Pre-Authorization of Inpatient Medical Facility Admissions And Outpatient Surgeries in the Important Information Section.

Organ or tissue transplant services include the following medically necessary services and supplies:

- Organ or tissue procurement. These consist of removing, preserving, and transporting the donated part.
- Compatibility testing undertaken prior to procurement is covered if medically necessary. This includes costs related to the search for, typing and testing, and identification of a bone marrow or stem cell donor for allogeneic transplant.
- Medical facility or Hospital room and board and medical supplies.
- Diagnosis, treatment, and surgery by a doctor.
- The rental of wheelchairs, hospital-type beds, and mechanical equipment required to treat respiratory impairment.
- Local ambulance services, medications, x-rays and other diagnostic services, laboratory tests, and oxygen.
- Rehabilitative therapy consisting of: speech therapy (not for voice training or lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy. Any of these must be in direct respect to rehabilitation from the covered transplant procedure.
- Surgical dressing and supplies.
- Transportation, lodging, and meals.
- Other services approved by the Plan Supervisor's Care Management Department.

Benefits for a donor are payable only in the absence of other coverage and shall not exceed the benefit limitation as shown in the Schedule of Benefits. Donor expenses are payable only when the organ recipient is covered under this Plan and are considered expenses of the recipient.

No benefits will be provided for the following:

- Any procedure that has not been proven effective, is experimental or investigative, or is not standard of care for the community. ***(See definition of Experimental and Investigative.)***
- When donor benefits are available through other group coverage.
- When government funding of any kind is available.
- When the recipient is not covered under this Plan.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).

GENERAL EXCLUSIONS TO THE MEDICAL PLAN

This section of your booklet explains circumstances in which all the medical benefits of this Plan are limited or in which no benefits are provided. Benefits may also be affected by the Care Management provisions of the Plan. Your eligibility and expenses are subject to all Plan conditions, exclusions, and limitations, including medical necessity. In addition, some limitations may apply to benefits.

In addition to the specific limitations stated elsewhere in this booklet, the Plan will not provide benefits for:

Abortion - Voluntary termination of pregnancy other than in the case of rape, incest or endangerment of the life of the mother. Complications resulting from an abortion are covered as required by the Pregnancy Discrimination Act (PDA) for the employee and spouse (note: the PDA does not apply to dependent children).

Adoption Expenses - Adoption expenses or any expenses related to surrogate parenting, except as provided herein under the maternity and preventive benefits for a covered member acting as a surrogate. Covered services are subject to the Plan's subrogation rights.

After the Termination Date - Charges arising from care, supplies, treatment, and/or services that are Incurred Charges by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol - Services, supplies, care or treatment you receive for an injury or sickness which occurred as a result of your illegal use of alcohol, based upon a court conviction or other documented court finding. Expenses will be covered for injured covered Participants, such as yourself, except the person illegally using alcohol, and expenses will be covered for substance use disorder treatment as specified in this Plan. This exclusion does not apply if the injury resulted from being the victim of an act of domestic violence or a documented medical (including both physical and mental health) condition.

Alternative Medicine - Services for acupressure, Rolfing, faith healing services, or reflexology.

Appointments (Missed, Cancelled, Telephonic and Electronic) - Missed or cancelled appointments or for telephone and electronic consultations, except as provided herein.

Biofeedback - Charges for biofeedback treatment.

Breast Implants - Charges for breast implants except as provided herein.

Broken Appointments - Charges arising from care, supplies, treatment, and/or services that are charged solely due to the Participant's having failed to honor an appointment.

Clinical Trials - Costs incurred due to the participation in a clinical trial, including but not limited to, the costs of the investigative item, device, or service; the costs of items and services provided solely to satisfy data collection and analysis, and the cost for a service that is inconsistent with commonly accepted and established standard of care for the diagnosis. However, routine medical expenses associated with an approved clinical trial (see Approved Clinical Trials at https://clinicaltrials.gov) will be covered under the Plan if medically necessary.

Cosmetic and Reconstructive Surgery - Cosmetic surgery or related medical facility admissions are excluded, unless made necessary due to one or more of the following:

1. When authorized for an illness or injury that is a covered benefit under this Plan, except as excluded herein.

2. Except as specifically excluded by this Plan, for correction of congenital anomalies when medically necessary.
3. If you are receiving benefits for a medically necessary mastectomy and elect breast reconstruction after the mastectomy, you will also receive coverage for:
    - Reconstruction of the breast on which the mastectomy has been performed
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance
    - Prostheses
    - Treatment of physical complications of all stages of mastectomy, including lymphedemas
    - Areola tattooing if performed in a surgeon's office and billed by a surgeon

This reconstructive surgery coverage will be provided in consultation with your attending physician/provider and yourself, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Counseling or Training Services - Charges for counseling or training services. This includes vocational assistance and outreach; job training such as work hardening programs; religious counseling; treatment by a pastoral or financial counselor; fitness counseling; and other services or supplies that are primarily educational in nature other than as defined herein.

Court Ordered - Services and supplies that are court-ordered or are related to deferred prosecution, deferred or suspended sentencing, or driving rights, if those services are not deemed medically necessary under the Plan.

Custodial Care - Charges for custodial care, except as specifically provided herein. Custodial care is care whose primary purpose is to meet personal rather than medical needs and which is provided by individuals with no special medical skills or training. Such care includes, but is not limited to: helping you walk, getting in or out of bed, and taking normally self-administered medicine.

Deductible - Charges arising from care, supplies, treatment, and/or services that are amounts applied toward satisfaction of deductibles and expenses that are defined as your responsibility in accordance with the terms of the Plan.

Dental - Dental services including treatment of the mouth, gums, teeth, mouth tissues, jawbones or attached muscle, orthodontic appliances, dentures and any service generally recognized as dental work. Hospital and physician services rendered in connection with dental procedures are only covered if adequate treatment cannot be rendered without the use of hospital facilities, and if you have a medical condition besides the one requiring dental care that makes hospital care medically necessary. The only exceptions to this exclusion are the services and supplies covered under the Dental Accident Benefit and TMJ Benefit or if treatment is necessary due to a malignant tumor.

Education or Training Services - Education or training services or supplies for disorders or delays in the development of a child's language, cognitive, motor, or social skills, including evaluations therefore, except as provided herein under the Neurodevelopmental Therapy, Mental Health and Substance Use Disorder Services, and Rehabilitation Services benefits.

Environmental Services - Milieu therapy and any other treatment designed to provide a change in environment or a controlled environment.

Excess - Charges arising from care, supplies, treatment, and/or services that exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental or Investigative - Services considered to be experimental, investigative (as defined in the Definition Section) or generally non-accepted medical practices at the time they are rendered.

Facility Charges - Facility charges for care, services or supplies provided in:

- Rest homes;
- Assisted living facilities;
- Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- Health resorts;
- Spas, sanitariums;
- Infirmaries at schools, colleges, or camps;

Fertility and Infertility - Except as provided herein, charges in association with infertility, and procedures to restore fertility or to induce pregnancy, including but not limited to: corrective or reconstructive surgery; hormone injections; in-vitro fertilization; embryo transfer; artificial insemination, gamma intra-fallopian transfer (G.I.F.T.); fertility drugs (including but not limited to Clomid, Pergonal or Serophene); or any other artificial means of conception.

Government Facility - Charges by a facility owned or operated by the United States or any state or local government unless you are legally obligated to pay. This does not apply to covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to you for a non-service related illness or injury. The exclusion also does not apply to covered expenses rendered by a United States military medical facility to you if you are not on active military duty.

Hearing Exams and Hearing Aids - Charges or supplies with regard to routine hearing exams and hearing aids.

Hospice Bereavement - Charges for hospice bereavement treatment.

Illegal Acts - Charges arising from care, supplies, treatment, and/or services that are for any injury or sickness, which are incurred charges while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies, even if the cause of the illness or injury is not related to the commission of the crime. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Illegal Treatment - Charges for any illegal treatment under the laws of the state where the care is rendered and treatment listed by the American Medical Association (AMA) as having no medical value.

Illegal Use of Substances, Drugs, or Other Medications - Services, supplies, care or medical treatment for injury or sickness resulting from taking of or being under the influence of any substance, drug, hallucinogen or narcotic not administered on the advice of your physician/provider, except as provided under the Substance Use Disorder Benefit. Expenses will be covered for injured covered Participants, such as yourself, except the person who took or was under the influence of substances, and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the injury resulted from being the victim of an act of domestic violence or a documented medical (including both physical and mental health) condition, or for treatment that is medically necessary due to an overdose.

Impotency - Charges associated with impotency and erectile dysfunction, and procedures to restore potency, including but not limited to: corrective or reconstructive surgery; medications specific for treatment of sexual dysfunction; penile implants; or impotency drugs whether or not a consequence of illness or injury. This exclusion does not apply to medically necessary hormones.

Incurred by Other Persons - Charges arising from care, supplies, treatment, and/or services that are expenses actually incurred charges by other persons.

Licensed/Certified - Any services outside the scope of the provider's license, registration, or certification, or that is furnished by a provider that is not licensed, registered or certified to provide the service or supply by the State in which the services or supplies are furnished. Treatment or services provided by anyone other than a physician/provider operating within the scope of their license, as defined herein.

Mail Expenses - Mailing and/or shipping and handling expenses.

Massage Therapy - Charges for massage therapy treatment, except as provided under the Rehabilitation Benefit, when administered by a registered, certified, or licensed physical therapist or massage therapist.

Medical Facility - Medical facility services performed in a facility other than as defined herein.

Medical Records and Reports - Expenses for preparing medical reports, itemized bills, or claim forms, except as expressly requested by or on behalf of the Plan.

Medical Tourism - Expenses for any care, services, drugs, or supplies incurred outside of the United States if you traveled to such a location for the purpose of obtaining the care, services, drugs, or supplies.

Mental Health and Substance Use Disorder Services - Charges are not covered for the following:

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
3. Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
4. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Plan.
5. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
6. Educational or correctional services or sheltered living provided by a school or halfway house, including any academic component of treatment; however, you may receive covered outpatient services while living temporarily in a sheltered living situation.
7. A court-required screening interview or treatment program unless determined to be medically necessary.
8. Support groups, including Alcoholics Anonymous or similar programs.
9. Personal items.
10. Custodial care or long-term care.
11. Tobacco cessation programs are not covered under the Mental Health and Substance Use Disorder benefit, please see the Tobacco Cessation benefit for coverage.
12. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

The Plan may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

Military Services - Charges for the treatment of a condition resulting from war or an act of war, declared or undeclared, or an injury sustained or illness contracted while on duty with any military service for any country.

