PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

PACE INDUSTRIES, INC. HEALTH BENEFIT PLAN

Benefits effective July 1, 2022

TABLE OF CONTENTS

INTRODUCTION

This document is incomplete without the Schedule of Benefits. When combined, the documents are a description of Pace Industries Health Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

At all times this Plan will comply with all applicable laws and regulations.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care Provider who is acting within the scope of the Provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of Providers as an In-Network Provider.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, Injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees include Active Employees, who qualify under one of the classes below

- **Regular Full-Time Employees:** Employees designated by the Employer as Regular Full-Time Employees who are scheduled to work at least 30 hours per week. Coverage for Regular Full-Time Employees becomes effective on the first day of the month following completion of the 30-day Waiting Period, subject to completion of enrollment requirements.

- **Qualifying Employee:** A Qualifying Employee is an Employee who is not a Regular Full-Time Employee but who averages at least 30 Hours of Service per week over the Employee's Initial Measurement Period. Coverage will be effective on the first day of the Qualifying Employee's New Employee Stability Period, subject to completion of enrollment requirements. A Qualifying Employee will remain eligible throughout the New Employee Stability Period to the extent that the employee remains employed, subject to the Plan's Break in Service rules, in accordance with applicable law.

  Note: if there is a gap between the end of the Qualifying Employee's New Employee Stability Period and the start of the Qualifying Employee's first Ongoing Employee Stability Period (see below), the Qualifying Employee will remain eligible under the Plan until the day preceding the start of the Ongoing Employee Stability Period (to the extent the employee remains employed, and subject to the Plan's Break in Service rules.)

  If a Qualifying Employee transfers to a Regular Full-Time Employee position prior to the start of the Qualifying Employee's New Employee Stability Period, the Employee will become eligible for coverage. Coverage for the new Regular Full-Time Employee will become effective on the first day of the month following completion of the 30-day Waiting Period, subject to completion of the enrollment requirements.

- **Ongoing Employees:** Once an Employee has completed the Plan's Initial Measurement Period, eligibility will be based solely on the Employee's Hours of Service during the Plan's Standard Measurement Period. Any Employee who averages 30 Hours of Service per week during the Plan's Standard Measurement Period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next Ongoing Employee Stability Period, provided that the Ongoing Employee remains employed, and subject to the Plan's Break in Service rules. Coverage will be effective on the first day of the Ongoing Employee Stability Period, subject to completion of the enrollment requirements, in accordance with applicable law.

Impact of Breaks in Service:
If an Employee has a Break in Service and then returns to work, he or she will be treated as a New Hire, and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. However, if an Employee is not actively at work for a period and returns to work or is otherwise credited with Hours of Service before incurring a Break in Service, he or she will be treated as a continuous employee and will be eligible for coverage under the Plan upon return if he or she was enrolled in coverage prior to the start of the period during which there were no Hours of Service. Coverage will be effective on the first day of the month that coincides with or follows the date the Employee resumes Hours of Service, subject to completion of enrollment requirements.

The Waiting Period is a period of 30 consecutive days as an Active Employee beginning on the first day of employment in an eligible class.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean with whom covered Employee has established a valid marriage under applicable State Law but does not include common law marriages. "Spouse" shall include an individual of the same sex as the covered Employee. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Spouse" shall also mean the person who is currently registered with the Employer as the Domestic Partner of the Employee, this includes opposite sex and same sex couples. An individual is a Domestic Partner of an Employee if that individual and the Employee meet each of the following requirements:

(a) The Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The Employee and the individual are not married to anyone.

(c) The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

(d) The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The Employee and the individual must have the intention that their relationship will be indefinite.

(e) The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this benefit, the Employee must contact the Plan Administrator.

In the event the domestic partnership is terminated, either partner is required to inform of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

(2) A covered Employee’s child less than 26 years of age.

(3) A covered Employee’s child who reaches age 26 and is Totally Disabled, unmarried, incapable of self-support because of intellectual or developmental disability or physical disability, provided:

(a) such child is or was under the limiting age of dependency at the time of application for coverage in the Plan, or;

(b) if not under such limiting age, has had continuous health plan coverage, i.e., no break in coverage greater than 63 days, at the time of application for coverage in the Plan.

The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once

each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

(4) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, adopted child, or a child placed with the Employee for adoption and children for whom the Employee is a Legal Guardian. An Employee's child will also include children, adopted children and children placed for adoption with the Employee's Domestic Partner, and children for whom the Employee's Domestic Partner is a Legal Guardian. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, martial status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Except for Dependents considered Totally Disabled, when a child reaches age 26, coverage will end on the last day of the child's birthday month.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; foster children; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; any former Domestic Partner or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both parents are Employees, their children will be covered as Dependents of one or the other, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

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

FUNDING

Cost of the Plan. Pace Industries, Inc. shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The electronic enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed and submitted to the Employer.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions at any time.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Acquisition of Another Organization's Employees. In the event of a merger, acquisition, agreement, or transaction that results in the acquisition of all or a substantial number of the active or retired employees of another organization, the newly acquired active employees or retired employees who were previously enrolled in the other organization's health plan will be allowed to enroll in this Plan under the terms of the contract.

A newly acquired active Employee who was not enrolled in the other organization's health plan at the time of the merger, acquisition, agreement, or transaction will be treated as a new hire and will be required to satisfy all Eligibility and Enrollment Requirements.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage for himself and any eligible Dependents by completing the electronic enrollment. Employees will receive detailed information regarding enrollment from the Employer.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

For coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn child must be enrolled as a Dependent under this Plan within 30 days of the child's birth in order for non-routine coverage to take effect from the birth.

If the child is not enrolled within 30 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the electronic enrollment process is completed no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two married Employees are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during annual enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on July 1.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage). Because this is a closed plan, Employees who have previous declined coverage in the PPO Plan will not be able to enroll in the PPO Plan following a Special Enrollment Period, but will have the opportunity to enroll in the Consumer Directed Health Plan.

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in the Consumer Directed Health Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

(1) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan, and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Because this is a closed plan, if the Employee was not already enrolled in the PPO Plan and the above circumstances occur, he or she will be permitted to enroll in the Consumer Directed Health Plan.

(2) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received, or in the case of domestic partnership, on the date of registration of the domestic partner relationship

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) Medicaid and State Child Health Insurance Programs. A Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Dependent is terminated due to loss of eligibility for such coverage, and the Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

Because this is a closed plan, if a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee and the Dependent will not be permitted to enroll in the PPO Plan, but will have the opportunity to enroll in the Consumer Directed Health Plan.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the day the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or 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 at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

(1) The date the Plan is terminated.

(2) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.)

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and 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 at least 30 days' advance written notice of such action.

Continuation During Periods of Employer-Certified Disability or layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability or layoff. This continuance will end as indicated below.

For Disability and other approved leave of absence: Coverage may be continued for up to 26 weeks from the last day the Employee worked as an Active Employee.

For layoff: Coverage will remain in effect until the end of the month in which the Employee worked as an Active Employee.

Any continuation of coverage will run concurrently with any leave taken under the Family and Medical Leave Act. While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired within 13 weeks from his or her termination will be reenrolled according to the same elections that the Employee had in place prior to termination of employment to the extent permitted by the terms of the Plan and applicable law.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

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

(a) The 24-month-period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options.)

(4) On the first date that a Dependent ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Options.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent 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 at least 30 days' advance written notice of such action.

ANNUAL ENROLLMENT

Every year during the annual enrollment period, eligible Employees and their eligible Dependents who are Late Enrollees will be able to enroll in the Plan. At this time, covered Employees and their covered Dependents will also be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices for Late Enrollees made during the annual enrollment period will become effective July 1.

Benefit choices made during the annual enrollment period will become effective July 1 and remain in effect until the next July 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Plan Participants will receive detailed information regarding annual enrollment from their Employer.

SCHEDULE OF BENEFITS
Point-of-Service/BlueCard PPO

All benefits described in this Schedule are subject to the Claims Administrator's established Coverage Policy, Allowable Charge and the benefit limits and exclusions described more fully herein including, but not limited to, the determination that: care and treatment is Medically Necessary; and that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called In-Network Providers. Because these In-Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

A list of In-Network Providers is available on the web at www.blueadvantagearkansas.com.

MEDICAL BENEFITS

Deductible payable by Plan Participants, per Plan Year

Plan Year Deductible	
Per Covered Person	$2,000
Per Family Unit	$4,000

Deductible Accumulation
A deductible is an amount of money that is paid once a Plan Year per Covered Person. On the first day of each Plan Year, a new deductible amount is required. For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For two-member or family coverages, each family member must meet his or her own individual deductible until the total amount of deductible expenses paid by all family members meets the overall Family Unit deductible

In-Network and Out-of-Network charges both contribute to the Plan Year Deductible.

The pharmacy Plan Year Deductible and the medical Plan Year Deductible are totally separate and do not contribute toward or offset each other, though both accrue toward the In-Network annual out-of-pocket limit.

The Plan Year deductible is waived for the following charges:
- In-Network Primary Care Physician Charges in any setting other than the Emergency Room.
- Emergency Room facility services
- In-Network Urgent Care services
- In-Network Standard Preventive Care
- In-Network routine vision exams
- Diabetic retinopathy screening
- MDLIVE
- Prescription Drug Charges

Maximum out-of-pocket payments, per Plan Year
The Plan will pay 80% of In-Network Covered Charges and 60% of Out-of-Network Covered Charges until the following amounts of out-of-pocket payments are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.

In-Network Annual Out-of-Pocket Limit
Per Covered Person $7,000
Per Family Unit $14,000

Out-of-Network Annual Out-of-Pocket Limit
Per Covered Person $7,000
Per Family Unit $14,000

Out-of-Pocket Accumulation
The In-Network and Out-of-Network Out-of-pocket amounts are totally separate and do not contribute toward or offset each other.

Covered Charges incurred under the Pharmacy Benefits Plan will accrue toward the In-Network Annual Out-of-Pocket Limit.

This Plan has embedded individual out-of-pocket limits, meaning that individuals enrolled with two-member or family coverage will never be required to pay more than the individual out-of-pocket limits before the Plan pays Covered Charges at 100%.

The charges for the following do not apply to the Annual Out-of-Pocket Limit:
- Cost containment penalties
- Amounts in excess of the Allowable Charge
- Non-Covered Charges

HOSPITAL BENEFITS

Prior Approval is required for all inpatient hospital admissions, except for a Hospital admission following a Medical Emergency.
The Covered Person is responsible for obtaining prior approval of an Out-of-Network admission. Failure to obtain prior approval will result in a $500 reduction in benefits paid by the Plan. The Covered Person is responsible for reimbursing the provider for the penalty amount. Penalty is in addition to any deductible amount and will be applied to charges billed by the facility.

NOTE: For inpatient admissions related to treatment of a Medical Emergency, the Covered Person or the treating Provider should notify the Plan of the admission within 48 hours of the admission.

Room and Board Allowances
Covered Charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.

Inpatient and Outpatient Services
In-Network facility copay, per inpatient admission .....$100 per day, not to exceed $500 per admission
In-Network facility reimbursement rate ..... copay, then 80%, after deductible
Out-of-Network facility reimbursement rate..... copay, then 60%, after deductible
- Covered Charges for inpatient or outpatient services rendered by an Out-of-Network anesthesiologist, pathologist or radiologist in connection with an In-Network facility will be paid at the In-Network level of benefits.

Emergency Room Services
In-Network and Out-of-Network facility copay, per visit. $250
In-Network and Out-of-Network facility reimbursement rate..... copay, then 80%, deductible waived

- Emergency Room Physician charges billed separately are subject to deductible and coinsurance.
- The copay will be waived if the patient is admitted to the Hospital for an inpatient stay directly from the Emergency Room.

PHYSICIAN BENEFITS

Primary Care Physicians
Includes In-Network general practitioners, family practitioners, doctors of internal medicine, pediatricians, geriatricians and obstetrician/gynecologists**.**

Covered Charges billed by physician assistants, registered nurse practitioners, certified nurse practitioners, and clinical nurse specialists that work under the direction of a Primary Care Physician will also be paid at the Primary Care Physician reimbursement rate.

