**PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR**

# NEIMAN ENTERPRISES, INC.
# EMPLOYEE HEALTH BENEFIT PLAN

**Neiman Sawmill, Inc.**
**Gilchrist Forest Products, LLC**
**Spearfish Forest Products, Inc.**
**Spearfish Pellet Company, LLC**
**Montrose Forest Products, LLC**
**Neiman Management, LLC**

**EFFECTIVE:**
**Effective: August 1, 2011**
**Revised: January 1, 2026**

**Third Party Claims Administrator**
**Rocky Mountain Administrators (RMA)**
**P.O. Box 788**
**809 S Railway**
**Worland, WY 82401**
**(307) 347-2606 or (800) 383-8808**

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**ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION**

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by Neiman Enterprises, Inc. (the "Company" or the "Plan Sponsor") as of January 01, 2026, hereby sets forth the provisions of the Neiman Enterprises Employee Health Benefit Plan (the "Plan"), which was originally adopted by the Company, effective August 01, 2011 (original effective date) or May 01, 2016 (effective date of last signed plan). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

**Effective Date**
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the "Effective Date").

**Adoption of the Plan Document**
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by sections 402 and 102 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

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

**Neiman Enterprises, Inc.**

Name: _____

Title: _____

By: _____ Date: _____

## ARTICLE I
## INTRODUCTION

This document is a description of Neiman Enterprises, Inc. Employee 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 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.

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

Failure to follow the eligibility or enrollment requirements of this Plan may result in suspension 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.

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. An expense for a service or supply is Incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

**Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable. Further, any legal action brought against the Plan must be brought in Federal Court. The Plan Participant, or any Authorized Representative, submits to and accepts the exclusive jurisdiction of such courts for the purpose of such legal action. To the fullest extent permitted by law, Plan Participant, and any Authorized Representative, irrevocably waive any objection which they may now or in the future have as to venue, as well as any claim that any legal action or proceeding brought in such court has been brought in an inconvenient forum.**

If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Expenses Incurred before termination, amendment or elimination.

This Plan is an employee welfare benefit plan within the meaning of ERISA. This Plan is a self-funded medical plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Code so that the portion of the cost of coverage paid by the Employer, and any benefits received by a Plan Participant through this Plan, are not taxable income to the Plan Participant. The specific tax treatment of any Plan Participant will depend on the individual's personal circumstances; the Plan does not guarantee any particular tax treatment. Plan Participants are solely responsible for any and all federal, state, and local taxes attributable to their participation in this Plan, and the Plan expressly disclaims any liability for such taxes. This Plan is “self-funded,” which means benefits are paid from the Employer's general assets and are not guaranteed by an insurance company.

The Plan is administered by the Plan Administrator, which is the primary Named Fiduciary of the Plan, within the purview of ERISA and in accordance with these provisions. The Plan Administrator may delegate certain responsibilities for the operation and administration of the Plan. The Plan Administrator shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service Providers, adjust their compensation (if any), and exercise general administrative authority over them. The Plan Administrator has the sole

authority and responsibility to review and make final decisions on all claims to benefits hereunder, unless otherwise delegated herein.

**The Affordable Care Act**
This group health plan believes this plan is a "Grandfathered Health Plan" under the Affordable Care Act (ACA). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to Other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

**Neiman Enterprises, Inc.**
**PO Box 218**
**Hulett, WY 82720**
**Phone:1-307-467-5252**

Participants may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers. This website (in the Regulations and Guidance/Grandfathered Health Plans section) has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

**Non-English Language Notice**
This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

**Legal Entity; Service of Process**
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

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

**Non-Discrimination**
No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

This document serves as both the written Plan Document and the Summary Plan Description ("SPD") required under ERISA. This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

**This part should be read carefully since each Plan Participant is required to take action to assure that the maximum payment levels under the Plan are paid. This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:**

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

**Eligibility, Funding, and Enrollment Provisions.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Medical Benefits.** Explains when the benefit applies and the types of charges covered.

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

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

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

**Claims Procedures.** 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, Subrogation and Reimbursement.** Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person because of injuries sustained.

**COBRA Continuation Coverage.** 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 Plan Participant's rights under the Plan.

**Health Insurance Portability and Accountability Act of 1996.** The Health Insurance Portability and Accountability Act (HIPAA) amended ERISA and was enacted, among other things, to improve portability and continuity of health care coverage. HIPAA also requires that Plan Participant and beneficiaries receive a summary of any change that is a "Material Reduction in Covered Services or benefits under a group health plan" within sixty (60) days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of ninety (90) days or less.

**Pregnancy Discrimination Act of 1978.** Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent Spouse of an Employee.

**Family and Medical Leave Act of 1993 ("FMLA").** If a Covered Employee ceases Active Employment due to an Employer-approved Family Medical Leave of Absence in accordance with the requirements of Public Law 103, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in Active Employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

**Omnibus Budget Reconciliation Act of 1993 ("OBRA").** OBRA 1993 requires that an eligible Dependent Child of an Employee will include a Child who is adopted by the Employee or placed with him for adoption prior to age eighteen (18) and a Child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law

under State law and which satisfies the QMCSO requirements of ERISA (section 609(a)). Plan Participants may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

**Newborns' and Mothers' Health Protection Act of 1996.** The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn Children following delivery, as follows: All applicable benefit provisions still apply, including existing Deductibles, Copayments and/or Coinsurance.