Negligence - Charges arising from care, supplies, treatment, and/or services that are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Charge - Charges that you are not legally required to pay for or for charges which would not have been made in the absence of this coverage.

No Coverage - Charges arising from care, supplies, treatment, and/or services that are incurred charges at a time when no coverage is in force for you or your dependent(s).

Non-Covered Services - Services or supplies directly related to any condition, service, or supply that is not covered by this Plan. This includes any complications arising from any treatment, services or supplies not covered by this Plan, except as provided herein.

Non-U.S. Providers - Expenses are not covered for any care, services, drugs, or supplies incurred outside of the United States. This exclusion does not apply to emergency care received outside of the United States.

Not Medically Necessary - Services and supplies not medically necessary (as defined in the Definition Section) for the diagnosis or treatment of an illness or injury, unless otherwise listed as covered.

Obesity (and Morbid Obesity) - Treatment for obesity (excessive weight and morbid obesity) including surgery, wiring of the jaw or procedures of similar nature, diet programs and/or other therapies, except as provided herein and as required by the Affordable Care Act.

Off Label Drug Use - Expenses related to Off-Label Drug Use, unless medically necessary; would otherwise be a covered expense under the Plan; and the use meets the definition of Off-Label Drug Use, (as defined in the General Definition section).

Orthotics - All over the counter orthotics.

Other than Attending Physician - Charges arising from care, supplies, treatment, and/or services that are other than those certified by your attending physician, as being required for the treatment of injury or disease, and performed by an appropriate provider.

Over-the-Counter - Over the counter drugs, supplies, food supplements, foods related to dietary restrictions or gluten free diets, infant formulas, and vitamins, except as required by the Affordable Care Act (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations).

Personal Comfort Items - Service animals, appliances or equipment primarily for comfort convenience, cosmetics, environmental control, education or general physical fitness, including but not limited to televisions, telephones, air conditioners, humidifiers, whirlpools, heat lamps, weight lifting equipment physical fitness program and therapy, including the cost of training and maintenance.

Prior to Coverage - Charges arising from care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Professional (and Semi-Professional) Athletics (Injury/Illness) - Charges in connection with any injury or illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law - Charges arising from care, supplies, treatment, and/or services that are to the extent that payment under this Plan is prohibited by law.

Provider Error - Charges arising from care, supplies, treatment, and/or services that are required as a result of unreasonable provider error.

Providers - Charges submitted for services by an unlicensed hospital, physician or other health care provider or not within the scope of the health care provider's license.

Public Programs - Charges that are reimbursed, or that are eligible to be reimbursed by any public program except as otherwise required by law.

Relatives - Charges incurred for treatment or care by any provider if he or she is your relative, or treatment or care provided by any individual who ordinarily resides with you.

Rest Home - Any services rendered by an institution, which is primarily a place of rest, a place for the aged, a nursing home, sanitarium, or a convalescent home.

Reversal of Sterilization - Charges for reversal or attempted reversal of sterilization.

Routine Services - Services or supplies that are not directly related to an illness, injury, or distinct physical symptoms. Routine services include health examinations required:

- By a third party, including examinations and treatments required to obtain or maintain employment (excluding exams required by the Department of Transportation), or which
- An employer is required to provide under a labor agreement;
- For securing insurance, school admissions or professional or other licenses;
- For administrative purposes;
- As a premarital requirement;
- To travel;
- To attend a camp, sporting event, or to participate in other recreational activities;
- Any special medical reports not directly related to treatment except when provided as part of covered service.

This exclusion does not apply to services and supplies specified under the Preventive Care Benefit, or to routine mammograms.

Self-Help Programs - Non-medically necessary, self-help, recreational, or educational therapy.

Third Party Liability - Benefits payable under the terms of any automobile medical, personal injury protection, automobile no fault, homeowner, commercial premises, or similar contract of insurance when such contract of insurance is issued to, or makes benefits available to you. This also includes treatment of illness or injury for which the third party is liable.

Training - Services or supplies for learning disabilities; vocational assistance and outreach; job training or other education or training services; except as provided herein.

Transportation - Transportation by private automobiles, taxi service or other ground transportation, except as specifically provided herein.

Travel Expenses - Travel, whether or not recommended by your physician/provider, except as provided herein under the Ambulance, Gene and Adoptive Cellular Therapy and Transplant benefits.

Types of Care - The following types of care are excluded from coverage under the Plan:

1. Custodial Care or maintenance care.
2. Domiciliary care.

3. Private Duty Nursing.
4. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program for services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care Benefits within this Summary Plan Description.
5. Rest cures.
6. Services of personal care attendants.
7. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Unreasonable - Charges arising from care, supplies, treatment, and/or services that are not "Reasonable" and are required to treat illness or injuries arising from and due to a provider's error, wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating provider whose error caused the loss(es).

Vision Care - Eyeglasses, contact lenses, eye refractions or examinations for prescriptions or fitting of eyeglasses, contact lenses or charges for radial keratotomy, except as provided herein. Charges for vision analysis, therapy, or training relating to muscular imbalance of the eye, and orthoptics are not covered under the Plan.

War - Treatment made necessary as a result of war, declared or undeclared, or any act of war. An act of terrorism will not be considered an act of war, declared or undeclared.

Wigs - Charges for wigs.

Worker's Compensation - Services covered by or for which you are entitled to benefits under any Worker's Compensation or similar law.

Upon termination of this Plan, all expenses incurred prior to the termination of this Plan, but not submitted to the Plan Supervisor within 75 days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

PRESCRIPTION DRUG CARD PROGRAMS

Benefits will be provided as described below and as shown in the Schedule of Benefits for state and federal approved legend drugs requiring a prescription and for other items as specifically provided, when such drug or other items are furnished by an approved pharmacy or an approved mail order supplier. Benefits will be subject to any waiting periods, limitations and exclusions, except that prescription drug benefits will not be subject to Coordination of Benefits provisions.

Legend Drugs are those drugs which cannot be purchased without a prescription written by a physician or other lawful prescriber.

GENERIC SUBSTITUTION

Over 400 commonly prescribed drug products are now available in a generic form at an average cost of 50% less than the brand name products. This Plan encourages the use of generic prescription drugs. By law, generic and brand name drugs must meet the same standards of safety, purity, strength, and effectiveness. At the same time, brand name drugs are often 2 to 3 times more expensive than generic drugs. Use of generics with this benefit will save you money and we encourage you to ask your provider to prescribe generics whenever possible.

BRAND NAME FORMULARY DRUGS

An important element of your Express-Scripts Prescription Drug Card Program is the opportunity to select drugs from the Formulary Drug List. The Formulary Drug List is a guide to the best values within select therapeutic categories which helps the provider identify products that will provide optimal clinical results at a lower cost. The Formulary Drug List undergoes a thorough review and/or revision annually. Interim changes could occur to reflect changes in the market. These changes could include: entry of new products, entry of a generic option to a brand drug, or other events that alter the clinical or economic value of the products on the Formulary Drug List. Please see your Human Resources Department for a copy of the Formulary Drug List or visit www.expressscripts.com.

Other brand name drugs are any brand name drugs covered through the Express-Scripts Plan, but not listed on the Formulary Drug List.

PAYMENT SCHEDULE

A copay is payable for each prescription filled according to the amounts shown in the Schedule of Benefits. Any amounts paid through a prescription drug copay assistance program or coupon program will not apply towards satisfaction of your deductible or your out-of-pocket maximum.

This Plan requires your pharmacist to fill the prescription with a generic product whenever it is available, unless the prescription is written as "Dispense as Written." If the prescription is not specified as "Dispense as Written" and the prescription is filled with a name brand prescription at your request, then the copay **plus** the difference between the ingredient cost of the generic drug and the brand name drug will be charged.

DRUGS COVERED

Medications covered under this Prescription Drug Card Program include but are not limited to:

- Legend Drugs. Exceptions: See Exclusions below.
- Insulin.

- Preventive medications as required by the Patient Protection and Affordable Care Act.
- Any other drug which under the applicable state or federal law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Note: FDA approval of a drug does not guarantee inclusion as a covered medication under this Prescription Drug Card Program. In addition, coverage for some prescriptions may vary depending upon the medication's therapeutic classification. As a result, some medications may be subject to quantity limits or may require pre-authorization.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Express-Scripts at 800/925-9145.

DRUGS EXCLUDED AND LIMITED

In addition to exclusions listed elsewhere in this document, the following drugs are excluded from coverage under this Prescription Drug Card Program (this is **not** an all-inclusive list):

- Biological sera, blood, or blood plasma.
- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use.
- Charges for the administration or injection of any drug.
- Prescriptions which an eligible individual is entitled to receive without charge from any Worker's Compensation Laws.
- Drugs labeled Caution-limited by federal law to investigational use or experimental drugs, even though a charge is made to the individual.
- Medication which is to be taken by you or administered to you, in whole or in part, while you are a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home or similar institution which operates on its premises or allows to be operated on its premises, or a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number specified by your provider, or any refill dispensed after one year from your provider's original order.
- Prescription drugs which may be obtained without charge under local, state, or federal programs.
- Drugs purchased outside the U.S. that are not legal inside the U.S.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Express-Scripts at 800/925-9145.

PRESCRIPTION DRUG PREAUTHORIZATION

There may be certain prescription drugs that need to be pre-authorized prior to dispensing for reasons of treating one or more health conditions (some of these conditions may not be covered by the medical plan such as cosmetic procedures for wrinkles) and to determine if the medication is medically necessary. You can obtain a listing of drugs that require pre-authorization by contacting Express-Scripts at: 800/925-9145 or via the website at: www.expressscripts.com.

Pharmacies are generally notified if a prescription requires pre-authorization. Your prescribing provider must provide the information required to determine medical necessity for the medication.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Express-Scripts at 800/925-9145.