In-Network PCP reimbursement rates
Office visit charges:
Standard Preventive Care ..... 100%, deductible waived
Any other medical condition ..... $25 copay per office visit charge, then 100%, deductible waived
All other services in an office setting ..... 80%, deductible waived
Inpatient and Outpatient services ..... 80%, deductible waived
Emergency room services ..... 80%, after deductible

In-Network Specialist reimbursement rates
Office visit charges:
Standard Preventive Care ..... 100%, deductible waived
Any other medical condition ..... 80%, after deductible
All other services in an office setting ..... 80%, after deductible
Inpatient and Outpatient services ..... 80%, after deductible
Emergency room services ..... 80%, after deductible

Out-of-Network Physician reimbursement rates
Office visit charges:
Standard Preventive Care ..... 60%, after deductible
Any other medical condition ..... 60%, after deductible
All other services in an office setting ..... 60%, after deductible
Inpatient and Outpatient services ..... 60%, after deductible
Emergency room services ..... 80%, after deductible

MDLIVE - Telephone and Web-Based Video Consultations

Reimbursement rates
Medical services, per consultation ..... $10 copay, then 100%, deductible waived

In order to obtain this benefit, a Covered Person must complete their medical health history that will serve as an electronic medical record for consulting Physicians. This form can be completed via the MDLIVE website~~,~~ or via the call center. Once enrolled, a Covered Person may phone 1-888-995-1049 or access the MDLIVE website to request a consultation with a Physician. A Physician will then return the Covered Person's phone call. If a Covered Person requests a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a Prescription. The Prescription will be called in to a pharmacy of the Covered Person's choice.

STANDARD PREVENTIVE CARE
At all times, this Plan will comply with the Patient Protection and Affordable Care Act (the Affordable Care Act). A complete listing of Affordable Care Act preventative care services can be accessed at www.HealthCare.gov/center/regulations/prevention.html and www.cdc.gov/vaccines/.

In-Network reimbursement rate..... 100%, deductible waived
- Out-of-Network services are not covered.

OTHER COVERED BENEFIT LIMITATIONS AND MAXIMUMS

Ambulance Services

Ground ambulance benefit limit.....$1,000 per trip
In-Network reimbursement rate..... 80%, after deductible
Out-of-Network reimbursement rate ..... 80%, after deductible
- Out-of-Network ground ambulance services will apply to the In-Network out-of-pocket limit

Air ambulance benefit limit.....$5,000 per trip, not to exceed one trip per Plan Year
In-Network reimbursement rate..... 80%, after deductible
Out-of-Network reimbursement rate ..... 80%, after deductible
- Out-of-Network air ambulance services will apply to the In-Network out-of-pocket limit.

Diagnostic Imaging Services
In-Network reimbursement rate ..... 80%, after deductible
Out-of-Network reimbursement rate ..... 60%, after deductible

Dietitian Services for Treatment of Morbid Obesity, as defined by the Plan
Plan Year limit ..... 12 visits
- Dietitian services for treatment of obesity are not covered unless services are classified as standard preventive care.

Genetic Testing
Per test maximum.....$1,000

Home Health Care
Plan Year limit ..... 40 visits
In-Network reimbursement rate ..... 80%, after deductible
Out-of-Network reimbursement rate ..... 60%, after deductible
- The Plan Year maximum applies to Home Health Care visits only.

Hospice Care
In-Network reimbursement rate ..... 80%, after deductible
Out-of-Network reimbursement rate ..... 60%, after deductible

Morbid Obesity Treatment
In-Network and Out-of-Network reimbursement rate..... 50%, after deductible
Lifetime limit.....one surgery
Plan Year benefit maximum $4,000
- Requires prior written approval.

Oral Surgery
In-Network reimbursement rate ..... 80%, after deductible
Out-of-Network reimbursement rate ..... 60%, after deductible

Prenatal Care
The Expectant Mother is encouraged to enroll in the **Special Delivery Program** by the 14th week of Pregnancy. Special Delivery can be accessed by calling 1-800-225-1891 ext. 202258. This program is designed to encourage the Covered Person to actively participate in obtaining comprehensive prenatal care. Services that are not normally offered, such as skilled nursing assessments or nursing assistant care in the home for conditions including Pregnancy-induced hypertension, diabetes mellitus, and preterm labor, are covered through the Special Delivery program. The Special Delivery nurse can assist in coordinating Home Health Care in lieu of hospitalization for those high risk patients who the Physician feels would benefit from this alternative care.

Residential Treatment Facilities
Plan Year limit ..... 30 days
In-Network reimbursement rate ..... 80%, after deductible
Out-of-Network reimbursement rate ..... 60%, after deductible

Routine obstetrical ultrasound
Benefit limit, per pregnancy ..... one ultrasound

Skilled Nursing Facility
Plan Year day limit ..... 30 days
In-Network reimbursement rate ..... 80%, after deductible
Out-of-Network reimbursement rate ..... 60%, after deductible

Telehealth Benefits

Telemedicine services reimbursement rate
In-Network ..... $10 copay, per consultation, then 100%, deductible waived
Out-of-Network reimbursement rate ..... not covered

Telephone-based services
In-Network ..... $10 copay, per consultation, then 100%, deductible waived
Out-of-Network reimbursement rate ..... not covered

Therapy Services
Includes: speech therapy, cardiac, occupational and physical therapy and chiropractic care
Combined Plan Year limit ..... 45 visits
In-Network reimbursement rate ..... 80%, after deductible
Out-of-Network reimbursement rate ..... 60%, after deductible

Temporomandibular Joint (TMJ) Disorder Treatment
Lifetime Benefit limit ..... one surgical procedure

Urgent Care Clinics

For treatment sought due to a Medical Emergency, as defined by the Plan:
In-Network reimbursement rate, per visit charge ..... $25 copay, deductible waived
In-Network reimbursement rate, all other charges ..... 80%, after deductible
Out-of-Network reimbursement rate, per visit charge ..... $25 copay, deductible waived
Out-of-Network reimbursement rate, all other charges ..... 80%, after deductible
- The Out-of-Network Urgent Care services will apply to the In-Network Out-of-Pocket Limit.

For urgent care services which are not related to a Medical Emergency, as defined by the Plan:
In-Network reimbursement rate, per visit charge ..... $25 copay, deductible waived
In-Network reimbursement rate, all other charges ..... 80%, after deductible
Out-of-Network reimbursement rate ..... 60%, after deductible

Vision Services

Routine Vision Exams
In-Network reimbursement rate..... 100%, deductible waived
Out-of-Network reimbursement rate ..... 80%, after deductible
Benefit limit, routine vision exam .....one exam every 18 months

Diabetic Retinopathy Screening
In-Network reimbursement rate..... 100%, deductible waived
Out-of-Network reimbursement rate ..... 100%, after deductible
Benefit limit, diabetic retinopathy screening.....one screening per year

Medically Necessary Vision Services
In-Network reimbursement rate..... 80%, after deductible
Out-of-Network reimbursement rate ..... 60%, after deductible

- Vision exams ordered by a Physician during treatment of an Illness or Injury are not subject to a frequency limit.
- Coverage includes eyeglasses and contact lenses following cataract surgery, as well as any Medically Necessary surgical procedures which are not corrective in nature.

PRESCRIPTION DRUG BENEFITS

Prescription drugs are available through the prescription drug card program administered by the pharmacy benefits manager.

Each Prescription is covered only after the Member pays the applicable copayment or coinsurance to the participating Pharmacy or Mail Order Pharmacy; deductible is waived.

Retail and Mail Order Pharmacy member liability, per 31-day supply
Generic drugs (Tier 1).....$10 copay
Preferred Brand Name drugs (Tier 2).....$60copay
Non-Preferred Brand Name drugs (Tier 3) ..... $80 copay

Specialty Pharmacy member liability, per 30-day supply
Specialty drugs..... 20% coinsurance

- Prior approval required.
- The member is responsible for 20% of the actual cost of the medication, not to exceed $500.
- The member is responsible for 50% of the actual cost for medication for treatment of Hepatitis C.

Day-supply limit. Each initial fill of a Prescription drug purchased from a retail Pharmacy is limited to a 34-day supply. Subsequent refills of Maintenance Drugs may be purchased from a mail order Pharmacy for up to a 100-day supply.

Generic Incentive. If a Brand Name drug is filled when a Generic equivalent is available and the Brand Name drug is not indicated as Medically Necessary, the Covered Person pays the difference in cost of the Brand Name drug plus the higher Brand copay.

Specialty Medications. Coverage of Specialty Drugs is limited to a 30-day supply per fill. Specialty medications must be purchased through CVS Caremark Specialty Pharmacy. **This may not apply to limited distribution specialty medications.**

PROVIDER NETWORK PROVISIONS AND COST SHARING PROCEDURES

The Plan may afford significant savings to members who obtain coverage from In-Network Providers. This Section describes how Covered Persons can maximize their benefits under the Plan by using In-Network Providers.

NETWORK PROCEDURES

Standard Benefits. All benefits described in this document are subject to the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan, the Allowable Charge (as defined herein), and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary and that services, supplies and care are or are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

In-Network Services. This coverage is most effective and advantageous when the services of In-Network Providers are used. Claims associated with services provided by In-Network Providers may have a more advantageous deductible, coinsurance and copayment than claims for services of Out-of-Network Providers. The In-Network deductible, coinsurance and any applicable copayment cited in the Schedule of Benefits are applied to Allowable Charges for services and supplies received from an In-Network Provider, unless this document shows a different deductible, coinsurance or copayment for the particular service.

Out-of-Network Benefits. Reimbursement for services by Out-of-Network Providers generally will be less than payment for the same services when provided by an In Network Provider and could result in substantial additional out-of-pocket expenses. The Out-of-Network deductible, coinsurance, and any applicable copayment described in the Schedule of Benefits are applied to Allowable Charges for services and supplies received from an Out-of-Network Provider, except under the following circumstances:

(1) **Plan Provision.** If, this document specifies elsewhere that a different deductible, coinsurance or copayment is applicable to the particular service or supply that is the subject of the claim.

(2) **Emergency Services.** The Intervention is for a Medical Emergency, in which case the In-Network deductible, coinsurance and copayment apply.

(3) **Continuity of Care, Change in the Plan's Claims Administrator.** A Covered Person may notify the Claims Administrator that prior to the effective date of the Plan's coverage with BlueAdvantage Administrators of Arkansas as the Claims Administrator, the Covered Person was engaged with an Out-of-Network Provider for a scheduled procedure or ongoing treatment covered under this Plan, that such procedure or treatment is for a condition requiring immediate care, and that the Covered Person requests In-Network benefits for such scheduled procedure or ongoing treatment. If the Claims Administrator approves In-Network coverage for the scheduled procedure or ongoing treatment, any applicable In-Network deductible, coinsurance, and any Copayment will apply to claims for eligible services and supplies rendered by the Out-of-Network Provider for such condition until the procedure or treatment ends or until the end of 90 days, whichever occurs first.

(4) **Continuity of Care, Pregnancy, Prior to Coverage.** A Covered Person may notify the Claims Administrator that prior to the effective date of coverage, the Covered Person was receiving obstetrical care from an Out-of-Network Provider for a Pregnancy covered under the terms of this Plan, and request In-Network benefits for continuation of such obstetrical care from the Out-of-Network Provider. If the Claims Administrator approves In-Network coverage for the requested obstetrical care, any applicable In-Network deductible, coinsurance and copayment will apply to claims for services and supplies received from this Out-of-Network Provider and will continue to apply to claims for eligible services and supplies rendered by the Out-of-Network Provider until the completion of the Pregnancy, including two months of postnatal visits.

(5) **Provider Leaves Network.** A Covered Person may notify the Claims Administrator that their Out-of-Network Provider was formerly an In-Network Provider when ongoing treatment for an acute condition

began, and request In-Network benefits for the continuation of such ongoing treatment. If the Claims Administrator approves In-Network coverage for the ongoing treatment, any applicable In-Network deductible, coinsurance and copayment will apply to claims for eligible services and supplies rendered by the Out-of-Network Provider for such condition until the end of the current episode of treatment or until the end of 90 days, whichever occurs first.

(6) **Services Not Available or Accessible from In-Network Provider.** If a Covered Person notifies the Claims Administrator prior to receiving a Health Intervention and the Claims Administrator determines that the required covered services or supplies associated with such Health Intervention are not accessible or available from an In-Network Provider, the Claims Administrator may provide the Covered Person with written approval of In-Network coverage for such services or supplies, and any In-Network deductible, coinsurance and copayment will apply to the claims for the eligible services that are received from the Out-of-Network Provider. In the event that a member fails to notify the Claims Administrator prior to receiving a Health Intervention from an Out-of-Network Provider, the Claims Administrator will determine whether or not an exception will be made to allow In-Network benefits due to potential inaccessibility or unavailability of an In-Network provider.