**The Women's Health and Cancer Rights Act of 1998 (WHCRA).** The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. In the case of an Employee or Dependent who receives benefits under the Plan in connection with a Mastectomy or Lumpectomy and who elects breast reconstruction (in a manner determined in consultation with the attending *Physician* and the patient), coverage will be provided for:

- Reconstruction of the breast on which the Mastectomy or Lumpectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the Mastectomy and Lumpectomy, including lymphedemas.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy and Lumpectomy coverage, and will be provided in consultation with you and your attending Physician.

**Genetic Information Nondiscrimination Act of 2008 ("GINA").** GINA prohibits the Plan from:

**(1)** Adjusting premiums or contribution amounts for the group as a whole on the basis of Genetic Information.
**(2)** Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study as long as the results are not used for underwriting purposes.
**(3)** Requesting, requiring or purchasing Genetic Information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes. GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA? Under GINA, the term "Genetic Information" includes:

**(1)** Information about an individual or his/her family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);
**(2)** The manifestation of a Disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and
**(3)** Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic Information does not include the sex or age of an individual.

**Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").** The Mental Health Parity and Addiction Equity Act requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, benefits for such conditions must be provided in the same manner as benefits for any Illness. Also, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

**Medicaid and The Children's Health Insurance Program ("CHIP") Offer Free Or Low-cost Health Coverage To Children And Families.** If you are eligible for health coverage from your Employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for Employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your Children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your Dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

**Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).** Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility:

- The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. *The effective date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer and its Employees. **For more information regarding special enrollment rights, contact the Plan Administrator.**

## ARTICLE II
## OVERVIEW OF BENEFITS

All benefits described in the Medical Benefits Schedule are subject to the Exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are limited to the Maximum Allowable Charge as defined; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are outlined under Defined Terms of this Plan.

This Plan pays Covered Expenses pursuant to the Maximum Allowable Charge, which is defined in Article XI of this document. **Plan Participants are responsible for any amounts determined to be in excess of the Maximum Allowable Charge.**

**Precertification of certain services is required by the Plan. Precertification provides information regarding coverage before the Plan Participant receives treatment, services or supplies.** ***A Precertification of services by CRITIQUE is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and Exclusions of the Plan at the time services are provided.***

**If Precertification is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care will be *reduced by $250* and such reduction will not go toward the Maximum Out-of-Pocket Amount.**

All services requiring Precertification, as noted in the Summary Plan Description are to be authorized in advance by the CRITIQUE, except for emergencies. The Plan Participant or their representative is required to call the phone number for Precertification located on the back of their ID card for the services specified in the Summary of Benefits section at least five (5) working days prior to the services being rendered. The Plan Participant or their representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Precertification determinations and service repricing. If Precertification is not obtained for these benefits the Plan payment for any expenses associated with these benefits will be **reduced by $250** and such reduction will not go toward the Maximum Out-of-Pocket Amount. This provision does not apply to urgent care admissions or if surgery is performed within 24 hours of the admission. Urgent care or Emergency admissions should be authorized as soon as reasonably possible.

Contact Critique at (888) 272-4002 to obtain Pre-Certification of a non-emergency admission and services.

### PROVIDER INFORMATION

The Plan has contracted with medical Provider Networks to access discounted fees for services for Plan Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Plan Participants:

**(1)** The Plan provides different levels of benefits based on whether the Plan Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Plan Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

- The Network Provider level of benefits is payable when a Plan Participant receives Emergency care either out-of-area or at a Non-Network Hospital for an Accident Bodily Injury or Emergency.

**(2)** If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Plan Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Plan Participants are not responsible for

any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given Assignment of Benefits or to proactively prohibit Assignment of Benefits to anyone, including any Provider, at its discretion.

**(3)** To receive benefit consideration, Plan Participants must submit claims for services provided by Non-Network Providers to the Claims Administrator. Network Providers have agreed to bill the Plan directly, so that Plan Participants do not have to submit claims themselves.

**(4)** Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

To request a Network Provider listing or to verify whether a Provider is a Network Provider or Non-Network Provider, refer to your ID card for your network information, call Rocky Mountain Administrators (RMA) at (800) 383-8808 or visit www.rockymountainadministrators.com **BEFORE** the charges are Incurred.

**Additionally, care provided by Monument Health Hospitals will be available at a lower out of pocket cost to the Plan Participant.**

Contact CRITIQUE at (888) 272-4002 to Precertify for Inpatient, Outpatient, Emergency and non-Emergency services.