SPECIALTY PHARMACY

Specialty pharmacy services include treatment of Participants with narrow-niche, high-cost, chronic conditions such as multiple sclerosis, hepatitis C, rheumatoid arthritis, hemophilia, growth hormone deficiency, alpha 1-antitrypsin disorder, and other special medical conditions. Products provided are typically injectable drugs but may also include infusion drug products. The Plan has established a specialty pharmacy program whereby certain pharmaceutical products that are generally biotechnological in nature and given by injection or otherwise require special handling (specialty medications), are provided by Express-Scripts specialty pharmacies.

In the event that you are prescribed a specialty medication, regardless of your diagnosis, you must participate in the Plan's specialty program for the medication to be covered under the Plan and therefore, the specialty medication must be dispensed by a Express-Scripts specialty pharmacy, Accredo. To inquire about or begin specialty pharmacy services, please call or have your healthcare provider call Accredo at 800/922-88279.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your specialty pharmacy benefit, please contact Express-Scripts at 800/925-9145.

PRESCRIPTION REFILLS

The prescription drug plan will cover prescription refills when you have taken 75% of the previous prescription (please note: Schedule II or III controlled substance medications may be refilled only after you have taken 85% of the previous prescription), if your prescribing physician has allowed refills of the prescribed medication. Refills obtained through the mail order pharmacy are allowed after you have taken all but 20 days of the previous prescription order. If you choose to refill your prescription sooner, you will be responsible for the full costs of the medication and these costs will not count toward your deductible (if applicable) or any Out-of-Pocket Maximum. If you feel you need a refill sooner than allowed, a refill exception may be considered at Express-Scripts's discretion on a case-by-case basis. You may request an exception by calling Express-Scripts at 800/925-9145.

RETAIL PRESCRIPTION DRUG PROGRAM

Express-Scripts

Dispensing Limitations

The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 30-day supply.

Benefit Limitations When Not Using the Drug Card

If you do not use the prescription card at the time of the prescription purchase or the prescription is purchased at a non-participating pharmacy, you must file a claim directly with the drug card service agency using the agency's claim form.

When you do not use the prescription card, the benefit is less because the prescription drugs cost more. When you submit a prescription claim to the drug card service agency, the following charges will be deducted from your total reimbursement: (1) the copay you would normally pay; (2) the difference between the pharmacy retail price and the amount the pharmacy would have charged if the prescription card was used; and (3) a handling fee will be deducted from your total reimbursement.

Benefits For Employees And Dependents Without A Card

Prescription drugs that are eligible for reimbursement by the prescription drug card program can be submitted to Express-Scripts prior to your receipt of the card. To claim this benefit, a receipt for the paid prescription with an Express-Scripts claim form must be submitted to Express-Scripts.

Express-Scripts will reimburse eligible claims as if the card had been used (100% reimbursement following the applicable copay).

MAIL ORDER PRESCRIPTION DRUG PROGRAM

Express-Scripts Mail Order Service

When to Use Your Mail Order Prescription Drug Card Program

You should continue to have non-maintenance prescriptions (prescribed for urgent illness or injury) filled at the local pharmacy. However, if you are ordering maintenance medications (those taken on a regular or long term basis such as heart, allergy, diabetes, or blood pressure medications), use the mail order program and have the medications delivered directly to your home.

Using the mail order program when purchasing prescriptions and paying the applicable copay, the Plan pays 100% of the eligible balance due direct to the pharmacy.

Dispensing Limitations

The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 90-day supply.

Ordering Information

For an existing prescription, provide Express-Scripts Mail Service Pharmacy with the information requested on the initial order form and an Express-Scripts Mail Service Pharmacist will transfer your existing prescription to the Express-Scripts Mail Service Pharmacy.

Have your physician/provider write a prescription for a 90 day supply and send the prescriptions along with a completed Express-Scripts Mail Service form with the information requested on the initial order form and an Express-Scripts Mail Service Pharmacist will transfer your existing prescription to the Express-Scripts mail service program.

Order forms can be obtained from HMA, your Human Resources Department or at the mail order website. Your physician can also phone in prescriptions to save time. Prescriptions can be reordered over the telephone with a credit card by calling 800/925-9145. You may also reorder by using a mail service order form and pay by check or credit card.

Express-Scripts mail order program maintains a quick turnaround time. Orders which do not require a conversation with you or the physician/provider, prior to dispensing, will be received within 7 to 10 days. Prescriptions that require communication with either you or your physician/provider will not be filled until all questions have been answered. For this reason, please be sure to allow at least 14 days for your prescription request, to avoid running out of medication.

GENERAL DEFINITIONS

ACCIDENT/ACCIDENTAL INJURY - Shall mean an accidental bodily injury which is the direct result of a sudden, unexpected, and unintended element, such as a blow or fall, which requires treatment by a physician/provider. It must be independent of sickness/illness or any other cause, including, but not limited to, complications from medical care.

ALLOWABLE EXPENSES - Shall mean the maximum allowable charge for any medically necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's allowable expenses shall in no event exceed the other plan's allowable expenses.

When some other plan provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any other plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

APPROVED CLINICAL TRIAL - An approved clinical trial means a clinical trial as defined at https://clinicaltrials.gov.

APPROVED TREATMENT PLAN - A written outline of proposed treatment that is submitted by the attending physician/provider to the Plan Supervisor for review and approval.

ASSIGNMENT OF BENEFITS - An arrangement whereby you, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less deductibles, copayments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to your provider. If your provider accepts said arrangement, your providers' rights to receive Plan benefits are equal to yours and are limited by the terms of this Plan Document. If your provider accepts this arrangement and indicates acceptance of an "Assignment of Benefits" and deductibles, copayments and the coinsurance percentage are your responsibility, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an assignment of benefits previously issued to your provider at its discretion and continue to treat you as the sole beneficiary.

AUTISM SPECTRUM DISORDERS - A group of neurobiological disorders that may include, but are not limited to Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrative Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

BIOFEEDBACK THERAPY - Biofeedback therapy is an electronic method which allows you to monitor the functioning of the body's autonomic systems (e.g., body temperature, heart rate) that were previously thought to be involuntary.

CALENDAR YEAR - The 12 months beginning January 1 and ending December 31 of the same year.

CARE MANAGEMENT - The individual or organization designated by the Plan Administrator to authorize medical facility admissions and surgeries and to determine the medical necessity of treatment for which Plan benefits are claimed.

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.

CHEMICAL DEPENDENCY - See Substance Use Disorder Services definition.

CONTRIBUTORY - You are required to pay a portion of the cost to be eligible to participate in the Plan.

COSMETIC - Services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

COUNSELING - Brief treatment that is focused most upon behavior. It targets a particular symptom or problematic situation and offers suggestions and advice for management.

COVERED EXPENSE(S) - A service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the maximum allowable charge for an eligible medically necessary service, treatment or supply, meant to improve a condition or your health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the covered expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as set forth elsewhere in this document.

COVERED INDIVIDUAL OR PARTICIPANT - You, your spouse, your domestic partner, your child, or a participating COBRA beneficiary meeting the eligibility requirements for coverage as specified in the Plan, and properly enrolled in the Plan.

CUSTODIAL CARE - Care or service which is not medically necessary and is designed essentially to assist you in the activities of daily living. Such care includes, but is not limited to: bathing, feeding, preparation of special diets, assistance in walking, dressing, getting into or out of bed and supervision over taking of medication which can normally be self-administered.

DEDUCTIBLE - The deductible is the amount of eligible expenses each calendar year that you must incur before any benefits are payable by the Plan. The individual deductible amount is listed in the Schedule of Benefits. However, certain covered benefits may be considered preventive care and paid first dollar. Your ability to contribute to a Health Savings Account (HSA) on a tax favored basis may be affected by any arrangement that waives this Plan's deductible.

If you are enrolled on a QHDHP plan and have other coverage that is not a QHDHP, you (and your employer on your behalf) will not be able to contribute to an HSA.

DEPENDENT - Any individual who is or may be eligible for coverage according to Plan terms due to a relationship to you.

DIAGNOSIS - The act or process of identifying or determining the nature and cause of a disease or injury through evaluation of your history, examination, and review of laboratory data.

DISABILITY, TOTAL DISABILITY AND DISABLED - The terms total disability and disabled mean for the:

- Employee - Your inability to engage, as a result of accident or illness, in your normal occupation with the Participating Company on a full-time basis.
- Dependent - Your inability to perform the usual and customary duties or activities of someone in good health and of the same age.

DOMESTIC PARTNER - Two adults, of the same or opposite sex, engaged in a spouse-like relationship and who have lived together for a period of not less than 6 consecutive months.

DONOR - A donor is the individual who provides the organ for the recipient in connection with organ transplant surgery. A donor may or may not be covered under the provisions of this Plan.

DOULA - A person that is a nonmedical birth coach or support person trained to provide physical, emotional, and informational support to birthing persons during pregnancy, antepartum, labor, birth, and the postpartum period. A doula will be considered as a covered provider for eligible services under this Plan.

DURABLE MEDICAL EQUIPMENT - Equipment prescribed by the attending physician/provider which meets all of the following requirements:

- Is medically necessary;
- Is designed for prolonged and repeated use;
- Is for a specific purpose in the treatment of an Illness or Injury and not solely your convenience;
- Would have been covered if provided in a medical facility;
- Is necessary for activities of daily living; and
- Is appropriate for use in the home.

EFFECTIVE DATE - The effective date shall mean the first day this Plan was in effect as shown under the General Plan Information. Your effective date is the first day the benefits under this Plan would be in effect, after satisfaction of the waiting period (if applicable) and any other provisions or limitations contained herein.

ELECTIVE SURGICAL PROCEDURE - A surgical procedure that need not be performed on an emergency basis because reasonable delay will not cause life endangering complications.

EMERGENCY SERVICES - Shall mean, with respect to a medical emergency, the following:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition.
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

When furnished with respect to an emergency medical condition, emergency services shall also include an item or service provided by an Out-of-Network provider or Out-of-Network health care facility (regardless of the department of the hospital in which items or services are furnished) after the participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency services are furnished, until such time as the provider determines that the participant is able to travel using non-medical transportation or non-emergency medical transportation, and the participant is in a condition to, and in fact does, give informed consent to the provider to be treated as an Out-of-Network provider.