PROVIDER DIRECTORY

The determination of whether a Physician or Hospital is an In-Network Provider is the responsibility of the Plan and Claims Administrator. The Claims Administrator can provide a list of In-Network Providers upon request. A Covered Person may also obtain a list of In-Network Providers on the web site www.blueadvantagearkansas.com. A Provider's status may change. A Covered Person can verify the Provider's status by calling Customer Service at the phone number on the back of their health plan identification card. If a Covered Person is informed incorrectly prior to receiving a Covered Service, either by accessing the directory or in response to a request for such information (via telephone, electronic, web-based or internet-based means), the Covered Person may be eligible for cost sharing that would be no greater than if the covered service had been provided by an In-Network Provider.

BlueCard PPO Program. The Plan includes access to the BlueCard PPO network. This benefit allows Covered Persons to receive In-Network benefits from Providers located outside of Arkansas, provided such Provider is in the BlueCard PPO network of the local Blue Cross or Blue Shield Company. A Covered Person may obtain a list of In-Network Providers in an out-of-Arkansas location or verify the status of an out of state Provider by calling Customer Service at the phone number on the back of their health plan identification card. A Covered Person may also obtain a list of In-Network Providers on the web site www.blueadvantagearkansas.com.

PROVIDER STATUS MAY CHANGE

It is possible that a Covered Person might not be able to obtain services from a particular In-Network Provider. The network of Providers is subject to change. A particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available, the Covered Person must choose another Provider to get In-Network benefits.

NO BALANCE BILLING FROM PREFERRED PROVIDERS AND CONTRACTING PROVIDERS

In-Network and Preferred Providers are Physicians or Hospitals who are paid directly by the Plan and have agreed to accept payment for covered services as payment in full except for the Covered Person's deductible, coinsurance, copayment, and any specific benefit limitation, if applicable. In contrast, a Covered Person is responsible for billed charges in excess of the Plan's payment when Out-of-Network Physicians or Hospitals render services, except as provided in OUT-OF-NETWORK PROVIDERS AND BALANCE BILLING, subsection (2), below. These excess charges could amount to thousands of dollars in additional out of pocket expenses to the Covered Person.

OUT-OF-NETWORK PROVIDERS AND BALANCE BILLING

(1) **NOTICE: Certain Services may not be eligible for In-Network Benefits.** Additional costs, including balance billing, may be incurred for a covered Health Intervention provided by an Out-of-Network Provider, even if treatment is rendered in an In-Network Hospital unless it meets the exception as provided in subsection 2 below. These additional charges may not count toward the In-Network Out-of-Pocket Limit. The Covered Person should not assume that an In-Network Provider's agreement includes all covered benefits or that all services provided at an In-Network Hospital are provided by In-Network Providers. Some Providers are contracted to provide only certain covered benefits, but not all covered benefits.

(2) **Balance billing by Out-of-Network Providers is prohibited in the following instances**:

(a) When Ancillary Services, as described in the No Surprises Act, are received at certain In-Network facilities on a non-emergency basis from Out-of-Network Providers.

(b) When Medical Emergency services are provided by an Out-of-Network Provider in an Emergency Room, a free-standing Emergency Department, or in an urgent care clinic which is licensed as a free-standing emergency department.

(c) When air Ambulance Services are provided by an Out-of-Network Provider.

(d) When a Provider leaves the network voluntarily, a Covered Person engaged with the Out-of-Network Provider for a scheduled procedure or ongoing treatment covered under this Plan, when such procedure or treatment is for a condition requiring immediate care, and the Covered Person's request is approved for Continuity of Care benefits until the end of the current episode of treatment or until the end of 90 days, whichever occurs first.

In these instances, when the services are eligible for coverage, the Out-of-Network Provider may not bill the Covered Person for amounts in excess of any In-Network copayment, coinsurance or deductible (cost share). Except for air ambulance, the cost share is based on the Recognized Amount as described in the No Surprises Act and as set forth in the Defined Terms section. The cost share for air ambulance is based on the rates that would apply if the service was provided by an In-Network Provider.

When Covered Services are received from Out-of-Network Providers as stated above, Allowed Amounts are based upon one of the following as applicable:

(a) The initial payment made by the Plan or the amount subsequently agreed to by the Out-of-Network Provider.

(b) The amount determined by Independent Dispute Resolution (IDR).

RELATION OF THE PLAN TO PROVIDERS.

The decision about whether to use a particular Provider is the sole responsibility of a Covered Person. A treating Provider is not an agent of the Plan or the Claims Administrator. The Plan and the Claims Administrator makes no representations or guarantees regarding the qualification or experience of any Provider with respect to any service. The evaluation of such factors and the decision about whether to use any Provider is the sole responsibility of the Covered Person.

CORONAVIRUS PANDEMIC, TEMPORARY BENEFITS

During the coronavirus (COVID-19) pandemic, the Plan will provide temporary benefits as specified below. These benefit enhancements apply solely and exclusively during the temporary period specified herein and will not be available at the conclusion of the public health emergency. All other terms, conditions, exclusions or limitations in the Plan Document continue to apply and must be satisfied in order for any benefits to be paid.

Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act

Effective March 18, 2020, in accordance with the FFCRA and CARES Act, the Plan shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during the federally-declared public health emergency period. Benefits are available for services rendered by an In-Network or Out-of-Network Provider.

(1) FDA-approved diagnostic testing products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 and the administration of such diagnostic tests.

(2) Items and services furnished to an individual during health care provider office visits (including in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a diagnostic test, or an evaluation to determine if a diagnostic test is necessary.

In the event that any new federal laws or regulations are enacted, the Plan will comply with the applicable law or regulation.

Qualifying coronavirus preventive services

For the duration of the Public Health Emergency relating to the COVID-19 pandemic, the Plan will provide coverage for any "qualifying coronavirus preventive service" without imposing any cost sharing (i.e., deductible, copayment or co-insurance) on such services. For this purpose, a "qualifying coronavirus preventive service" includes an item, service or immunization intended to prevent or mitigate COVID-19 and is an item or service with an A or B rating in the current recommendations of the United States Preventive Services Task Force or is an immunization recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Additional benefits

In addition to the services mandated by the FFCRA and CARES Act, the Plan will also provide the following additional benefits in an effort to help mitigate the spread of the coronavirus. Coverage will continue through the public health emergency.

(1) Waiver of prescription drug refill limitations that would apply for 30-day prescription maintenance medications for the treatment of COVID-19.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

PLAN ALLOWANCE

The Plan has defined an outer limit on Plan benefits that applies whether a Covered Person chooses to receive services from an In-Network Provider or an Out-of-Network Provider. This overall limit on the amount of Plan benefits available under the Plan is defined in this Plan Document description as the "Plan Allowance," and may also be referred to from time to time as the "Allowable Charge" or "Allowance" under the Plan. Benefits under the Plan will always be limited by the Plan Allowance that the Plan has adopted, as further defined in this section. This means that regardless of how much a health care Provider may bill for any service, drug, medical device, equipment or supplies, the benefits under the Plan will be limited to the Plan Allowance, as established in this section. The Plan Allowance may be established in the following ways:

(1) Covered In-Network Services

For covered In-Network services (those received from an In-Network Provider) received in Arkansas, the Plan Allowance is the Network Fee Schedule established by the terms of the Provider's contract with the Claims Administrator. For covered In-Network services received outside the state of Arkansas, the Claims Administrator may not have a direct contract with each Provider outside Arkansas; where that is the case, the Plan Allowance for covered In-Network services is determined by the allowance or fee schedule of the Provider's contract with the Blue Cross and Blue Shield plan in the state where services were provided (known as the "Host Plan").

(2) Covered Out-of-Network Services

For covered Out-of-Network services (those received from an Out-of-Network Provider), the Plan Allowance is the amount determined by the Claims Administrator, using the following standards:

(a) For services received in Arkansas, the Plan Allowance for covered Out-of-Network services of Physicians and other individual Providers, as well as Ambulatory Surgery Centers, Home Health Care Agencies, Hospice Agencies, and freestanding dialysis centers or imaging centers, will be the amount of the fee schedule that the Claims Administrator has contracted with Providers in Arkansas for its Preferred Payment Plan network ("PPP"). For Hospitals classified as acute care Hospitals, the Plan Allowance for covered Out-of-Network Inpatient and Outpatient Services will be the amount calculated using the Arkansas Blue Cross and Blue Shield Facility Pricing Guidelines. On some occasions, the Plan Allowance for Out-of-Network services inside Arkansas may be determined as referenced in (c), below.

(b) For services received outside of Arkansas, the Plan Allowance for covered Out-of-Network services will be either the amount provided to the Claims Administrator by the Host Plan in that state or, if no such amount is available to the Claims Administrator from a Host Plan, then the Plan Allowance will be the amount determined under the formulas for services received in Arkansas, as referenced in (a), above, or (c) or (d), below.

(c) The Claims Administrator has contracted with an independent network sponsor-facilitator and third party vendor (the "Wrap Network Vendor" or "WNV"), whereby, in many states/locations, the Plan has access to a suite of Out-of-Network potential savings strategies, which range from supplemental or "wrap networks" in numerous states, (in essence providing a discount option for otherwise Out-of-Network services in many areas of the nation), to certain reference pricing services and case-specific pricing negotiation services. The Plan participates in these WNV out-of-network pricing options, where available, and receives the benefit of any cost savings that the WNV may be able to provide in cases where a Plan participant or beneficiary goes outside the Plan's preferred BlueCard network for services. The WNV Out-of-Network pricing option is not available in all instances and thus neither the Claims Administrator nor WNV can or do guarantee any cost savings or availability of a WNV pricing or discount option in any given

state or area. However, to the extent that a WNV option is available in a given state/region/location with respect to any Out-of-Network provider services, the Claims Administrator may utilize and apply the WNV option and related pricing, in which case such pricing shall constitute the Plan Allowance for purposes of calculating and applying Plan benefits.

(d) For any services of any Provider that are not addressed in any of the existing Provider contracts or pricing guidelines referenced above, the Plan Allowance for covered Out-of-Network services will be the amount established by the Claims Administrator using such pricing methods, benchmarks or sources as the Claims Administrator may deem appropriate in the circumstances.

The Claims Administrator's calculation of a Plan Allowance shall be considered conclusive as to the amount that the Plan covers or will pay in Plan benefits for any covered service, treatment drug, supplies, equipment, or devices.

(3) Patient's Share of the Plan Allowance and Billed Charges of the Provider

The Plan calculates and pays Plan benefits on the basis of the Plan Allowance, an amount that may vary substantially from the amount a Provider chooses to bill. Once the Plan Allowance is determined with respect to any Provider's billed charges, the Covered Person may be responsible for a percentage or portion of the Plan Allowance, depending on the terms of the Plan with respect to copays, coinsurance and deductible. For example, if services are provided by an In-Network Provider, the Plan may pay 80% of the Plan Allowance, in which case the Covered Person would be responsible for the remaining 20% of the Plan Allowance, but not for the difference between the Plan Allowance and the Provider's billed charges. In this situation, the In-Network Provider contract protects the Covered Person from additional billing beyond the Plan Allowance. For an Out-of-Network Provider, the circumstances are substantially different. For example, if services are provided by an Out-of-Network Provider, the Plan may pay only 50% of the Plan Allowance, in which case the Covered Person would be responsible for the remaining 50% of the Plan Allowance. However, the Covered Person might also be held responsible by the Out-of-Network Provider for paying the difference between the Plan Allowance and the Provider's full, billed charges, leaving Plan participants or beneficiaries with "surprise" medical bills, in the form of so-called "balance billing" by Out-of-Network Providers.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the deductible shown in the Schedule of Benefits. The Plan Year Deductible is waived for some services as indicated in the Schedule of Benefits.

This amount will accrue toward the 100% maximum out-of-pocket payment.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Plan Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Plan Year.

COVERED CHARGES

All benefits described in this Schedule are subject to the Claims Administrator's established Coverage Policy, Allowable Charge, and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is Medically Necessary; that services, supplies and care are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care**. The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

If a Covered Person is hospitalized on the date of termination, the Plan will cover eligible Hospital facility charges only through the date of discharge from the Hospital. Any charges other than those billed by the Hospital, which are incurred in conjunction with an inpatient hospitalization, are not covered after the Covered Person's coverage is terminated.

(2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for an Employee or a Covered Spouse. There is no coverage for the pregnancy of a dependent daughter. However, any In-Network pre-natal, post-natal or maternity care that is required as Standard Preventive Care will be covered without cost sharing.