ENROLLMENT DATE - The enrollment date is the first day of coverage or, if there is a waiting period for coverage to begin under the Plan, the first day of the waiting period. The term "waiting period" refers to the period after employment starts and the first day of coverage under the Plan. If you are a late enrollee or you enroll on a special enrollment date, the "enrollment date" will be the first date of actual coverage. If you are receiving benefits under a group health plan and you change benefit packages, or if the Plan changes group health insurance issuers, your enrollment date does not change.

ERISA - The Employee Retirement Income Security Act of 1974 and its amendments.

ESSENTIAL HEALTH BENEFITS - Shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription

drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXPERIMENTAL OR INVESTIGATIVE TREATMENT - For the purpose of determining eligible expenses under this Plan (other than off-label drug use, see definition for "Off-Label Drug Use"), a treatment will be considered by the Plan to be experimental or investigative if:

1. The treatment is governed by the United States Food and Drug Administration ("FDA") or another United States governmental agency and the FDA or the other United States governmental agency has **not** approved the treatment for the particular condition at the time the treatment is provided;
2. The treatment is the subject of ongoing clinical trials as defined by the National Institute of Health, National Cancer Institute or the FDA, see https://clinicaltrials.gov; or
3. There is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity, or efficacy of the treatment.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) AS AMENDED - A leave of absence granted to you by the Employer in accordance with Public Law 103-3 for the birth or adoption of your child; placement in your care of a foster child; the serious health condition of your spouse, child or parent; your own disabling serious health condition; your spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation and this results in a qualifying exigency (as determined by the Secretary of Labor); or you are the spouse, son, daughter, parent, or next of kin of a member of the Armed Forces who suffered a serious injury or illness in the line of duty while on active-duty.

GENERAL ANESTHESIA - A drug/gas which produces unconsciousness and insensitivity to pain.

GENERIC DRUG - A drug that is generally equivalent to a higher-priced brand name drug and meets all FDA bioavailability standards.

HIPAA - Health Insurance Portability and Accountability Act. This Plan is subject to and complies with HIPAA rules and regulations.

HOMEBOUND - You are homebound when leaving the home could be harmful, involves a considerable and taxing effort, and you are unable to use transportation without the assistance of another.

ILLNESS - A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal state differing from other normal body states; typically indicates a disease, physical sickness or Mental Disorder. For purposes of the administration of this Plan, Illness also includes Pregnancy, childbirth, miscarriage or complications thereof.

INCURRED CHARGE - The charge for a service or supply is considered to be incurred on the date it is furnished or delivered. In the absence of due proof to the contrary, when a single charge is made for a series of services, each service will be considered to bear a pro rata share of the charge.

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT - Means a health care facility that is geographically separate and distinct, and licensed separately, from a hospital under applicable state law, and which provides any emergency services.

INJURY - See Accident/Accidental Injury.

INPATIENT - A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) which is covered by the Plan and to which the person has been assigned on a 24- hour-day basis.

If a Plan participant seeks emergency services through a hospital's emergency room and is admitted as a hospital inpatient at that time due to that emergency, coverage for that inpatient confinement will be provided as an inpatient hospital benefit, not as an emergency room benefit.

INPATIENT STAY - An uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

INTENSIVE OUTPATIENT TREATMENT - A structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

INTERMEDIATE LEVEL OF CARE - Mental Health or Substance Use Disorder treatment that encompasses the following:

- Care at a residential treatment facility.
- Care at a partial hospitalization/day treatment program.
- Care through an intensive outpatient treatment program.

LEAVE OF ABSENCE - Shall mean a period of time during which you, the employee must be away from your primary job with your employer, while maintaining the status of employee during said time away from work, generally requested by you and having been approved by your employer, and as provided for in your employer's rules, policies, procedures and practices where applicable.

LEGAL SEPARATION AND/OR LEGALLY SEPARATED - Shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

LIFE ENDANGERING CONDITION - An injury or illness which requires immediate medical attention, without which death or serious impairment to your bodily functions could occur.

LIFETIME - While covered under this Plan or any other Company plan. Wherever this word appears in this document in reference to benefit maximums and limitations. Under no circumstances does lifetime mean during the lifetime of the covered person.

MAXIMUM ALLOWABLE CHARGE - Shall mean the benefit payable for a specific coverage item or benefit under this Plan. The maximum allowable charge will be a negotiated rate, including a case/claims negotiation agreement, if one exists. In the event that the negotiated rate per the terms of an applicable provider contract is higher than billed, the Plan may reimburse at the higher allowance in order to comply with terms of the provider contract.

For claims subject to the No Surprises Act (see "No Surprises Act" within the section "Important Information") if no negotiated rate exists, the maximum allowable charge 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 are applicable, the maximum allowable charge will be at the discretion of the Plan Administrator and will be determined to be a percentage, as outlined in the Schedule of Benefits, multiplied by the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services ("CMS"), a percentage of billed charges, or multiplied by a percentage that the particular provider and/or others in the area customarily accept from all payers.

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on a percentage (as outlined in the Schedule of Benefits) of one of the following:

- Visium Medicare Equivalency tables (prices established by CMS utilizing standard Medicare payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS);

- Visium Approximation tool (prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care); or
- Visium Care Crosswalk (prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings).

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

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

MEDICAL EMERGENCY - An illness or injury which is life threatening or one that must be treated promptly to avoid serious adverse health consequences to yourself.

MEDICAL FACILITY (HOSPITAL) - An institution accredited by the Joint Commission on Accreditation of Healthcare Organizations and which receives compensation from its patients for services rendered. On an inpatient basis, it is primarily engaged in providing all of the following:

- Diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and ill Participants, such as yourself.
- Services performed by or under the supervision of a staff of physicians/providers who are duly licensed to practice medicine.
- Continuous 24 hours a day nursing services by registered nurses.

For the services covered under this Plan and for no other purpose, inpatient treatment of mental illness or substance use, provided by any psychiatric medical facility licensed by the State Board of Health or the Department of Mental Health, will be considered services rendered in a medical facility as defined subject to the limitations shown in this booklet.

The term "Hospital" or "Medical Facility" will **not** include an institution which is primarily: a place for rest or retirement; a residential treatment facility (except as provided under the Substance Use Disorder Treatment or Mental Health Services benefit), a health resort; a place for the aged; a convalescent home; or a nursing home.

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

MEDICALLY NECESSARY - Medical services and/or supplies which are absolutely needed and essential to diagnose or treat an illness or injury of yours while covered by this Plan. The following criteria must be met. The treatment must be:

- Consistent with the symptoms or diagnosis and treatment of your condition.
- Appropriate with regard to standards of good medical practice.

- Not solely for the convenience of you, your family members or your provider of services or supplies.
- The least costly of the alternative supplies or levels of service which can be safely provided to you. When specifically applied to a medical facility inpatient, it further means that the service or supplies cannot be safely provided in other than a medical facility inpatient setting without adversely affecting your condition or the quality of medical care rendered.

MEDICARE - The programs established by Title XVIII of the U.S. Social Security Act as amended and as may be amended, entitled Health Insurance for the Aged Act, and which includes Part A - Hospital Insurance Benefits for the Aged; and Part B - Supplementary Medical Insurance Benefits for the Aged.

MENTAL HEALTH PARITY ACT OF 1996 (MHPA) AND MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA), COLLECTIVELY, THE MENTAL HEALTH PARITY PROVISIONS IN PART 7 OF ERISA - Shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

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

MENTAL OR NERVOUS DISORDER - Any disease or condition, regardless of whether the cause is organic, that is classified as a mental or nervous disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant state guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

NON-EMERGENCY MEDICAL FACILITY ADMISSIONS - A medical facility admission (including normal childbirth) which may be scheduled at your convenience without endangering your life or without causing serious impairment to your bodily functions.

OFF-LABEL DRUG USE - The use of a drug for a purpose other than that for which it was approved by the FDA. For purposes of determining whether off-label use for a FDA approved drug is eligible for coverage under the Plan versus investigative, the following will apply:

1. Medically necessary off-label drug use will be accepted if the drug is otherwise covered by the Plan and if one of the following criteria are met:
   A. Drug Compendia: One of the following drug compendia indicates that the drug is recognized as effective for the indication:
      - The American Hospital Formulary Service Drug Information;
      - Drug Facts and Comparison;
      - The U.S. Pharmacopoeia Dispensing Information;
      - American Medical Association Drug Evaluation;

- National Cancer Care Network;
- National Cancer Institute; or
- Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services.

B. Scientific Evidence/Substantially Accepted Peer-Reviewed Medical Literature: The majority of the scientific evidence indicates that the drug is effective for the off-label indication. The evidence must:

1. Consist of an adequate number of well-designed studies with sufficient numbers of patients in relation to the incidence of the disease;
2. Be published in peer reviewed journals. The studies must be printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity, and reliability;
3. There must be enough information in the peer-reviewed literature to allow judgment of the safety and efficacy;
4. Demonstrate consistent results throughout all studies; and
5. Document positive health outcomes and demonstrate:
   i. That the drug is as effective as or more effective than established alternatives; and
   ii. Improvements that are attainable outside the investigational setting.

C. Recognized as effective for treatment of such indication by the Federal Secretary of Health and Human Services.

ORDER OF BENEFITS DETERMINATION - The method for ascertaining the order in which the Plan renders payment. The principle applies when another plan has a Coordination of Benefits provision.

ORTHOTICS - An orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve function of movable parts of your body.

OTHER PLAN - Shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering you.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

OUTPATIENT CARE AND/OR SERVICES - Treatment including services, supplies and medicines provided and used at a hospital under the direction of a physician/provider when you are not admitted as a registered inpatient; services rendered in a physician's/provider's office, laboratory or X-ray facility, an ambulatory surgical center, or your home.

OUTPATIENT SURGICAL FACILITY - A licensed surgical facility, surgical suite or medical facility surgical center in which a surgery is performed and you are not admitted for an overnight stay.

PALLIATIVE CARE - Palliative care means services received from a provider specialized in palliative care which can be provided in a home, inpatient or outpatient setting.

PARTIAL HOSPITALIZATION/DAY TREATMENT - A structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

PARTICIPANT - You, when you are an employee or a former employee and is or may become eligible to receive a benefit under the Plan.

PARTICIPATING (PAR) PROVIDER - A provider who is part of a network of providers who has entered into a current participating agreement with the Plan Supervisor, or a contractor for the Plan Supervisor.

PLAN - Shall mean the Benefits described in the Plan Document. The Plan is the Covered Entity as defined in HIPAA (§160.103).

PLAN ADMINISTRATOR/PLAN SPONSOR - The individual, group or organization responsible for the day-to-day functions and management of the Plan. The Plan Administrator/Plan Sponsor may employ individuals or firms to process claims and perform other Plan connected services. The Plan Administrator/Plan Sponsor is as shown under the General Plan Information.

PLAN DOCUMENT - The term Plan Document whenever used herein shall, without qualification, mean the document containing the complete details of the benefits provided by this Plan. The Plan Document is kept on file at the office of the Plan Administrator.

PLAN SUPERVISOR - The individual or group providing administrative services to the Plan Administrator in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it by the Plan Administrator.

PLAN YEAR - The term Plan Year means an annual period beginning on the effective date of this Plan and ending twelve (12) calendar months thereafter or upon termination of the Plan, whichever occurs earliest.

PREFERRED NETWORK HEALTH CARE FACILITY - Shall mean a hospital or hospital outpatient department, critical access hospital, outpatient surgical center, or other provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

PREFERRED PROVIDER - A provider who is part of a network of providers contracted to accept a negotiated rate as payment in full for services rendered.

PROTECTED HEALTH INFORMATION (PHI) - Individually Identifiable Health Information, as defined in HIPAA §164.501 (see §164.514(2)(b)(i) for individual identifiers), whether it is in electronic, paper or oral form that is created or received by or on behalf of the Plan Sponsor or the Plan Supervisor.

PROVIDER - An entity whose primary responsibility is related to the supply of medical care. Each provider must be licensed, registered, or certified by the appropriate state agency where the medical care is performed, as required by that state's law where applicable. Where there is no applicable state agency, licensure, or regulation, the provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a provider as defined herein if that entity is not deemed to be a provider by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS'

determination of an entity's status as a provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

QUALIFYING PAYMENT AMOUNT - Means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan Supervisor (if calculated by the Plan Supervisor), 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.

REASONABLE AND/OR REASONABLENESS - Shall mean in the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as related to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration (FDA); and (c) the Centers for Medicare and Medicaid Services (CMS). A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not reasonable.

To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are reasonable based upon information presented to the Plan Administrator.

Reasonableness may be based upon coding and billing standards which include but are not limited to those defined by the American Medical Association CPT (Current Procedural Terminology) and the Centers for Medicare and Medicaid Services National Correct Coding Initiative, Optum Coding resource manuals, Regence reimbursement guidelines and policies, as well as the UB04 Billing Manual coding guidelines and definitions and the National Uniform Billing Committee guidelines as applicable. Claims are subject to additional review upon submission prior to final payment.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not reasonable and therefore not eligible for payment by the Plan.

RECIPIENT - The recipient is the Participant who receives the organ for transplant from the organ donor. The recipient shall be a Participant covered under the provisions of this Plan. Only those organ transplants not considered experimental in nature and specifically covered herein are eligible for coverage under this Plan.

RECOGNIZED AMOUNT - Means, except for Non-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 your provider's billed charge or the qualifying payment amount.

RECONSTRUCTIVE - Services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

RELATIVE - When used in this document shall mean a husband, wife, domestic partner, son, daughter, mother, father, sister or brother of you, or any other person related to you through blood, marriage, domestic partnership or adoption.

RESIDENTIAL TREATMENT FACILITY - A facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a physician/provider and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A residential treatment facility that qualifies as a hospital is considered a hospital.

ROOM AND BOARD CHARGES - The institution's charges for room and board and its charges for other necessary institutional services and supplies, made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied.

SEMI-PRIVATE RATE - The daily room and board charge which an institution applies to the greatest number of beds in its semi-private rooms containing 2 or more beds. If the institution has no semi-private rooms, the semi-private rate will be the daily room and board rate most commonly charged for semi-private rooms with two or more beds by similar institutions in the area. The term "area" means a city, a county, or any greater area necessary to obtain a representative cross section of similar institutions.

SERIOUS AND COMPLEX CONDITION - 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. In the case of a chronic illness or condition, a condition that is, a) life-threatening, degenerative, potentially disabling, or congenital; and b) requires specialized medical care over a prolonged period of time.

SKILLED NURSING/REHABILITATION FACILITY - An institution or a distinct part of an institution meeting all of the following tests:

- It is licensed to provide and is engaged in providing, on an inpatient basis, for you if you are convalescing from injury or disease, professional nursing services rendered by a Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Graduate Nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
- Its services are provided for compensation from its patients and patients are under the full-time supervision of a physician/provider or Registered Graduate Nurse (R.N.).
- It provides 24 hours per day nursing services by a licensed nurse, under the direction of a full-time Registered Graduate Nurse (R.N.).

- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest for the aged, drug addicts, alcoholics, the mentally handicapped, custodial, or educational care, or care of mental disorders.

SPOUSE - Your lawfully wed, same or opposite gender spouse, which is legally recognized in the state in which you were married, not including a common-law marriage.

SUBSCRIBER - An employee of the Group who is enrolled in the Plan.

SUBSTANCE USE AND/OR 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 Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant state guideline or applicable sources. The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

SUMMARY PLAN DESCRIPTION - The document required by ERISA containing a summary of the benefits provided under the Plan. In the event of a discrepancy between the summary and the Plan Document, the provisions stated in the Plan Document will supersede.

SURGICAL PROCEDURE - A surgical procedure is defined as:

- A cutting operation.
- Treatment of a fracture.
- Reduction of a dislocation.
- Radiotherapy if used in lieu of a cutting operation for removal of a tumor.
- Electrocauterization.
- Injection treatment of hemorrhoids and varicose veins.

TEMPOROMANDIBULAR JOINTS (TMJ) - The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

THERAPY - Includes cognitive behavioral therapy, interpersonal therapy, dialectical behavior therapy, psychoanalysis, psychotherapy, family therapy, individual therapy, marriage therapy, or marital therapy.

TRANSITIONAL CARE - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist you with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide you with stable and safe housing and the opportunity to learn how to manage your activities of daily living. Supervised living arrangements may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist you with recovery.

TREATMENT - Administration or application of remedies to you for a disease or injury; medicinal or surgical management or therapy.

WAITING PERIOD - The period that must pass before coverage for you or your dependents that are otherwise eligible to enroll under the terms of the Plan can become effective. Periods of employment in an ineligible classification are not part of a waiting period.

GENERAL PROVISIONS

ADMINISTRATION OF THE GROUP MEDICAL PLAN

The Plan is administered through the Plan Administrator. The Plan Administrator has retained the services of an independent Plan Supervisor experienced in claims processing. The Plan Administrator has the right to determine eligibility for benefits and to construe the terms of the Plan. The Plan Administrator has made the Plan Supervisor its minister to carry out its decisions.

Legal notices may be filed with, and legal process served upon the Plan Administrator.

AMENDMENT OF PLAN DOCUMENT

The Plan Administrator may terminate, modify, or amend the Plan in its sole discretion without prior notice. The Plan Administrator must notify the Plan Supervisor in writing requesting an amendment to the Plan. The Plan Supervisor will prepare an amendment to be signed by the Plan Administrator. Once the Plan Administrator has signed the amendment, such termination, amendment or modification which affects you and your dependents will be communicated to you in the manner of a new Plan document or employer communication. The amended Plan Benefits shall be the basis for determining all Plan payments for all expenses incurred on or after the effective date of such amendment. Plan payments made under the Plan prior to amendment shall continue to be included as Plan payments in determining the total benefits remaining toward satisfaction of any benefit maximums calculated on a Plan year, calendar year or lifetime basis.

APPLICATION AND IDENTIFICATION CARD

To obtain coverage, you must complete and deliver to the Plan Administrator an application on the enrollment form supplied by the Plan Supervisor.

Acceptance of this application will be evidenced by the delivery of an identification card showing your name, by the Plan Supervisor to the Plan Administrator.

ASSIGNMENT OF BENEFITS

Assignment by you to your provider of your right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an assignment of benefits, if and only if your provider accepts said assignment of benefits as consideration in full for services rendered. If benefits are paid, however, directly to you, the claimant – despite there being an assignment of benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be your responsibility to compensate the applicable provider(s). The Plan will not be responsible for determining whether an assignment of benefits is valid; and you shall retain final authority to revoke such assignment of benefits if a provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by you, the Claimant, has been received.

You shall not, at any time, either during the time in which you are a Claimant in the Plan, or following your termination as a claimant, in any manner, have any right to assign your right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which you may have against the Plan or its fiduciaries. This prohibition applies to providers as well.

A provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Preferred Provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

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, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

AUDIT AND REVIEW FEES

In addition to the Plan's medical record review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not maximum allowable and/or medically necessary and reasonable, if any, and may include your medical billing records review and/or audit of your medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the maximum allowable amounts or other applicable provisions, as outlined in this Plan Document. Cost containment fees may be charged as a percent of savings under the Plan due to the application of cost containment provisions and are considered covered expenses under the Plan.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a maximum allowable charge, in accord with the terms of this Plan Document.

BALANCE BILLING

In the event that a claim submitted by a Preferred or Non-Preferred Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that you should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over Out-of-Network Providers that engage in balance billing practices.

In addition, with respect to services rendered by a Preferred or Participating Provider being paid in accordance with a discounted rate, it is the Plan's position that you should not be responsible for the difference between the amount charged by the Preferred or Participating Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Preferred or Participating Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Preferred or Participating Provider.

You are responsible for any applicable payment of coinsurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

CANCELLATION

You may cancel your coverage by giving written notice to the Plan Administrator who will notify the Plan Supervisor.

No person shall acquire a vested right to receive benefits after the date this Plan is terminated.

In the event of the cancellation of this Plan, or the cancellation of the Participating Group's participation in the Plan, you and your dependents coverage shall cease automatically without notice. You and your dependents shall not be entitled to further coverage or benefits, whether or not any medical condition was covered by the Plan prior to termination or cancellation.