The Expectant Mother is encouraged to enroll in the Special Delivery Program by the 14th week of Pregnancy. Special Delivery can be accessed by calling 1-800-225-12891 ext. 20225. This program is designed to encourage the Covered Person to actively participate in obtaining comprehensive prenatal care. Services that are not normally offered, such as skilled nursing assessments or nursing assistant care in the home for conditions including Pregnancy-induced hypertension, diabetes mellitus, and preterm labor, are covered through the Special Delivery program. The Special Delivery nurse can assist in coordinating Home Health Care in lieu of hospitalization for those high risk patients who the Physician feels would benefit from this alternative care.

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

(3) **Skilled Nursing Facility Care**. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;

(b) the confinement starts within 24 hours of a Hospital confinement or a period of Home Health Care Utilization;

(c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient. If coverage is provided for two or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate.

(b) Payment for a covered assistant surgeon shall be limited to a single Physician, qualified to act as an assistant for the surgical procedure. Covered Charges for assistant surgery services or minimum assistant surgery services will be paid at a reduced rate which will never exceed 20% of the surgeon's Allowable Charge.

(5) **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required.

A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(6) **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Bereavement counseling services are covered for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

(7) **Mental Illness and Substance Abuse Services (Alcohol and Drug Abuse).** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Plan Document, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse.

Outpatient Health Interventions

(a) Coverage of Mental Illness and Substance Abuse Health Interventions during office visits and other forms of outpatient treatment, including partial or full-day program services is subject to the Deductible and Out-of-Pocket Limit set out in the Schedule of Benefits.

(b) Coverage is provided for a Health Intervention at a licensed psychiatric or substance use disorder treatment facility and accredited by the Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF International).

(c) Coverage for counseling or treatment of marriage, family or child relationship dysfunction is only covered if the dysfunction is due to a condition defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions

(a) Coverage for Inpatient Hospitalization, Partial Hospitalization Programs or Intensive Outpatient Programs for Mental Illness or Substance Abuse Health Interventions.

(i) Inpatient Hospitalization requires a patient to receive covered services 24 hours a day as an inpatient in a Hospital.

(ii) Partial Hospitalization Programs generally require the patient to receive covered services six to eight hours a day, five to seven days per week in a Hospital.

(iii) Intensive Outpatient Programs generally require the patient to receive covered services lasting two to four hours a day, three to five days per week in a Hospital.

(b) Coverage is subject to the Inpatient Hospital copayment and to the deductible and out-of-pocket limit set forth in the Schedule of Benefits.

(c) Inpatient Hospital admissions require Prior Approval.

(8) **MDLIVE telehealth services.** This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses. MDLIVE is available 24 hours a day, 7 days a week, and 365 days a year, even on holidays. A Covered Person may use MDLIVE anytime they have a non-emergency medical condition, are unable to see their primary care provider, or when they simply prefer a convenient, cost effective alternative to the emergency room, urgent care center, or clinic.

MDLIVE may be used:

(a) When immediate medical consultation is needed.

(b) When considering the ER or urgent care center for non-Emergency issues.

(c) When a Covered Person is on vacation or on a business trip.

MDLIVE can provide Physician consultation via electronic conferencing for the following types of conditions:

(a) General medicine, including, but not limited to:

- Sinusitis
- Colds and flu
- Sore throats
- Ear infections
- Allergies

(b) Dermatology, including, but not limited to:

- Poison ivy
- Rashes
- Hives
- Eczema
- Acne

(c) A refill of a recurring Prescription.

(d) Pediatric care.

(e) Non-Emergency medical assistance.

Please note that MDLIVE and the Physicians it makes available are not a service of BlueAdvantage Administrators of Arkansas or of the Plan; neither BlueAdvantage nor the Plan provide any medical services, advice, treatment or consultation in any form. All MDLIVE services are provided by MDLIVE, which is solely responsible for the service and for any advice or consultation of the Physicians working with MDLIVE

(9) **Other Medical Services and Supplies**. These services and supplies not otherwise included in the items above are covered as follows:

(a) **Acquired Immunodeficiency Syndrome (AIDS) treatment** is covered the same as any other Illness.

(b) **Ambulance Services.** Coverage is provided for Ambulance Services for local transportation to the nearest Hospital in the event Medical Emergency care is needed, for Medically Necessary transportation between health care facilities, or to the nearest neonatal special care unit for newborn infants for treatment of accidental Injuries, Illnesses, congenital birth defects or complication of premature birth that require the level of care provided at a neonatal special care unit.

Specific Ambulance Service Exclusions. No benefits will be paid for:

(i) expenses incurred for Ambulance Services covered by a local governmental or municipal body, unless otherwise required by law;

(ii) non-emergency ambulance, including services provided for a Covered Person's comfort or convenience;

(iii) non-emergency transport by any means other than ambulances; or,

(iv) charges billed by an Ambulance Service Provider which do not result in transport are not covered.

(c) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(d) **Audiology testing** is limited to medically necessary diagnostic services due to Injury or Illness.

(e) **Autism Spectrum Disorder.** Coverage is provided for the treatment of autism spectrum disorder, including applied behavioral analysis when ordered by a medical doctor or a psychologist and provided by a Board Certified Behavioral Analyst (BCBA).

(f) **Cardiac rehabilitation** as deemed Medically Necessary.

(g) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(h) Initial **contact lenses** or glasses required following cataract surgery.

(i) **Diabetes Management Services.** The Plan will pay for one Diabetes Self-Management Training Program per lifetime per Covered Person. Such training program must be in compliance with the national standards for diabetes self-management education programs developed by the American Diabetes Association. If there is significant change in the Covered Person's symptoms or conditions which under Coverage Policy make it necessary to change the Covered Person's diabetic management process, the Plan will pay for an additional Diabetes Self-Management Training Program. This benefit is payable for training in or out of the hospital that has been prescribed by a Physician.

(j) **Dietitian services** for Diabetes Self-Management Training and for treatment of Morbid Obesity are covered, subject to the limits shown in the Schedule of Benefits.

(k) Coverage for **Durable Medical Equipment (DME)** when prescribed by a Physician according to the guidelines specified below.

(i) Durable Medical Equipment is equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home.

(ii) Coverage for Durable Medical Equipment and Medical Supplies is provided when the Durable Medical Equipment is provided in accordance with Coverage Policy. Examples of Durable Medical Equipment include, but are not limited to, oxygen equipment, wheelchairs and crutches.

(iii) Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.

(iv) When it is more cost effective, the Plan, in its discretion will purchase rather than lease equipment. In making such purchase, the Plan may deduct previous rental payments from its purchase Allowance.

(l) **Genetic testing** is covered in accordance with established Coverage Policy.

(m) **Laboratory studies.**

(n) **Inhalation Therapy** to administer drugs or provide oxygen.

(o) **Morbid Obesity** treatment coverage, including gastric bypass surgery or any other procedure performed for the purpose of weight loss, is subject to prior written approval from the Claims Administrator, acting on behalf of the Plan Administrator. Benefits for approved treatment will be limited as described in the Schedule of Benefits. Surgical procedures are limited to one weight loss surgery per Lifetime and are only eligible for coverage if the individual has never experienced weight loss surgery before their coverage under this Plan became effective.

(p) **Oral Surgery, Dental Care and Orthodontic Services.** Oral Surgery, Dental Care and orthodontic services are generally not covered. However, coverage is provided for the following specific conditions.

(i) **Benefits for Oral surgery.** The Plan will pay only for the following non-dental oral surgical procedures:

a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required.

b. Surgical procedures required to treat an Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Treatment of an injury to a tooth or teeth incurred while eating is not covered.

c. Excision of exostoses of jaws and hard palate.

d. External incision and drainage of abscess.

e. Incision of accessory sinuses, salivary glands or ducts.

f. Removal of impacted teeth is covered.

(ii) **Benefits for Injury.** If a Covered Person has an Injury, benefits will be provided for Dental Care and x-rays necessary to correct damage to a Non-Diseased Tooth or surrounding tissue caused by the Accidental Injury. The Covered Person must seek treatment within seven days of the Accidental Injury for services to be covered.

a. Only the non-diseased tooth or teeth avulsed or extracted as a direct result of the Injury and the non-diseased tooth or teeth immediately adjacent will be considered for replacement.

b. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.

c. This benefit is limited to the first 12 months immediately following the Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such 12-month period will be provided if:

- such reimbursement is requested within such 12-month period,
- the request for reimbursement is accompanied by a plan of treatment
- under standard dental practices the treatment could not have been provided within such 12-month period, and
- coverage for the injured Covered Person is in force when the treatment is rendered.

d. Injury to teeth while eating is not considered an Accidental Injury.

e. Any Health Intervention related to dental caries or tooth decay is not covered.

(iii) **Benefits for dental services required in connection with Covered Services.**

a. Dental services in connection with radiation treatment for any malignancy of the head or neck are covered.

b. Dental services perioperative to organ transplant when dental infection precludes listing for a transplant are covered.

c. Dental services perioperative to valve replacement or surgery when dental infection precludes surgery are covered.

d. Dental services perioperative for hematopoietic stem cell transplant when dental infection precludes listing for a transplant are covered; and

(iv) **Benefits for anesthesia services.** Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures, including services to children, are covered in connection with treatment for a complex dental condition provided to: (i) a Participant under seven years of age who is determined by two dentists (in separate practices) to require the dental treatment without delay; (ii) a Participant with a diagnosis of serious mental or physical condition; or (iii) a Participant, certified by his or her primary care physician to have a significant behavioral problem.

(v) Benefits for dental reconstructive surgery.

a. Dental implants of titanium osseointegrated fixtures, or of any other material, are not covered regardless of the diagnosis, medical condition, accident or injury.

b. Subject to Prior Approval, coverage is provided for surgery and orthodontics performed on a child for the correction of a cleft palate when prescribed or ordered by a Physician and consistent with established Coverage Policy.

(q) Organ transplant limits. Coverage is provided for human-to-human organ or tissue transplants in accordance with the following specific conditions:

(i) Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Covered Person must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this Plan Document.

(ii) Except for kidney and cornea transplants, coverage for transplant services requires Prior Approval from the Claims Administrator. A request for approval must be submitted to the Claims Administrator prior to receiving any transplant services, including transplant evaluation.

(iii) The transplant benefit is subject to the deductible, coinsurance and any applicable copays specified in the Schedule of Benefits.

(iv) Notwithstanding any other provisions, the Allowable Charge for an organ transplant, including any charge for the procurement of the organ, Hospital services, Physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) 90% of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers for Transplant participating facility, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network, but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network and does not contract with the local Blue Cross and/or Blue Shield plan, the Allowable Charge for the transplant services provided in the Transplant Global Period is 80% of the average usual and reasonable charge authorized by participating facilities in the Blue Distinction Centers for Transplant network located in the geographic region where the transplant is performed.

(v) Please note that payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; payment will not be made for any amounts in excess of the global payment for services the facility or any Physician or other Health Care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If a Covered Person uses a facility participating in the Blue Distinction Centers for Transplant network, that facility has agreed to accept the global payment as payment in full, and should not bill for any excess amount above the global payment, except for applicable deductible, coinsurance or non-covered services; however, a non-participating facility may bill the Covered Person for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out-of-pocket expenses.

(vi) Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for evaluating the organ or tissue, removing the organ or tissue from the donor, and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

(vii) When the Covered Person is the potential transplant recipient, a living donor's Hospital costs for the removal of the organ are covered with the following limitations:

- Allowable Charges are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less; and

- Donor testing is covered only if the tested donor is found compatible

(r) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Repair and replacement due to loss or misuse is not covered.

(s) **Prescription** Drugs (as defined) are covered under the prescription drug card program administered by the pharmacy benefits manager. Please see the Prescription Drug Card Program Section for more information. Coverage under Medical Benefits is available for injectable medications while confined as an inpatient, or when provided and administered by a Physician in a clinic setting.

(t) **Renal dialysis.**

(u) **Standard Preventive Care** shall be provided as required by applicable law. Standard Preventive Care includes services with an "A" or "B" rating from the United States Preventive Services Task Force.

Examples of Standard Preventive Care for adults include:

(i) Screenings for: breast cancer (including 3-D mammograms), cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.

(ii) Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(iii) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

-Women's contraceptives, sterilization procedures, and counseling.
-Breastfeeding support, supplies, and counseling.
-Gestational diabetes screening.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.html and www.cdc.gov/vaccines/.

Examples of Standard Preventive Care for children include:

(i) Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:

-Diphtheria,
-Pertussis,
-Tetanus,
-Polio,
-Measles,
-Mumps,
-Rubella,
-Hemophilus influenza b (Hib),
-Hepatitis B,
-Varicella.