The Plan may be cancelled or terminated at any time without advance notice by the Participating Group or Groups. Any Participating Group may cancel its participation at any time without notice and without effect on any remaining Participating Group.

Upon termination of this Plan, or the cancellation of the Participating Group's participation in the Plan, all claims incurred prior to termination, but not submitted to the Plan Supervisor within 75 days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

CLAIMS FOR BENEFITS AND APPEALING A CLAIM

All claims and questions regarding health claims should be directed to the Plan Supervisor. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. All claims must be received within the Plan's timely filing limits and will be processed based upon available benefits and the terms and conditions of the Plan once the claim and all necessary supporting documentation is received by the Plan Supervisor. The Plan has no control over when claims are submitted, nor when all required records and other requested documentation (i.e., itemizations, medical records, etc.) to process the claim, will actually be received. Therefore, due to the multitude of factors that impact the timing of claim processing, claims cannot and will not be considered in the same order the services were actually received by you. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that you are entitled to the benefits. The responsibility to process claims in accordance with the Plan Document may be delegated to the Plan Supervisor; provided, however, that the Plan Supervisor is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

If you are claiming benefits under the Plan you shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that you have not incurred a covered expense or that the benefit is not covered under the Plan, or if you should fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a provider who wants to know if you are covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a clean claim (a claim which includes all the information necessary to make a decision) must be filed with the Plan (which will be considered a "Post-Service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

You have the right to request a review of an adverse benefit determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final adverse benefit determination. If you receive notice of a final adverse benefit determination, or if the Plan does not follow the claims procedures properly, you then have the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to you, or to a provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

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

  A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician/provider with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  If the Plan does not require you to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file the claim as a post-service claim.

- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or
  - You request an extension of the course of treatment beyond that which the Plan Administrator has approved.

  If the Plan does not require you to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file the claim as a post-service claim.

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

When Health Claims Must Be Filed

Post-service health claims must be filed with the Plan Supervisor within one year from the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.** If you can show that it was not reasonably possible to submit the claim within one year from the date of service or if you can provide proof that you had attempted to submit the claim within one year, we will waive the timely filing provision and process the claim in accordance with the terms of the Plan.

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Plan Supervisor in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Plan Supervisor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be

received by the Plan Supervisor within 45 days from your receipt of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify you, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Urgent Care Claims:
  - If you have provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
  - If you have not provided all of the information needed to process the claim, then you will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
  - You will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
    - The Plan's receipt of the specified information; or
    - The end of the period afforded you to provide the information.
  - If there is an adverse benefit determination, a request for an expedited appeal may be submitted orally or in writing by you. All necessary information, including the Plan's benefit determination on review, may be transmitted between you and the Plan by telephone, facsimile, e-mail, or other similarly expeditious method. Alternatively, you may request an expedited review under the external review process.
- Pre-service Non-urgent Care Claims:
  - If you have provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If you have not provided all of the information needed to process the claim, then you will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. You will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and yourself (if additional information was requested during the extension period).
- Concurrent Claims:
  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying you of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, you will be notified sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
  - Request by You Involving Urgent Care. If the Plan Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments and the claim is involving urgent care, the claim will be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

  - Request by You Involving Non-urgent Care. If the Plan Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments and the claim is not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
  - Request by You Involving Rescission. With respect to rescissions, the following timetable applies:
    - Notification to You - 30 days
    - Notification of adverse benefit determination on appeal - 30 days

- Post-service Claims:
  - If you have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then the claim will be decided prior to the end of the 15-day extension period.
  - If you have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then you will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then you will be notified of the determination by a date agreed to by the Plan Administrator and yourself.
- Extensions - Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
- Extensions - Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
- Extensions - Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide you with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile, e-mail, or similar method, with written or electronic notice). The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by you. The notice will contain the following information:

- Information sufficient to allow you to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for you to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon the expert's advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to you, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to you, free of charge, upon request;
- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist you with the internal claims and appeals and external review processes; and
- In the case of a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determination

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and you believe the claim has been denied wrongly, you may appeal the denial and review pertinent documents. The claims procedures of this Plan provide you with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- 180 days following your receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;
- The opportunity for you to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon the expert's advice;

- That you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits in possession of the Plan Administrator or the Plan Supervisor; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances; and
- In the case of an urgent care claim, for an expedited review process pursuant to which:
  - A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by you; and
  - All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and yourself by telephone, facsimile, e-mail, or other available similarly expeditious method.

Requirements for First Appeal

You must file the first appeal in writing using an Appeals Submission Form (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an adverse benefit determination. If you would like to authorize another individual to act on your behalf in regard to the appeal, an Appointment of Authorized Representative form must be submitted with the appeal (an Authorized Representative form is not required in the case of an urgent care claim). An Appeals Submission Form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Care Department at 800/869-7093, or at www.accesshma.com.

For pre-service urgent care claims, if you choose to orally appeal, you may telephone:

Healthcare Management Administrators, Inc.
425/462-1000 Seattle Area
800/869-7093 All Other Areas

To file an appeal in writing, your appeal must include an Appeals Submission Form and be addressed and mailed, e-mailed, or faxed as follows:

Healthcare Management Administrators, Inc.
Attn: Appeals
P.O. Box 85016
Bellevue, Washington 98015-5016
425/462-1000 - Seattle Area
800/869-7093 - All Other Areas
855/462-8875 – Fax
appeals@accesshma.com – E-mail

It shall be your responsibility to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- A completed Appeals Submission Form;
- Your name;
- Your ID number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any facts or theories in the appeal will result in the facts and theories being deemed waived. In other words, you will lose the right to raise factual arguments and theories which support this claim if you fail to include the facts and theories in the appeal;**

- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that you have which indicates that you are entitled to benefits under the Plan.

If you provide all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Review

The Plan Administrator shall notify you of the Plan's benefit determination on first review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim - pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 30 days per internal appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the first appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

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

The Plan Administrator shall provide you with notification, with respect to pre-service urgent care claims, by telephone, facsimile, e-mail, or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- Information sufficient to allow you to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for you to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon the expert's advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to you, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to you, free of charge, upon request; and
- 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."

Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse benefit determination regarding the first appeal, you must submit a second appeal in writing using an Appeals Submission Form (although oral appeals are permitted for pre-service urgent care claims) within 60 days. If you would like to authorize another individual to act on your behalf in regard to the second appeal, an Appointment of Authorized Representative form must be submitted with the appeal (an Authorized Representative form is not required in the case of an urgent care claim). An Appeals Submission Form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Care Department at 800/869-7093, or at www.accesshma.com.

As with the first appeal, your second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Two Levels of Appeal

This Plan requires two levels of appeal by you before the Plan's internal appeals are exhausted. For each level of appeal, you and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the same submission and response guidelines.

Once you receive an Adverse Benefit Determination in response to an initial claim for benefits, you may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If you receive an Adverse Benefit Determination in response to that initial appeal, you may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If you receive an Adverse Benefit Determination in response to your second appeal, such Adverse Benefit Determination will constitute the final Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

Timing of Notification of Benefit Determination on Second Review

The Plan Administrator shall notify you of the Plan's benefit determination on second review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim - pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the first appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

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

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

- A description of any additional information necessary for you to perfect the claim and an explanation of why such information is needed; and
- A description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

If, for any reason, you do not receive a written response to the appeal within the appropriate time period set forth above, you may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted (first level and second level review) before any legal action is brought.**

External Review Process

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.

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

1. Any eligible adverse benefit determination (including a final internal adverse benefit determination) 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 investigational; 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 non-quantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An adverse benefit determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

A. Standard external review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow you to file a request for an external review with the Plan if the request is filed within four (4) 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 for external review 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.

   You must request the external review in writing using an Appeals Submission Form. If you would like to authorize another individual to act on your behalf, an Appointment of Authorized Representative form must be submitted with the external review request. An Appeals Submission Form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Care Department at 800/869-7093, or at www.accesshma.com.

   You must submit the request for external review in writing, and it must be addressed and mailed, e-mailed, or faxed as follows:

   Healthcare Management Administrators, Inc.
   Attn: Appeals
   P.O. Box 85016
   Bellevue, Washington 98015-5016
   425/462-1000 - Seattle Area
   800/869-7093 - All Other Areas
   855/462-8875 – Fax
   appeals@accesshma.com – E-mail

2. Preliminary review. Within five (5) business days following the date of receipt of the Appeals Submission Form requesting external review, the Plan will complete a preliminary review of the request to determine whether:

   (a) You are or were 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;

   (b) The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

   (c) You have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations; and

   (d) You have provided all the information and forms required to process an external review.

   Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to you. 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 you to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. 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 Plan Supervisor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method 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.

4. 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 immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

B. Expedited external review

1. Request for expedited external review. The Plan will allow you to make a request for an expedited external review with the Plan at the time you receive:

   (a) An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   (b) A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your 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 you received emergency services, but has not been discharged from a facility.

You may request an expedited external review orally or in writing. Written requests must include an Appeals Submission Form. If you would like to authorize another individual to act on your behalf, an Appointment of Authorized Representative form must be submitted with the expedited external review request. An Appeals Submission Form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Care Department at 800/869-7093, or at www.accesshma.com.

Oral requests for expedited external review can be made by telephone at:

Healthcare Management Administrators, Inc.
425/462-1000 - Seattle Area
800/869-7093 - All Other Areas

A written request for an expedited external review may be addressed and mailed, e-mailed, or faxed as follows:

Healthcare Management Administrators, Inc.
Attn: Appeals
P.O. Box 85016
Bellevue, Washington 98015-5016
425/462-1000 - Seattle Area
800/869-7093 - All Other Areas
855/462-8875 – Fax
appeals@accesshma.com – E-mail

2. 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 in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to you of its eligibility determination.

3. 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 in paragraph A.3 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 considered appropriate by the IRO, 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.

4. Notice of final external review decision. The Plan's (or Plan Supervisor'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 in paragraph A.3 above, as expeditiously as your 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.

CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

You or your dependent shall present the Plan identification card to the provider of service upon admission to a medical facility or upon receiving service from a physician/provider.

Written proof of the nature and extent of service performed by a physician or other provider of service shall be furnished to the Plan Supervisor within one year after the service was rendered. Claim forms are available through the Plan Supervisor and are required along with an itemized statement with a diagnosis, your name and subscriber identification number and the name of the Plan Administrator or the Participating Group.