(ii) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

(v) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts. Repair or replacement due to loss or misuse is not covered.

(w) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

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

(x) **Sleep apnea and sleep studies** are covered in accordance with established Coverage Policy.

(y) **Spinal Manipulation/Chiropractic services** by a Provider acting within the scope of his or her own license. Coverage is limited as shown in Schedule of Benefits when performed by a licensed D.C.

(z) **Sterilization** procedures.

(aa) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(bb) **Telehealth benefits.** Coverage is provided for Telemedicine services performed by a person licensed, certified, or otherwise authorized to administer health care in the ordinary course of the practice of his or her profession at the same rate as if it had been performed in-person provided the Telemedicine service is comparable to the same service provided in person.

Coverage also includes communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers.

Audio-only communication is covered if it is real-time, interactive, and substantially meets the requirements for a covered service that would otherwise be covered by the Plan.

However, electronic consultations such as, but not limited to fax; email; or for services, which are, by their nature, hands-on (e.g., surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered.

(cc) Medically Necessary services for care and treatment of **Temporomandibular Joint (TMJ)** Syndrome are covered. Surgical services are limited as shown in the Schedule of Benefits.

(dd) **Therapy Services.** Coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical and occupational therapy. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board. Coverage is limited is described in the Schedule of Benefits.

(ee) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowable Charges for nursery care for the first five days after birth while the newborn child is Hospital confined as a result of the child's birth or until the mother is discharged, whichever is less.

Charges for covered routine nursery care will be applied toward the Plan of the mother. If the mother is not covered under this Plan, charges will be applied toward the Plan of the newborn child.

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

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for routine pediatric care for the first five days after birth while the newborn child is Hospital confined, or until the mother is discharged, whichever is less.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(ff) Diagnostic **x-rays.**

COST MANAGEMENT SERVICES

UTILIZATION REVIEW SERVICES PROGRAM

Utilization review is a program for Covered Persons which promotes access to necessary and appropriate health care.

The program consists of:

(1) Prior Approval of the Medical Necessity for the following services before Medical and/or Surgical services are provided:

Inpatient Admissions

(2) Retrospective review of the Medical Necessity for hospitalizations provided on the basis of an Emergency Illness or Emergency Injury.

(3) Concurrent review, based on the admitting diagnosis, for hospitalizations requested by the attending Physician.

(4) Planning for discharge from a Hospital or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not Prior Approved, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain Prior Approval from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

To maximize Plan reimbursements, please read the following provisions carefully.

> **PLEASE NOTE: Failure to receive Prior Approval may result in a denial or reduction of benefits payable by the Plan. The Covered Person will be responsible for reimbursing the Provider for any penalty amounts. Any costs incurred because of reduced reimbursement due to failure to follow Prior Approval procedures will not accrue toward the Covered Person's Out-of-Pocket Limit.**

Here's how the program works:

The responsible party must call the appropriate telephone number on the Covered Person's health plan identification card.

Through the Prior Approval process, the number of days of medical care facility confinement which are Medically Necessary will be determined.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a medical care facility are parts of the utilization review program. The Covered Person's medical care facility stay or use of other medical services will be monitored and either the scheduled release or an extension of the medical care facility stay or extension or cessation of the use of other medical services will be coordinated with the attending Physician, medical care facility and Covered Person.

Responsibility for Obtaining Prior Approval
The following table identifies services which are subject to Prior Approval. If the service or procedure is provided by an In-Network Provider, in some cases the Provider may be held financially responsible for failure to obtain Prior Approval. However, it is always in the Covered Person's best interest to verify that the treating Provider did obtain Prior Approval in order to avoid any potential penalties that could result in additional out-of-pocket expenses. If the service or procedure is provided by an Out-of-Network Provider, any penalty for failure to receive Prior Approval will be the Covered Person's responsibility.

SERVICES REQUIRING PRIOR APPROVAL
Inpatient admissions, including concurrent care extensions, at a Hospital and similar facilities, such as: Acute Care Facility — Skilled Nursing Facility Inpatient Rehabilitation (Physical) **NOTE:** For inpatient admissions related to treatment of a Medical Emergency, the Covered Person or the treating Provider should notify the Plan of the admission within 48 hours of the admission.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

PREADMISSION TESTING SERVICE

Benefits for diagnostic lab tests and x-ray exams will be payable at standard Plan reimbursement levels when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

CASE MANAGEMENT

Case Management is a program under which nurses communicate with Plan Participants' Physicians to facilitate access to benefits under the Plan Participants' Medical Benefits Plan, to identify benefit options for outpatient or home treatment settings, and, where appropriate in the Physician's independent professional judgment, to identify and offer Plan Participants a choice of cost-effective alternatives to hospitalization. Case management nurses are licensed professionals who use their specialized skills to communicate effectively with Physicians; they do not, however, provide any medical services to Plan Participants. All treatment decisions remain exclusively with the Plan Participant and his or her Physicians.

Case management services can provide the following value-added benefits for Plan Participants and the Plan:

(1) maximize the benefits available under the Medical Benefits Plan;

(2) at the same time, identify cost-effective alternatives to high-cost treatment settings such as hospitalization;

(3) educate Plan Participants and their Physicians on cost-effective alternatives from which they may choose;

(4) provide health education to Plan Participants to empower them and their families to self-manage aspects of their care as deemed appropriate by their Physician; and,

(5) help Plan Participants better understand and deal with the complexities of the health care system and their Medical Benefits Plan

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Allowable Charge when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Claims Administrator, in its sole discretion, to be reasonable. The customary allowance is the basic Allowable Charge. However, Allowable Charge may vary, given the facts of the case and the opinion of the Claims Administrator.

Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan. Please note that all benefits under this Plan are subject to and shall be paid only by reference to the Allowable Charge as determined at the discretion of the Plan. This means that regardless of how much a health care Provider may bill for a given service, the benefits under this Plan will be limited by the established Allowable Charge. If services are rendered by a participating Provider, that Provider is obligated to accept the established rate as payment in full, and should only bill the member for the Deductible, Coinsurance and any non-covered services; however, if services are rendered by a non-participating Provider, the member will be responsible for all amounts billed in excess of the Allowable Charge.

Ambulance Service means surface or air transportation in a regularly equipped ambulance licensed by an appropriate agency and where the use of any other means of transportation is not medically indicated.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Ancillary Services means services provided by Out-of-Network Providers at an In-Network facility such as: related to emergency medicine – anesthesiology, pathology, radiology and neonatology; provided by assistant surgeons, hospitalists and intensivists; diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary (as that term is applied in the No Surprises Act); provided by such other specialty practitioners as determined by the Secretary; and provided by an Out-of-Network Physician when no other In-Network Physician is available.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Break in Service means a period of at least 13 consecutive weeks during which the Employee has no Hours of Service. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves.

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

Coverage Policy - With respect to certain drugs, treatments, services, tests, equipment or supplies, the Claims Administrator has developed specific Coverage Policies, which have been put into writing, and are available upon request from the Claims Administrator. If the Claims Administrator has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that a Covered Person received or seeks to have covered under the Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the coverage criteria; however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the coverage criteria.

Covered Person is an Employee or Dependent who is covered under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Pace Industries, Inc., its subsidiaries and affiliates.

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

Experimental or Investigational. The Plan shall have full discretion to determine whether a drug, device or medical treatment is experimental or investigational. Any drug, device or medical treatment may be deemed experimental or investigational, in the Plan's discretion, if:

(1) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished; or

(2) the drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval;

(3) Reliable Evidence (as defined below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;

(4) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

(5) Reliable Evidence (as defined below) shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure neither supports nor denies its use for a particular condition or disease.

(6) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that it

should not be used as a first line therapy for a particular condition or disease.

"Reliable Evidence" shall mean only the following sources:

(a) the patient's medical records or other information from the treating Physician(s) or from a consultant(s) regarding the patient's medical history, treatment or condition;

(b) the written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;

(c) any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;

(d) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the Injury, Illness or condition at issue; or

(e) the written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Health Intervention or Intervention means an item or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital means an acute general care Hospital, a psychiatric Hospital and a rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law: Hospitals owned or operated by state or federal agencies, convalescent homes or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries, or any institution operated mainly for treatment of long-term chronic diseases.
Hours of Service means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. For a Covered Employee or their Covered Spouse, Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Independent Dispute Resolution is the process that Out-of-Network or non-participating Providers may use following the end of an unsuccessful open negotiation period to determine the Out-of-Network rate for certain services. More specifically, the Federal IDR process may be used to determine the Out-of-Network rate for certain emergency services, non-emergency items and services furnished by non-participating Providers at participating health care facilities, and air ambulance services furnished by non-participating Providers of air Ambulance Services where an All-Payer Model Agreement or specified state law does not apply. Additionally, a party may not initiate the Federal IDR process if, with respect to an item or service, the party knows or reasonably should have known that the Provider or facility provided notice and obtained consent from a participant, beneficiary, or enrollee to waive surprise billing protections consistent with PHS Act sections 2799B-1(a) and 2799B-2(a) and the implementing regulations at 45 CFR 149.410(b) and 149.420(c)-(i).

Initial Measurement Period means the period beginning on either the first day of the Calendar Month coinciding with or next following the Employee's Date of Hire, as determined by the Employer in accordance with applicable law. Notwithstanding the foregoing, the Employer may make adjustments to the Initial Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein

Injury means an accidental physical Injury to the body caused by unexpected external means.

In-Network Provider means a health care Provider who has entered into a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan").

In-Network Transplant Center means a health care facility that provides organ and/or tissue transplants and which has entered into a network participation contract with either the Claims Administrator, or outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan"), or with the national Blue Cross and Blue Shield Association.

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Maintenance Drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that a condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Medically Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient. All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Illness means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Morbid Obesity is a diagnosed condition in which the patient has a body mass index (BMI) of 40 or greater, or a BMI of 36-39 with the presence of other high-risk co-morbid conditions.

New Employee Stability Period means the period that begins on the first day of the Calendar Month beginning on or after the Employee's anniversary date, as determined by the Employer in accordance with applicable law.

Ongoing Employee Stability Period means the period that begins on the first day of the month following the end of each Standard Measurement Period, as determined by the Employer in accordance with applicable law.

Out-of-Network Provider means a health care Provider who does not have a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan"). Out-of-Network Providers are free to bill and collect from members any charges for Covered Charges which are in excess of the Plan's Allowance or Allowable Charge except when prohibited by law.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed health intervention at the time and place such intervention is rendered.

Plan means Pace Industries, Inc. Health Benefit Plan, which is a benefits plan for certain employees of Pace Industries, Inc. and is described in this document.

Plan Allowance means the maximum amount the Plan will cover or pay for any health care services, drugs, medical devices, equipment, supplies or benefits covered by the Plan. This overall limit on the amount of Plan benefits available under the Plan may also be referred to as the "Allowable Charge or "Allowance" under the Plan

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year means July 1st through June 30th of the following year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prior Approval means a health plan coverage management feature which requires that an approval be obtained from the Claims Administrator or from a subcontractor engaged by the Claims Administrator, acting on behalf of the Plan, before incurring expenses for certain Covered Charges. The Plan's procedures and timeframes for making decisions on Prior Approval requests may differ depending on when the request is received, and the type of service involved. Ongoing therapy of a prior authorized medication may require periodic assessments that could include an efficacy measure intended to demonstrate positive outcomes for continuation of therapy.

Please note that Prior Approval does NOT guarantee coverage for, or the payment of, the service or procedure reviewed. The sole effect and meaning of receiving Prior Approval is simply that, if Prior Approval is given, coverage for the specific service will not be denied for lack of Medical Necessity, including length of stay in a facility. All other Plan coverage criteria, including but not limited to, eligibility, contribution payment, if any, Coverage Policies, exclusions, and limitations shall continue to apply, and must be satisfied in order to receive Plan coverage for the Prior Approved services. In other words, if a Covered Person or their treating Provider receives Prior Approval, that Prior Approval takes care of the Medical Necessity issue for the particular admission or service that is Prior Approved, but there may be other Plan coverage standards that still must be reviewed, and if any of those standards are not also met, coverage for the Prior Approved service still could be denied upon further review of the Plan benefits claim. Prior Approval does not in any way control or attempt to control whether or not a Covered Person receives any particular medical service, drug, supply, equipment, device, or treatment – the decision on whether to undergo any particular course of treatment is entirely up to the Covered Person and their treating health care Providers. The only effect of a denial of Prior Approval is that a Covered Person may not receive Plan benefits for the service, drug, supply, equipment, device, or treatment in question. Accordingly, if the Covered Person and their treating health care Provider believe that a particular service, drug, supply, equipment, device, or treatment is essential or in the Covered Person's best interests, even though Prior Approval has been denied, the Covered Person should make their own decision regarding such matters, without regard to the Prior Approval decision. In other words, Prior Approval will only affect the Plan's coverage of medical care or treatment; it does not prevent a Covered Person and their doctors or other health care Providers from doing whatever they believe necessary in the best interests of the Covered Person's health and safety**.**

Provider means a Hospital or a Physician. Provider also means a certified registered nurse anesthetist; advanced practice registered nurse; a licensed audiologist; a chiropractor; a dentist; a licensed certified social worker; a licensed Durable Medical Equipment Provider; an optometrist; a pharmacist; a physical therapist; a podiatrist; a psychologist; a respiratory therapist; a speech pathologist and any other type of health care Provider which the Plan Administrator, in its sole discretion, approves for reimbursement for services rendered.