You and all your dependents agree that in order to receive benefits, any physician, nurse, medical facility or other provider of service, having rendered service or being in possession of information or records relating thereof, is authorized and directed to furnish the Plan Supervisor, at any time, upon request, any and all such information and records, or copies thereof.

The Plan Supervisor shall have the right to review these records with the Plan's Insurance Company and with any medical consultant or with the UR Coordinator as needed to determine the medical necessity of the treatment being rendered.

COORDINATION OF BENEFITS

Definitions

The term "allowable expense" shall mean the maximum allowable, at least a portion of which is paid under at least one of any multiple plans covering you. In no event will more than 100% of total allowable expenses be paid between all plans, nor will total payment by this Plan exceed the amount which this Plan would have paid as primary Plan.

A credit savings may be established if this Plan is secondary. A credit savings is the difference between the benefits this Plan would pay if you had no other coverage and the benefits this Plan actually paid. Credit savings may be used to provide 100% payment rather than partial payment of allowable expenses that you incur within the same calendar year.

Coordination of Benefits does not apply to outpatient prescription drug card programs.

The term "order of benefits determination" shall mean the method for ascertaining the order in which the Plan renders payment. The principle applies when another plan has a Coordination of Benefits provision.

This Plan will coordinate benefits with another health plan that you or your eligible dependents are enrolled on. However, if the other coverage is not considered a Qualified High Deductible Health Plan (as defined in the Internal Revenue Code) you (and your employer on your behalf) will not be able to contribute to an HSA.

Application

Under the order of benefits determination method, the plan that is obligated to pay its benefits first is known as the primary plan. The plan that is obligated to pay additional benefits for allowable expenses not paid by the primary plan is known as the secondary plan. When you are enrolled under two or more plans (policies), an order of benefits determination will be made regarding which plan will pay first. The order of benefit determination is as follows:

1. The plan which does not include a Coordination of Benefits provision will be primary.
2. The plan covering you as a retiree will be secondary for you and any of your enrolled dependents.
3. The plan covering you as the employee (or insured, member, Participant, or subscriber) of the policy will be primary.
4. This Plan will pay secondary to any individual policy.
5. If this Plan is covering you as a COBRA Participant or a Participant of continuation coverage pursuant to state law, this Plan is secondary to your other plan.
6. When your dependent child is covered under more than one plan, the following rules apply. Unless there is a court decree stating otherwise, plans covering your dependent child shall determine the order of benefits as follows:
   (a) For your dependent child whose parents are married or are living together, who have or have not ever been married:
      (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      (ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
   (b) For your dependent child whose parents are divorced or separated or are not living together, who have or have not ever been married:
      (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
      (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

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

I. The plan covering the custodial parent;

II. The plan covering the custodial parent's spouse;

III. The plan covering the non-custodial parent; and then

IV. The plan covering the non-custodial parent's spouse.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

7. Where the order of payment cannot be determined in accordance with (1), (2), (3), (4), (5), or (6) above, the primary plan shall be deemed to be the plan which has covered you for the longer period of time.
8. Where the order of payment cannot be determined in accordance with (1), (2), (3), (4), (5), (6), or (7) above, the primary plan shall be deemed to be the plan which has covered you for the longest time.

Coordination of benefits with Medicare is governed by the Medicare Secondary Payer rules.

Coordination of Benefits with Medicaid

In all cases, benefits available through a state or Federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Excess Insurance

If at the time of Injury, sickness, disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

1. Any primary payer besides the Plan.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

CREDIT FOR PRIOR GROUP COVERAGE

This Plan amends and replaces the prior Plan. You and your dependents who were covered under the prior Plan sponsored by the Employer immediately prior to the time this Plan became effective shall not lose eligibility or benefits due to the change in Plans. All charges incurred on or after the effective date of this Plan will be subject to the benefits available under this Plan and not the prior Plan. Credit will be given for time enrolled under the prior Plan for payments towards coinsurance and deductibles.

EFFECT OF TERMINATION OF THE PLAN

Upon complete or partial termination of the Plan, the Plan Administrator may, after the payment or provision for payment of all benefits to you if you have incurred covered expenses and charges properly payable, including all expenses incurred and to be incurred in the liquidation and distribution of the Trust Fund or separate account, direct the disposition of all assets held in the Trust Fund or separate account to the Participating Group or Groups, subject to any applicable requirement of an accompanying Trust Document or applicable law or regulation.

EVIDENCE BASED MEDICINE

In making a medical necessity determination, the discretion and standard of review is neither arbitrary nor capricious and is based upon the following provisions and approved citations:

- MCG, Milliman Care Guidelines.
- NCCN, National Cancer Care Network.
- Cambia Medical Policy including clinical practice guidelines, clinical position statements and referenced citations.
- Wolters Kluwer Facts and Comparisons.
- Other authoritative compendia (references) as identified from time to time by the Federal Secretary of Health and Human Services or other approved policy.

FACILITY OF PAYMENT

If, in the opinion of the Plan Supervisor, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Plan Supervisor may, at its option, make such payment to the individuals as have, in the Plan Supervisor's opinion, assumed the care and principal support of you and are therefore equitably entitled thereto. In the event of your death prior to such time as all benefit payments due you have been made, the Plan Supervisor may, at its sole discretion and option, honor benefit assignments, if any, prior to your death.

Any payment made by the Plan Supervisor in accordance with the above provisions shall fully discharge the Plan and the Plan Supervisor to the extent of such payment.

FIDUCIARY OPERATION

Each fiduciary shall discharge duties with respect to the Plan solely in the interest of you and your beneficiaries and: (1) for the exclusive purposes of providing benefits to you and your beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan to the extent that they are consistent with the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

FREE CHOICE OF PHYSICIAN

You and your dependents shall have free choice of any licensed physician/provider or surgeon, and the physician-patient relationship shall be maintained. Please refer to the Schedule of Benefits for the appropriate coinsurance reimbursement level.

Nothing contained herein shall confer upon you or your dependent any claim, right, or cause of action, either at law or in equity, against the Plan for the acts of any medical facility in which you receive care, for the acts of any physician/provider from whom you receive service under this Plan, or for the acts of the Care Manager performing duties under this Plan.

FUNDING

If contributions are required of you or your dependents covered under this Plan, the Plan Administrator will maintain a Trust or otherwise account for the receipt of money and property to fund the Plan, for the management and investment of such funds and for the payment of claims and expenses from such funds. The terms of the Trust (when applicable) are hereby incorporated by reference, as of the effective date of the Trust, as a part of this Plan.

The Participating Group(s) shall deliver from time to time to the Plan Administrator or the Trust such amounts of money and property as shall be necessary to provide the Trust with sufficient funds to pay all claims and reasonable expenses of administering the Plan as the same shall be due and payable. The Plan Administrator may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose in the state of situs and may pay the premiums therefore directly or by funds deposited in the Trust.

All funds received by the Trust and all earnings of the Trust shall be applied toward the payment of claims and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan Documents. The Plan Administrator may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

Any fiduciary, employee, agent, representative, or other individual performing services to or for the Plan or Trust shall be entitled to reasonable compensation for services rendered, unless such individual is the Plan Administrator, and for reimbursement of expenses properly and actually incurred.

HIPAA PRIVACY AND SECURITY

Use and Disclosure of Protected Health Information

Under the HIPAA privacy rules the Plan Sponsor must establish the permitted and required uses of Protected Health Information (PHI).

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose summary health information to the Plan Sponsor, provided that the Plan Sponsor requests the summary health information for the purpose of obtaining premium bids, determining participant enrollment status, or for modification, amendment or termination of the Plan.

Plan Sponsor's Certification of Compliance

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the Employer (Plan Sponsor) unless the Employer (Plan Sponsor) certifies its compliance with 45 Code of Federal Regulations §164.504(f)(2) (collectively referred to as The Privacy Rule) as set forth in this Article and agrees to abide by any revisions to The Privacy Rules.

Notice of Privacy Practices

The Plan provides each participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling your Human Resources Department.

Restrictions on Disclosure of Protected Health Information to Employer (Plan Sponsor)

The Plan and any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the Employer (Plan Sponsor) only to permit the Employer (Plan Sponsor) to carry out plan administration functions for the Plan consistent with the requirements of the Privacy Rule. Any disclosure to and use by the Employer (Plan Sponsor) of your Protected Health Information will be subject to and consistent with the provisions of paragraphs on **Employer (Plan Sponsor) Obligations Regarding Protecting Health Information** and **Adequate Separation Between the Employer (Plan Sponsor) and the Plan** of this Article.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the Employer (Plan Sponsor) unless the disclosures are explained in the Notice of Privacy Practices distributed to you.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the Employer (Plan Sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).

Employer (Plan Sponsor) Obligations Regarding Protecting Health Information

The Employer (Plan Sponsor) will:

- Neither use nor further disclose your Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.
- Ensure that any agent, including any subcontractor, to whom it provides your Protected Health Information, agrees to the restrictions and conditions of the Plan Documents, including this Article, with respect to your Protected Health Information.
- Not use or disclose your Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).
- Report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed under this Article promptly upon learning of such inconsistent use or disclosure.
- If you are the subject of information, make Protected Health Information available to you in accordance with 45 Code of Federal Regulations § 164.524.
- Make your Protected Health Information available for amendment, and will on notice amend your Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.
- Track disclosures it may make of your Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.
- Make available its internal practices, books, and records, relating to its use and disclosure of your Protected Health Information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.
- If feasible, return or destroy all of your Protected Health Information, in whatever form or medium (including in any electronic medium under the Employer's (Plan Sponsor's) custody or control),

received from the Plan, including all copies of and any data or compilations derived from and allowing identification of you if you are the subject of the Protected Health Information, when your Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all of your Protected Health Information, the Employer (Plan Sponsor) will limit the use or disclosure of any of your Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation Between the Employer (Plan Sponsor) and the Plan

The following classes of employees or other workforce members under the control of the Employer (Plan Sponsor) may be given access to your Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan:

- Human Resources Director.
- Chief Financial Officer.
- Benefits and Compensation Specialist.

This list includes every class of employees or other workforce members under the control of the Employer (Plan Sponsor) who may receive your Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The identified classes of employees or other workforce members will have access to your Protected Health Information only to perform the plan administration functions that the Employer (Plan Sponsor) provides for the Plan.