Recognized Amount is the amount which a Covered Person's cost sharing is based on for the following Covered Services when provided by Out-of-Network Providers: Out-of-Network Emergency Care; non-Emergency Care received at certain In-Network facilities by Out-of-Network Providers, when such services are Ancillary Services. For the purpose of this provision, "certain In-Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary. The Recognized Amount is based on the qualifying payment amount as determined under applicable law.

Note: Covered Services that use the Recognized Amount to determine a Covered Person's cost sharing may be higher or lower than if cost sharing for these Covered Services were determined based upon an Allowed Amount.

Sickness is

For a Covered Employee or a Covered Spouse: Illness, disease or Pregnancy (including complications).

For a Dependent child: Illness or disease.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

Special Unpaid Leave of Absence means any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the Employer).

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Standard Measurement Period means the period that begins each year on the date(s) established by the Employer in accordance with applicable law. Notwithstanding the foregoing, the Employer may make adjustments to the Standard Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein

Substance Abuse means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

Telemedicine means the use of information and communication technology to deliver healthcare services, including without limitation to the assessment, diagnosis, consultation, treatment, education, care management, and self-management. Telemedicine includes store-and-forward technology and remote patient monitoring but does not include audio-only communication, unless it is real-time, interactive and substantially meets the requirements for a covered service that would otherwise be covered by the Plan, including without limitation interactive audio, a facsimile machine, text messaging, or electronic mail systems.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Transplant Global Period means a period of time that begins on or prior to the day of the transplant procedure and extends for a number of days after the transplant procedure. The length of the Transplant Global Period varies, depending upon the type of transplant involved.

Urgent Care Services means care and treatment for an Illness, Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.
For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion**. Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest. This plan exclusion does not apply to Medical Emergency services for a Medically Necessary Pregnancy termination rendered in an emergency room, a free-standing emergency department, or in an urgent care clinic which is licensed as a free-standing emergency department.

(2) **Acupuncture** for analgesic purposes or treatment of an Illness or Injury.

(3) **Administrative Fees.** Fees incurred for acquiring or copying medical records, sales tax, preparation of records for other insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage are not covered.

(4) Charges for inpatient services where the covered individual terminates such inpatient admission **against medical advice.**

(5) **Appointments.** Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider are not covered.

(6) **Bereavement services.** Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care, are not covered.

(7) **Biofeedback.** Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.

(8) **Clinical Trials.** Services or supplies provided in connection with a phase I, II, III or IV clinical trial or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. This exclusion will not apply to routine items and services that (a) would have been Covered Expenses had they not be incurred during an approved clinical trial, and (b) are provided during an approved clinical trial, as required and defined under PHSA Section 2709.

(9) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

(10) **Cosmetic services.** Care and treatment provided for cosmetic reasons. This exclusion will not apply if the care and treatment is for repair of damage from an accident or is for correction of abnormal congenital condition. Reconstructive mammoplasty will be covered after Medically Necessary surgery.

(11) **Cranial mandibular disharmony.** Charges related to the treatment of cranial mandibular disharmony.

(12) **Custodial care.** Services or supplies for custodial, convalescent, domiciliary or support care and non-medical services to assist a Covered Person with activities of daily living are not covered.

(13) **Custodial Care Facility.** Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged are not covered. Youth homes schools, or therapeutic wilderness, ranch or camp programs, or any similar institution are not covered.

(14) **Delivery Charges.** Charges for shipping, packaging, handling or delivering Medications are not separately covered.

(15) **Dental expenses.** Charges for **Dental expenses** unless specifically listed in the Medical Benefits Section under treatment of oral surgery, dental care and orthodontic services**.**

(16) **Dependent daughter Pregnancy.** Charges related to the Pregnancy of a dependent daughter. This exclusion does not apply to covered In-Network services that are classified as Standard Preventive Care, as defined by the Plan.

(17) **Educational or vocational testing.** Services for educational or vocational testing or training.

(18) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.

(19) **Exercise programs.** Exercise programs for treatment of any condition, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, or work hardening. This exclusion does not apply to Physician-supervised cardiac rehabilitation or occupational or physical therapy.

(20) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(21) **Eye care.** Radial keratotomy or other eye surgery to correct near-sightedness. Also, including refractions, lenses for the eyes and exams for their fitting. A procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.

(22) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, foot orthoses, metatarsalgia, bunions or other such routine foot care, are not covered unless services are medical related open cutting operations, or treatment is in relation to a metabolic or peripheral vascular disease.

(23) **Foreign travel.** Care, treatment or supplies out of the United States if travel is for the sole purpose of obtaining medical services. Services received outside of the United States must be Medically Necessary to be considered eligible for coverage.

(24) **Habilitative Services.** Services provided in order for a person to attain and maintain a skill or function that was never learned or acquired are not covered.

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

(26) **Hearing aids and routine hearing exams.** Charges for services or supplies in connection with hearing aids or routine hearing exams for their fitting unless needed as the result of an accidental Injury.

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

(28) **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition.

(29) **Infertility treatment.** Services, supplies, treatment and any medical procedure performed to achieve Pregnancy are not covered.

(30) **Learning Disabilities.** Services or supplies provided for learning disabilities, i.e., reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties, are not covered.

(31) **Nicotine replacement products.** Charges for nicotine replacement products, including lozenges, nasal sprays, inhalers, nicotine gum and transdermal nicotine patches purchased over the counter or with a prescription, are not covered under Medical Benefits. Coverage of nicotine replacement products is available under Prescription Drug Benefits as described in the Prescription Drug Benefits Section.

(32) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(33) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(34) **Not specified as covered.** Care, treatments and supplies which are not specifically outlined as a covered expense of this Plan and not meeting the established Medically Necessary guidelines and criteria of the Claims Administrator.

(35) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered.

(36) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(37) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(38) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(39) **Prescription Medications used in connection with Health Interventions Not Covered by Plan.** Prescription Medications used or intended to be used in connection with or arising from a treatment, service, condition, Sickness, disease, Injury, or bodily malfunction that is not covered under this Plan, or for which this Plan’s benefits have been exhausted, are not covered.

(40) **Private duty nursing.** Private duty nursing is not covered, unless services are rendered as part of a pre-approved Home Health treatment plan.

(41) **Provider not defined.** Services or supplies provided by an individual or entity that is not a Provider as defined in this Plan Document are not covered.

(42) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(43) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(44) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventative medical care, or treatment or services not directly relate to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonable suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(45) **Seasonal Affective Disorder (SAD).** Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.

(46) **Seasonal Employees.** Seasonal employees are not eligible for coverage under this Plan, regardless of whether they meet other eligibility requirements for Full-Time Active employees, such as number of hours worked per week.

(47) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury, while sane or insane. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental) condition.

(48) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan. However, if a Covered Person is hospitalized on the date of termination, dependent on the type of contractual agreement with the Hospital, the Plan may cover eligible Hospital facility charges through the date of discharge from the Hospital. Any charges other than those billed by the Hospital, which are incurred in conjunction with an inpatient hospitalization, are not covered after the individual's coverage is terminated

(49) **Sex changes/sex therapy.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medications and sex therapy.

(50) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(51) **Telephone and Other Electronic Consultation.** Electronic consultations such as, but not limited to fax; email; or for services, which are, by their nature, hands-on (e.g., surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered. Audio-only communication is not covered unless it is real-time, interactive, and substantially meets the requirements for a Covered Service that would otherwise be covered by the Plan.

(52) **Unlicensed Provider. Coverage is not provid**ed for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not include within its scope the treatment, procedure or service provided.

(53) **War.** Any loss that is due to a declared or undeclared act of war.

(54) **Weight Control.** Medications prescribed, dispensed or used for the treatment of obesity, or for use in any program of weight control, weight reduction, weight loss or dietary control are not covered.

(55) **Wigs** or **hairpieces.**

PRESCRIPTION DRUG BENEFITS
MANAGED PHARMACY PROGRAM

The Plan accesses services with the pharmacy benefits manager to provide participants with prescription medication coverage. To use this benefit, participants must present their identification card to a participating Pharmacy. Participants can obtain Prescription Drugs subject to the terms, conditions and limitations outlined in this Plan Document

Cost-Sharing. Each prescription is covered only after the Covered Person pays the appropriate copayment or coinsurance to the participating pharmacy as shown in the Schedule of Benefits.

Day-supply limit. Each initial fill of a Prescription drug purchased from a retail Pharmacy is limited to a 34-day supply. Subsequent refills of Maintenance Drugs may be purchased from a retail Pharmacy or from a mail order Pharmacy for up to a 100-day supply.

Generic Incentive. If a Brand Name drug is filled when a Generic equivalent is available and the Brand Name drug is not indicated as Medically Necessary, the Covered Person pays the difference in cost of the Brand Name drug plus the higher Brand copay.

Specialty Drugs. Coverage of Specialty Drugs is limited to a 30-day supply per fill. Specialty Drugs must be purchased through CVS Caremark Specialty Pharmacy. This may not apply to limited distribution specialty medications. **This may not apply to limited distribution specialty medications.**

COVERED PRESCRIPTION DRUGS

(1) All drugs, prescribed by a Physician that require a prescription either by Federal or state law (except insulin), unless listed as an exclusion below.

(2) Insulin when prescribed by a Physician. Insulin syringes and other diabetic supplies are also covered under the Managed Pharmacy Program. Insulin pumps and pump supplies are not covered under the Pharmacy plan, but are covered under Medical Benefits.

(3) Injectable drugs are covered, but require Prior Approval.

(4) Coverage of any prescription medication is subject to the Formulary. Note: the Formulary is subject to change throughout the year as new medications, dosages or strengths are added to the market.

BENEFIT LIMITS

(1) **Contraceptive** coverage is limited to a list of product specific rings, patches, diaphragms and prescribed generic oral contraceptives, at no cost. At all times, this Plan will comply with the Affordable Care Act. A complete listing of Affordable Care Act women preventative services can be accessed at www.HealthCare.gov/center/regulations/prevention.html.

(2) **Smoking cessation products** available over the counter and medications prescribed for the treatment of nicotine addiction are subject to the following criteria.

(i) Coverage is limited to a 168-day supply per Calendar Year of each of the following products: generic nicotine replacement products (nicotine patch, gum and lozenges), brand Nicotrol (inhaler system), brand Nicotrol NS (nasal spray), brand Chantix and generic Zyban.

(ii) Prescription Drugs and over-the-counter products require a prescription.

(iii) Brand Name drugs are only covered until Generic versions of the same become available.

(3) **Immunizations** from a retail Pharmacy are limited to list of specific immunizations identified in the Formulary, available at zero-cost to the member.

(4) **Hepatitis C treatment.** Coverage of drugs prescribed for the treatment of Hepatitis C are payable at 50%.

(5) **Quantity-Versus-Time Edits.** Some medications have quantity limitations that are more restrictive than the Plan's standard 31-day supply limit. These are medications that are appropriate for dispensing through an outpatient Pharmacy, but because of their high cost and potential for misuse, should be monitored closely.

Often, Physicians will write open-ended or "as needed" prescriptions for non-addictive pain treatments (such as the migraine-relief medications on this list). This allows the member to decide how much of the prescription to have filled within their 31-day supply benefit period.

By regulating the quantity that can be obtained each time the prescription is filled and within each 31-day supply benefit period, the Plan can monitor those cases where the member is getting a quantity that is greater than the manufacturer recommends. This is beneficial information for the prescribing Physician and protects the Plan's financial risk.