The identified classes of employees or other workforce members will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer (Plan Sponsor), for any use or disclosure of your Protected Health Information in breach or violation of or noncompliance with the provisions of this Article to the Plan Documents. Employer (Plan Sponsor) will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance for you, if the privacy of your Protected Health Information may have been compromised by the breach, violation or noncompliance.

Employer (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information

Employer (Plan Sponsor) will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Ensure that the adequate separation between the Plan and Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures.
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect the electronic PHI.
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

INADVERTENT ERROR

Inadvertent error by the Plan Administrator in the keeping of records or in the transmission of your application shall not deprive you or your dependents of benefits otherwise due, provided that such inadvertent error is corrected by the Plan Administrator within ninety (90) days after it was made.

MEDICARE

Medicare - As used in this section shall mean Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added to by the Social Security Amendments of 1965, the Tax Equity and Fiscal Responsibility Act of 1982, or as later amended.

Eligible Expenses - As used in this section services, supplies and treatment shall mean the same benefits, limits, and exclusions as defined in this Plan Document. However, as allowed pursuant to Federal Medicare Secondary Payer regulations, if you are eligible for benefits as an employee or dependent of this Plan and you are entitled to be covered by Medicare Parts A and B, whether or not actually enrolled, then Eligible Expenses shall mean the lesser of the total amount of charges allowable by Medicare, whether enrolled or not, and the total eligible expenses allowable under this Plan exclusive of coinsurance and deductible, but only if the provider accepts Medicare assignment as payment in full. Expenses in excess of the above Eligible Expenses may result in balanced billing, unless prohibited under Federal Medicare regulations.

Order of Benefits Determination - As used in this section shall mean the order in which Medicare benefits are paid, in relation to the benefits of this Plan.

Total benefits of this Plan shall be determined as follows:

Active Employees - If you are an active employee and/or non-working spouse of an active employee age 65 or over: This Plan will be primary and Medicare will be secondary.

Disabled Employees with Medicare (Except those with End-Stage Renal Disease) - If you are eligible for Medicare by reason of Disability the order of determination will be as shown below:

If employed by a company with 100 or more employees: This Plan will be primary and Medicare will be secondary. The Employer will remain the primary payor of medical benefits until the earliest of the following events occurs: (1) the group coverage ends for all employees; (2) your group coverage as an active individual ends.

If employed by a company with less than 100 employees: This Plan will be secondary and Medicare will be primary.

The Omnibus Budget Reconciliation Act of 1986 defines a large group health plan as one that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year. A typical business day is defined as 50 percent or more of the employer's regular business days during the previous calendar year.

Disabled Employees with End-Stage Renal Disease (ESRD)

This Plan shall be primary for you if you are an ESRD Medicare beneficiary during the initial 30 months of entitlement to Medicare coverage, in addition to the usual three month waiting period, or a maximum of 33 months, referred to as the "Coordination Period". ESRD Medicare Entitlement usually begins on the fourth month of renal dialysis, but can start as early as the first month of dialysis if you take a course in self-dialysis training during the three month waiting period. Upon completion of the Coordination Period, this Plan shall be secondary to Medicare and shall coordinate benefits.

MISREPRESENTATION

Any material misrepresentation on the part of the Plan Administrator or yourself in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage null and void.

NOTICE

Any notice given under this Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Plan Supervisor, when addressed to it at its office; or if given to you, when addressed to you at your address as it appears on the records of the Plan Supervisor on your enrollment form and any corrections made to it.

PHOTOCOPIES

Reasonable charges made by a provider for photocopies of medical records when the copies are requested by the Plan Supervisor shall be payable. The Plan does not reimburse administrative fees charged related to records requests.

PLAN ADMINISTRATION

The Plan Administrator shall be responsible for compliance by the Plan with all requirements of Part 1, Subtitle B of Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA).

PRIVILEGES AS TO DEPENDENTS

You shall have the privilege of adding or withdrawing the name or names of any of your dependent(s) to or from this coverage, as permitted by the Plan, by submitting to the Plan Administrator an application for reclassification on the enrollment form furnished by the Plan Supervisor. Each dependent added to the coverage shall be subject to all conditions and limitations contained in this Plan.

RIGHT OF RECOVERY OF PAYMENTS

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

You, your dependent, your 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, 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. If the Plan must bring an action against you, your provider or other person or entity to enforce the provisions of this section, then you, your provider, or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

STATE AND FEDERAL EMERGENCY OR EXECUTIVE ORDER

This Plan intends to comply with and shall deem its Plan terms automatically amended to conform to any Plan coverage requirement deemed mandatory or otherwise necessary as a result of a declared public health emergency or other state or federal executive order(s) that is applicable to this Plan and/or any regulatory action or sub-regulatory guidance that applies directly to this Plan as a result of a declared

emergency and its associated order(s). Upon the conclusion of such declared emergency and expiration of any such state or federal executive orders, the Plan's terms shall automatically revert to pre-emergency order coverage terms, unless express action is taken by the Plan Sponsor or Plan Administrator to modify this Plan's terms via an executed amendment or restated Summary Plan Description to extend such coverage beyond the timeframe of the emergency order.

STATUTE OF LIMITATIONS CLAUSE

Any and all claims or legal cause of action against this Plan and its designated fiduciaries must be brought and filed with the courts within the time periods specified under WA State Law not to exceed 3 years from the date the Plan Participant exhausts their internal appeal rights under this Plan.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT - THE PLAN'S RIGHT TO RESTITUTION

The Plan does not provide benefits for any accident, injury or sickness for which you or your eligible dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by you or your eligible dependents which expenses arise from an accident, injury, or sickness, subject to the terms of the Plan, the Plan may conditionally advance the payment of the eligible medical benefits.

Payment Condition

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

You, your 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 Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(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 Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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

Subrogation

As a condition to participating in and receiving benefits under this Plan, you agree 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 you are entitled, regardless of how classified or characterized, at the Plan's discretion, if you fail to so pursue said rights and/or action.

You further agree that as a condition to participating in and receiving benefits under this Plan, you have a duty to cooperate. The duty to cooperate extends to the Plan's right of subrogation and requires you to provide any such necessary information as requested by the Plan to determine and evaluate subrogation interests including but not limit to: demand letters, complaints, independent medical examination(s), and other documents requesting any recovery on behalf of you.

If you receive or become entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which you may have against any coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. You are 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. You are also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in your name, commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If you fail to file a claim or pursue damages against any of the following, you authorize the Plan to pursue, sue, compromise and/or settle any such claims in your and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims:

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

You agree and assign all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid without deduction for attorneys' fees or costs without regard to whether you are fully compensated by your recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If your recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by you is deemed held in constructive trust and should not be dissipated or disbursed until such time as your obligation to reimburse the Plan has been satisfied in accordance with these provisions. You are also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by you.

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

Participant is a Trustee Over Plan Assets

If you receive benefits, you are subject to the terms of this section and are hereby deemed a recipient and holder of Plan assets and are 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, you understand that you are required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct your attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where you are not represented by an attorney, instruct the insurance company or any third party from whom you obtain a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent you dispute this obligation to the Plan under this section, you or any of your agents or representatives are 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 attorney's fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

Neither you, your beneficiary, or your 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.

Excess Insurance

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

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

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

Separation of Funds

Benefits paid by the Plan, funds recovered by you, and funds held in trust over which the Plan has an equitable lien exist separately from your property and estate, such that your death, or your filing of bankruptcy, 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 you die as a result of your 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 you and all others that benefit from such payment.

Obligations

It is your obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the sickness, disease, disability, or Injury, including accident reports, Independent Medical Examination(s), settlement demands, settlement information, demand letters, and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that you may have against any responsible party or coverage.
8. To instruct your attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where you are not represented by an attorney, instruct the insurance company or any third party from whom you obtain a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between you and the Plan over settlement funds is resolved.

If you and/or your attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, you will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from you.

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

Offset

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

Minor Status

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

If your 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 you. Any court costs or legal fees associated with obtaining such approval shall be paid by your parents or court-appointed guardian.

Language Interpretation

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

Severability

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

Surrogacy Arrangement or Agreement

If you enter into a surrogacy arrangement or agreement and you receive compensation or reimbursement for medical expenses, you must reimburse the Plan for covered services you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the compensation you receive under the surrogacy arrangement or agreement. A surrogacy arrangement or agreement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Note: This "Surrogacy Arrangement or Agreement" section does not affect your obligation to pay your portion of the coinsurance for these services, but we will credit any such payments toward the amount you must reimburse the Plan under this provision.

By accepting Surrogacy Health Services, you automatically assign to the Plan, your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement or agreement, regardless of whether those payments are characterized as being for medical expenses. To secure the

rights of the Plan, the Plan will also have a lien on those payments. Those payments shall first be applied to satisfy the lien. The assignment and our lien will not exceed the total amount of your obligation to the Plan under the preceding paragraph.

Within 30 days after entering into a surrogacy arrangement or agreement, you must provide written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents, explaining the arrangement, to the Plan.

You must complete and provide to the Plan, all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this Surrogacy Arrangement or Agreement section and to satisfy those rights. You may not agree to waive, release, or reduce the Plans rights under this provision without prior written consent from the Plan.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement or agreement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plans liens and other rights to the same extent as if you had asserted the claim against the third party. The Plan may assign its rights to enforce the Plans liens and other rights.

SUMMARY PLAN DESCRIPTION

This document is the Summary Plan Description.

TAXES

Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) and other state imposed surcharges (as applicable to the Plan), will be considered covered expenses by this Plan. Local, State and Federal taxes, associated with supplies or services covered under this Plan, will also be considered covered expenses by this Plan.

STATEMENT OF ERISA RIGHTS

As a Participant in the Lakeside Industries, Inc. Group Medical and Dental Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, 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 [*note: previously called the Pension and Welfare Benefits Administration*].

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

Receive a summary of the Plan's annual financial report [*note: this means the Form 5500*]. The Plan Administrator is required by law to furnish you with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules, under the Plan's claims procedures.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and the documents or report are not received within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, 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 medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you

are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

Plan Effective January 1, 2006

Plan Restated and Amended January 1, 2024

Plan Arranged By:

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