(6) **Prior Approval.** Medications that are expensive, have a high risk for misuse, or whose effectiveness is limited to very specific indications are placed on the Prior Approval list. Also on the list are medications which cause adverse or harmful reactions or have been ineffective in the treatment of a particular disease or condition.

To obtain coverage for a medication that requires Prior Approval, the prescribing Physician should provide a letter of medical necessity or contact the customer service department at the number printed on the Plan Participant's identification card. Once a determination is made, a letter will be sent to the Plan Participant announcing the decision.

(7) **Step Therapy.** Some Prescription Medications are subject to Step Therapy restrictions. Such Step Therapy must be completed before coverage for the selected Prescription Medication is provided. For example, a Step Therapy may require that medication "X" be used for a period of time before medication "Y" or that a weaker strength of a medication be used for a period before a stronger strength of the same medication. The Step Therapy requirements for a particular Prescription Medication are available from the Plan upon request.

(8) **Specialty Medications.** Selected Prescription Medications are designated as "Specialty Medications" due to their route of administration, approved indication, unique nature, or inordinate cost. These medications usually require defined handling and home storage demands, crucial patient education, and careful monitoring. Coverage for specialty medications is subject to Prior Approval and may only be purchased through a specialty pharmacy vendor under contract with the pharmacy benefits manager. The benefit for a Specialty Medication is payable as specified in the Schedule of Benefits. A list of specialty medications is available upon request or, on the web at https://www.healthcare.gov/sbc-glossary

Some specialty medications may qualify for third party copayment assistance programs which could lower the Covered Person's Out-of-Pocket costs for those products. For any such specialty medication where third party copayment assistance is used, the Covered Person shall not receive credit toward their out-of-pocket limit or deductible for any copayment amounts or coinsurance amounts that are applied from a manufacturer coupon or rebate. This may not apply to limited distribution specialty medications.

EXPENSES NOT COVERED BY THE MANAGED PHARMACY PROGRAM

The following medications and supplies are not covered:

(1) **Abuse of Medications.** Medications, drugs or substances used in an abusive, destructive of injurious manner are not covered.

(2) **Administration.** Any charge for the administration of a covered Prescription Drug.

(3) **Compound Medication.** Compound Medications are not covered.

(4) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(5) **Cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.

(6) **Delivery.** Charges for delivering medications.

(7) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(8) **Durable Medical Equipment.** A charge for Durable Medical Equipment of any type (even though such devices may require a prescription order). This exclusion does not apply to disposable insulin pumps which are included on the Formulary.

(9) **Excess refills.** A prescription refill in excess of the quantity specified in the Prescription order, any Prescription refill dispensed after one year from the date of the prescription order, or any refill of a Prescription not authorized by a Physician is not covered.

(10) **Excessive Use.** Excessive use of medications is not covered. For purposes of this exclusion, the Plan shall be entitled to deny coverage of medications on grounds of excessive use when it is determined (1.) that a Covered Person has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by medical literature, standard reference compendia or by the pharmacy benefits manager; or (2.) that a Covered Person has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or (3.) that the pattern of Prescription purchases, changes of Physicians or pharmacy or other information indicates that a Covered Person has obtained or sought to obtain excessive quantities of medications. The Plan may communicate with any necessary Physician, health care Provider or pharmacy for the purpose of reviewing and discussing the Covered Person's prescription history, use or activity to evaluate for excessive use.

(11) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(12) **Fertility drugs.** Drugs prescribed to enhance fertility.

(13) **FDA.** Any drug not approved by the Food and Drug Administration.

(14) **Fraud or Material Misrepresentation.** Medications obtained by unauthorized or fraudulent use of the identification card or by material misrepresentation are not covered.

(15) **Growth hormones.** A charge for growth hormones, unless Prior Approval has been received from the Plan.

(16) **Hair Loss or Growth.** Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth or replace lost hair, are not covered.

(17) **Illegal Use.** Medications for use or intended use of which would be illegal or abusive

(18) **Injectable drugs.** Injectable medications, unless Prior Approval has been received from the Plan.

(19) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

(20) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(21) **Intravenous drugs.** Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion.

(22) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".

(23) **Lost medications.** Replacement of previously filled Prescription Drugs because the initial Prescription Drug was lost, stolen, spilled, contaminated, etc. are not covered.

(24) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(25) **Medical supplies.** Charges for medical supplies such as colostomy supplies, bandages, and similar items.

(26) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(27) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(28) **Non-participating pharmacy.** Medications purchased from a non-participating Pharmacy.

(29) **Not Covered.** Medications used or intended to be used in the treatment of a condition, Sickness, disease, Injury, or bodily malfunction which is not covered by the Plan, or for which benefits have been exhausted.

(30) **Not Medically Necessary.** Medications which are not Medically Necessary.

(31) **Off-Label Use.** Prescription Drugs that are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given are not covered. From time to time a particular clinical use of a Prescription Drug may be determined to be safe and efficacious by the pharmacy benefits manager, even without labeling of such indication or use by the FDA. This occurs because of clear and convincing evidence from the medical literature, and often in consultation with practicing Physicians of the appropriate specialty in the community. Such "off-label" use will be covered, though Prior Approval is often (but not always) required. A complete list of medications and their approved off-label indications is not available.

(32) **Over the Counter Medications.** Medications (except insulin) which do not by law require a prescription from a Physician are not covered.

(33) **Sexual Enhancement Medications.** Medications used for the treatment of sexual enhancement, including but not limited to medications for erectile dysfunction, are not covered regardless of the reason(s) for the sexual dysfunction.

(34) **Vitamins.** Vitamins or food/nutrient supplements except those which are Prescription Medications.

(35) **Weight Loss.** A charge for appetite suppressants or medications prescribed and dispensed for the treatment of obesity, or for use in any program of weight reduction, weight loss, or dietary control.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator, in its discretion, interprets the Plan to provide such benefits to the Covered Person.

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." 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 the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described later in this section.

Both the Claims and the Appeal 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.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If the Covered Person has any questions regarding these procedures, the should contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Claims Administrator must decide whether to approve or deny the Claim. The Claims Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Claims Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Claims Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Claims Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of Claim determination .....72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing .....24 hours

Response by claimant, orally or in writing .....48 hours

Benefit determination, orally or in writing .....48 hours

Notification of Adverse Benefit Determination on Appeal .....72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. 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.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction.....Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal

Notification to claimant of rescission.....30 days

Notification of determination on Appeal of
Urgent Care Claims .....24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)

Notification of Adverse Benefit Determination
on Appeal for non-Urgent Claims .....15 days

Notification of Adverse Benefit Determination
on Appeal for Rescission Claims.....30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits, pre-certification or mandatory second opinions. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination.....15 days

Extension due to matters beyond the control of the Plan.....15 days

Insufficient information on the Claim:
Notification of.....15 days
Response by claimant.....45 days

Notification, orally or in writing, of failure to follow
the Plan's procedures for filing a Claim .....5 days

Notification of Adverse Benefit Determination on Appeal .....30 days

Reduction or termination before the end of the treatment .....15 days

Request to extend course of treatment.....15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination.....30 days

Extension due to matters beyond the control of the Plan.....15 days

Extension due to insufficient information on the Claim.....15 days

Response by claimant following notice of insufficient information.....45 days

Notification of Adverse Benefit Determination on Appeal.....60 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the health care Provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The specific reason or reasons for the adverse determination, 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.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

PREFERRED PAYMENT PLAN AND HOSPITAL REIMBURSEMENT PROGRAM PARTICIPATING PROVIDERS

The Plan participates in the Preferred Payment Plan (PPP) and the Hospital Reimbursement Program (HRP) with BlueAdvantage Administrators of Arkansas. Participating Providers agree to accept the allowances of BlueAdvantage Administrators of Arkansas and not charge the Covered Person more than that amount. No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

A list of In-Network Providers is available on the web at www.blueadvantagearkansas.com.

The Claim Process

This Plan uses a direct claims administration system. Under this approach, the PPP or HRP Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by Preferred Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-Preferred Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan participates in a Preferred Provider Organization (PPO). Participating Providers agree to accept the PPO allowances and not charge the Covered Person more than that amount.

No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

A list of In-Network Providers is available on the web at www.blueadvantagearkansas.com.

The Claims Process

The Plan uses a direct claims administration system. Under this approach, the PPO Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by PPO Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-PPO Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

BLUECARD® PROGRAM

Out-of-Arkansas Services. The Health Plan participates in a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever a Covered Person obtains health care services outside of the State of Arkansas (“the service area”), the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Health Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the service area, a Covered Person will obtain care from health care Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, a Covered Person may obtain care from nonparticipating health care Providers. The Health Plan's practices for consideration of payment in both instances are described below.

(1) BlueCard® Program.

(a) Under the BlueCard® Program, when a Covered Person accesses covered health care services within the geographic area served by a Host Blue, the Health Plan will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers. Whenever a Covered Person accesses covered health care services outside the service area and the claim is processed through the BlueCard Program, the amount a Covered Person pays for covered health care services is calculated based on the lower of:

- The billed Covered Charges for the covered services; or
- The negotiated price that the Host Blue makes available to the Health Plan.

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

(c) Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price used for a Covered Person's claim because the adjustments will not be applied retroactively to claims already paid.

(d) Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Health Plan would then calculate the Covered Person's liability for any covered health care services according to applicable law.

(2) Non-Participating Health Care Providers Outside the Service Area

(a) When covered health care services are provided outside of the service area by non-participating health care Providers, the amount a Covered Person pays for such services will generally be based on either the Host Blue's nonparticipating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating health care Provider bills and any payment made for the covered services as set forth in this paragraph.

(b) In certain situations, the Health Plan may use other payment bases, such as billed Covered Charges, the payment the Health Plan would make if the health care services had been obtained within the service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Health Plan will pay for services rendered by nonparticipating health care Providers. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating health care Provider bills and the payment the Health Plan will make for the covered services as set forth in this paragraph

BLUE CROSS BLUE SHIELD GLOBAL CORE

If the Covered Person is outside the United States (hereinafter "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists individuals with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when a Covered Person receives care from Providers outside the BlueCard service area, they will typically have to pay the Provider directly. If a Covered Person needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, they may contact customer service at the number on the back of their health plan identification card or additional information can be found at www.bcbsglobalcore.com.

(1) **Inpatient Services.** In most cases, if the Covered Person contacts Blue Cross Blue Shield Global Core for assistance, Hospitals will not require a Covered Person to pay for covered inpatient services, except for applicable cost-share amounts (deductibles, coinsurance, etc.). In such cases, the Hospital will submit claims to the service center to begin claims processing. However, if the Covered Person paid in full at the time of service, they must submit a claim to receive a benefit determination. Contact the Claims Administrator to obtain prior approval for non-emergency inpatient services.

(2) **Outpatient Services.** Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require the Covered Person to pay in full at the time of service. A claim must be submitted to receive a benefit determination.

(3) **Submitting a Blue Cross Blue Shield Global Core Claim.** When the Covered Person pays for services outside the BlueCard service area, a claim must be submitted to receive a benefit determination. For institutional and professional claims, a Blue Cross Blue Shield Global Core claim form should be completed and sent with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from the service center or online at www.bcbsglobalcore.com.

ALL OTHER PROVIDERS

When a Covered Person has a Claim to submit for payment that person must:

- Obtain a Claim form from the Personnel Office or the Plan Administrator.
- Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- Have the Physician complete the Provider's portion of the form. For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

  Name of Plan
  Employee's name
  Name of patient
  Name, address, telephone number of the Provider of care
  Diagnosis
  Type of services rendered, with diagnosis and/or procedure codes
  Date of services
  Charges

Send the above to the Claims Administrator at this address:

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas
72203

WHEN CLAIMS SHOULD BE FILED

The Plan has established and will enforce a claims timely filing deadline of December 31st (following the date charges for the service were incurred) for benefits under the Plan, meaning that the Covered Person, the treating Provider, or an Authorized Representative acting on the Covered Person's behalf, must submit the claim to the Claims Administrator. However, In-Network Providers must submit claims within the time limits provided in their applicable provider contract, if shorter than the December 31st following the date charges for the service were incurred. Claims are not payable if they are not submitted to the Claims Administrator within the applicable time limit.

EXPLANATION OF BENEFITS (EOB)

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied. Upon making a determination of a claim, the Claims Administrator will deliver to the Covered Person an Explanation of Benefit Determination (EOB) containing the following information:

(1) the specific reason or reasons for the determination;

(2) specific reference to those Plan provisions on which the denial is based;

(3) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(4) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

CLAIMS REVIEW PROCEDURE

The Plan Participant will receive an EOB explaining the claim determination, and if applicable, the reason or reasons for any denial or reduction of benefits. In cases where a claim for benefits payment is denied or reduced in whole or in part, the Plan Participant or the Authorized Representative may request an informal claim review.

In a situation where the determination, after informal review, remains adverse, the Plan Participant or the Authorized Representative may request an appeal of the denial. This appeal provision will allow the Plan Participant to:

(1) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(2) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 180 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60-day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits. If a lawsuit is brought, it must be filed within two years after the final determination of an appeal.

The following describes the informal review and appeals processes:

(1) **Informal Claim Review.** Requests for review may be submitted in writing, email, or by telephone to the Claims Administrator. The request should provide the patient's name, Plan identification number and the specific claim(s) to be reviewed. Additional relevant documentation may also be provided to the Claims Administrator to assist in the review. A request for an informal claim review must be submitted within 180 days after notice is received of the denial or reduction in benefits.

A determination shall be rendered with a reasonable period of time, but notification of the determination will be provided not later than 60 days after received.

If the review is in regard to a Pre-Service Claim, response will be provided within 30 days of received.

If the review is in regard to an Urgent Care Pre-Service Claim, response will be provided within 24 hours of receipt.

(2) **Appeals.** When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(a) was relied upon in making the benefit determination;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan

provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a manner calculated to be understood by the claimant:

(a) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the health care Provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(b) The specific reason or reasons for the adverse determination, 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.

(c) Reference to the specific Plan provisions on which the determination was based.

(d) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(e) A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(f) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(g) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol,

or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(h) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(i) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. This request must be filed in writing within four months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the four-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating Provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Appeals Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the plan.

AUTHORIZED REPRESENTATIVE

One Authorized Representative. A Covered Person may have one representative, and only one representative at a time, to assist in submitting a claim or appealing an Adverse Benefit Determination.

Authority of Authorized Representative. An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person’s claim or appeal of a claim determination. If the

Covered Person has an Authorized Representative, references to "Covered Person" in the provision of this document entitled "How to Submit a Claim" refer to the Authorized Representative.

Designation of Authorized Representative. Except to the extent mandated by the U.S. Department of Labor claims rules in the case of a treating health care professionals and urgent care claims, the Plan does not permit appeals on Covered Person's behalf by any other person or entity not properly designated as an "authorized representative" in the manner specified in this section.

One of the following persons may act as a Covered Person's Authorized Representative:

(1) An individual designated by the Covered Person in writing in a form approved by the Claims Administrator. A "Designation of Authorized Appeal Representative" form is available from the Claims Administrator or the Plan Administrator;

(2) The treating Provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the Provider in writing in a form approved by the Claims Administrator. A "Designation of Authorized Appeal Representative" form is available from the Claims Administrator or the Plan Administrator;

(3) A person holding the Covered Person's durable power of attorney;

(4) If the Covered Person is incapacitated due to Illness or Injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or

(5) If the Covered Person is a minor, the Covered Person's parent or legal guardian, unless the Claims Administrator is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or legal guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.

Term of the Authorized Representative. The authority of an Authorized Representative shall continue for the period specified in the Covered Person's appointment of the Authorized Representative or until the Covered Person is legally competent to represent him or herself and notifies the Claims Administrator in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative.

(1) If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or legal guardian or attorney in fact under a durable power of attorney, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

(2) If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

(3) If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Claims Administrator will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Claims Administrator will provide copies of such correspondence to the Authorized Representative upon request.

(4) The Covered Person understands that it will take the Claims Administrator at least 30 days to notify all its personnel about the termination of the Covered Person's Authorized Representative and it is possible that the Claims Administrator may communicate information about the Covered Person to the Authorized Representative during this 30-day period.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula. The total reimbursement will never be more than the secondary (or subsequent) plan's formula -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable charge. For a charge to be allowable at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or

Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(f) When a person is covered as a dependent on their parent’s plan and as a dependent on their spouse’s plan, the benefit plan which has covered the patient for the longer time will be considered first.

(g) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, which benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Plan Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

Reimbursement

This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the "Covered Person") recovers damages, by settlement, verdict or otherwise, for an Injury, Sickness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an Injury or Illness or the treatment of such an Injury or Illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an Injury, Sickness or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representative, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not [1] the Covered Person has been fully compensated, or "made-whole" for his/her loss; [2] liability for payment is admitted by the Covered Person or any other party; or [3] the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person's behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In order to secure the rights of the Plan under this section, and because of the Plan's advancement of benefits, the Covered Person hereby [1] acknowledges that the Plan shall have first priority against proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and [2] assigns the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement of judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan' rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's Injury, Sickness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's Injury or Illness, or is or may be liable for the payment for the medical treatment of such Injury or occupational Illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available when group health coverage is lost. For example, an individual may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, he or she may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which he or she is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Federal law does not recognize a Domestic Partner or his or her children as Qualified Beneficiaries. However, the Plan will treat a Domestic Partner and his or her Children or Qualified Dependents as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this Section, the Domestic Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Domestic Partner ceases to be met. This gives the Domestic Partner, Children and Qualified Dependents the contractual rights outlined in this Section but does not extend statutory remedies to them. This provision does not apply to same sex spouses who are legally married. Same sex spouses who are covered under the Plan are Qualified Beneficiaries if they are covered under the Plan on the day before the Qualifying Event.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan 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 even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day after the leave ends, if the Employee does not return to work in an Eligible Class.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care Provider. Individuals may want to check to see if their current health care Providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare Eligibility:** Individuals should be aware of how COBRA coverage coordinates with Medicare eligibility. If an individual is eligible for Medicare at the time of the Qualifying Event, or if he or she will become eligible soon after the Qualifying Event, he or she has eight months to enroll in Medicare after employment -related health coverage ends. Electing COBRA coverage does not extend this eight-month period. For more information, see https://www.medicare.gov/sign-up-change-plans/.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. More information about these options is available at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce, termination of domestic partnership or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), the Covered Person or someone acting on their behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. This notice must be sent to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. The notice must be mailed, faxed or hand-delivered to the Human Resource office at the Employer's location of operation.

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state:

- the **name of the plan or plans** under which coverage has been lost or is being lost,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, the notice must include **a copy of the divorce decree or the legal separation agreement.**

There are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If an individual does not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage may terminate if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

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

available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

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

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

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

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

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

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

For More Information
If an individual has questions about COBRA continuation coverage, they should contact the Plan Sponsor. For more information about 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep The Plan Administrator Informed Of Address Changes
In order for an individual to protect his or her family's rights, they should keep the Plan Administrator informed of any changes in the addresses of family members. The individual should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Pace Industries, Inc. Health Benefit Plan is the benefit plan of Pace Industries, Inc., the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or a committee may be appointed by Pace Industries, Inc. to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Pace Industries, Inc. shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

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

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS
The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

ASSIGNMENT OF BENEFITS

Any payment due for eligible services rendered by Preferred Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-Preferred Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person

Any payment due for eligible services rendered by PPO Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-PPO Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

HIPAA PRIVACY FIREWALL
The following summary establishes the circumstances under which the Plan may share a Plan Participant’s protected health information with the Plan Administrator (the Employer), and limits the uses and disclosures that the Plan Administrator may make of a Plan Participant’s protected health information. This is intended to establish the firewall protections required under the Health Insurance Portability and Accountability Act of 1996 and its attendant privacy regulations, 45 C.F.R. Parts 160 and 164, as amended (the “HIPAA Privacy Rules” or “Rules”).

There are three circumstances under which the Plan may disclose a Plan Participant’s protected health information to the Plan Administrator.

First, the Plan may inform the Plan Administrator whether a Plan Participant is enrolled in the Plan.

Second, the Plan may disclose summary health information to the Plan Administrator. The Plan Administrator must limit its use of that information to obtaining quotes from reinsurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying the Plan Participant.

Third, the Plan may disclose a Plan Participant's protected health information to the Plan Administrator for Plan administrative purposes. This is because employees of the Plan Administrator perform many of the administrative functions necessary for the management and operation of the Plan.

CERTIFICATION OF FIREWALL AMENDMENT

The Plan Administrator hereby certifies to the Plan that the Plan's terms have been amended to incorporate the terms of this summary. The Plan Administrator has agreed to abide by the terms of this summary. The Plan's privacy notice also permits the Plan to disclose the Plan Participant's protected health information to the Plan Administrator as described in this summary.

RESTRICTIONS ON USE OR DISCLOSURE OF PHI

Here are the restrictions that apply to the Plan Administrators use and disclosure of a Plan Participant's protected health information.

(1) The Plan Administrator will only use or disclose a Plan Participant's protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA Privacy Rules. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.

(2) If the Plan Administrator discloses any protected health information to any of its agents or subcontractors, the Plan Administrator will require the agent or subcontractor to keep Plan Participants' protected health information as required by the HIPAA Privacy Rules.

(3) The Plan Administrator will not use or disclose a Plan Participant's protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Administrator.

(4) The Plan Administrator will promptly report to the Plan any use or disclosure of a Plan Participant's protected health information that is inconsistent with the uses or disclosures allowed in this summary.

(5) The Plan Administrator will allow a Plan Participant or the Plan to inspect and copy any protected health information about the Plan Participant that is in the Plan Administrator's custody and control, as permitted or required by the HIPAA Privacy Rules, subject to certain exceptions recognized in the Rules.

(6) The Plan Administrator will amend, or allow the Plan to amend, any portion of a Plan Participant's protected health information to the extent permitted or required under the HIPAA Privacy Rules.

(7) With respect to some types of disclosures for purposes other than payment or health care operations, the Plan Administrator will keep a disclosure log. The disclosure log will go back for six years. Plan Participants have a right to see the disclosure log. The Plan Administrator does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations, or if a Plan Participant authorized the disclosures.

(8) The Plan Administrator will make its internal practices, books, and records, relating to its use and disclosure of a Plan Participant's protected health information available to the Plan and to the U.S. Department of Health and Human Services upon their request.

(9) The Plan Administrator will, if feasible, return or destroy all of protected health information in the Plan Administrator's custody or control that the Plan Administrator has received from the Plan or from any business associate when the Plan Administrator no longer needs the protected health information to administer the Plan. If it is not feasible for the Plan Administrator to return or destroy protected health

information, the Plan Administrator will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

DESIGNATION OF FIREWALL DEPARTMENT
The following classes of employees or other workforce members under the control of the Plan Administrator (sometimes referred to as the "Firewall Department" for HIPAA Privacy Rules purposes) are hereby designated in accordance with HIPAA Privacy Rules firewall provisions to be given access to protected health information for the purposes set forth in this document:

Employees assigned to and working in the Human Resources Department, including but not limited to all employees whose job duties require communication and interaction with the third party administrator for the group health plan regarding any plan administration, claims or eligibility-related matters.

The above designation includes every class of employees or other workforce members under the control of the Plan Administrator who may receive protected health information. If any of these employees or workforce members use or disclose protected health information in violation of the rules that are set out in this summary, the employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Administrator becomes aware of any such violations, the Plan Administrator will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to Plan Participants.

PLAN IS NOT AN EMPLOYMENT CONTRACT
The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR
Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN
If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA
Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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 Pension and Welfare Benefits Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such

coverage.

Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

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

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME: Pace Industries, Inc. Health Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 71-0416822

PLAN EFFECTIVE DATE: 07/01/1990 and is amended and restated effective 07/1/2022.

PLAN YEAR ENDS: 06/30

EMPLOYER INFORMATION

Pace Industries, Inc.
2049 E. Joyce Blvd
Fayetteville, Arkansas 72702

PLAN ADMINISTRATOR

Chief Human Resources Officer
Pace Industries, Inc.
2049 E. Joyce Blvd
Fayetteville, Arkansas 72702

NAMED FIDUCIARY

Pace Industries, Inc.
2049 E. Joyce Blvd
Fayetteville, Arkansas 72702

AGENT FOR SERVICE OF LEGAL PROCESS

Stefan Sarkin
Pace Industries, Inc.
2049 E. Joyce Blvd
Fayetteville, Arkansas 72702

CLAIMS ADMINISTRATOR

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas 72203-1460
1-888-872-2531

BlueAdvantage Administrators of Arkansas is an independent licensee of the Blue Cross and Blue Shield Association. BlueAdvantage Administrators does not underwrite or assume any financial risk with respect to the claims liability of the Plan.

BY THIS AGREEMENT, Pace Industries, Inc. Health Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Pace Industries, Inc., on or as of the day and year first below written.

By _____
Pace Industries, Inc.

Date 10-4-2022

Witness _____

Date _____