## ARTICLE III
## MEDICAL BENEFITS SCHEDULE

| | MEDICAL BENEFITS |
|---|---|
| Claims must be received by the Claims Administrator within ***365 days*** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.<br><br>The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion. | |
| **LIFETIME MAXIMUM BENEFIT** | **UNLIMITED** |
| **CALENDAR YEAR BENEFIT AMOUNT** | **UNLIMITED** |
| **DEDUCTIBLE, PER CALENDAR YEAR** | |
| Per Plan Participant<br>Per Family Unit | $2,500<br>$5,000 |
| **MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR** | |
| Per Plan Participant<br>Per Family Unit | $4,500<br>$9,000 |
| The Maximum Out-of-Pocket Amount includes Coinsurance and Deductibles applied toward covered medical benefits as shown above.<br><br>The following expenses do not count toward the Maximum Out-of-Pocket Amount and will not be paid at 100%, even when the Maximum Out-of-Pocket Amount has been met:<br>• Any penalties for failure to Precertify;<br>• Charges in excess of the Maximum Allowable Charge; or<br>• Expenses Incurred for non-covered services. | |
| **Maximum Allowable Charge for Covered Expenses is limited to the Reasonable and Allowed Amount as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.** | |

| DESCRIPTION | MONUMENT HEALTH FACILITIES | ALL OTHER PROVIDERS |
|---|---|---|
| **Physician Services** | | |
| Office Visits | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| Specialist Office Visit | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Accidental Injury Benefit**<br>*First $500 payable at 100%, Deductible waived.* | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Allergy Injections, Testing and Serums** | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Ambulance** | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Ambulatory Surgical or Outpatient Surgical Facility** | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Cardiac Rehabilitation Therapy** | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Children's Eye Exam – (Under age 19)** | No cost to Plan Participant, Deductible does not apply. | No cost to Plan Participant, Deductible does not apply. |

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| **Chiropractic Care**<br>Limited to $750 per Calendar Year. | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Diabetes Treatment** | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Dialysis** | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Diagnostic Testing** | | |
| X-ray and Lab | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| Advanced Imaging (CT scans, MRIs, MRAs<br>and PET scans) and Nuclear Medicine | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Durable Medical Equipment and Prosthetics** | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Emergency Room Services** | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Home Health Care** | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Hospice Care**<br>Six (6) month benefit period. | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Hospital Services** | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Human Organ and Tissue Transplants**<br>***See LIMITATIONS** | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Infertility Services** | | |
| Diagnosis of Underlying Condition | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| Infertility Treatment | Not Covered | Not Covered |
| **Maternity Care** | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Morbid Obesity Surgery**<br>Limited to $15,000 Lifetime Maximum<br>***See LIMITATIONS** | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Novel Coronavirus (COVID-19)** | | |
| COVID-19 Testing | No cost to Plan Participant, Deductible does not apply. | No cost to Plan Participant, Deductible does not apply. |
| COVID-19 Treatment | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Occupational Therapy** | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |
| **Orthotics**<br>Limited to $500 per Calendar Year | 10% after Deductible is met. | 20% after Deductible is met.<br>Subject to the Maximum Allowable Charge. |

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| **Physical Therapy** | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Preventative Care** | | |
| Routine Well Care (Birth through Adult) | No cost to Plan Participant, Deductible does not apply. | No cost to Plan Participant, Deductible does not apply. |
| Influenza Vaccinations | No cost to Plan Participant, Deductible does not apply. | No cost to Plan Participant, Deductible does not apply. |

**Routine Well Care services** will be subject to age, and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) or as otherwise required by law, *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

**Routine Well Care services will include, but will not be limited to, the following routine services:** Office visits, routine physical exams, prostate screening, sterilization procedures patient education and counseling for men, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well childcare examinations.

**Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune- deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. Additional information can be located using the following website: https://www.healthcare.gov/preventive-care-women

**Maximum Allowable Charge for Covered Expenses is limited to the Reasonable and Allowed Amount as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.**

| DESCRIPTION | MONUMENT HEALTH FACILITIES | ALL OTHER PROVIDERS |
|---|---|---|
| **Private Duty Nursing (Inpatient Only)** | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Second & Third Surgical Opinion** | No cost to Plan Participant. | No cost to Plan Participant. |
| **Skilled Nursing Facility** Limited to 120 days per Calendar Year. | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Speech Therapy** | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Temporomandibular/Craniomandibular Joint Disorder (TMJ)** *Limited to Surgery Only* | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| **Treatment of Mental or Nervous Disorders or Substance Abuse** | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |

| | | |
|---|---|---|
| **Urgent Care** | 10% after Deductible is met. | 20% after Deductible is met. Subject to the Maximum Allowable Charge. |
| | | |

**Precertification.** The following services require Precertification:

- All Inpatient Stays;
- Chemotherapy and Radiation;
- Clinical Trials;
- Home Health Care Services;
- Hospice Services;
- Outpatient Surgical Procedures;
- Rehabilitation program (cardiac, chemical dependency, pain management or pulmonary);
- Skilled Nursing Care; and
- Transplant Services.
- Colonoscopies

All services requiring Precertification, as noted in the Summary Plan Description are to be authorized in advance by CRITIQUE, except for emergencies. The Plan Participant or their representative is required to call the phone number for Precertification located on the back of their ID card for the services specified above at least five (5) working days prior to the services being rendered. The Plan Participant or their representative must identify the services to be rendered and the associated Diagnosis and Procedure Codes necessary for Precertification determinations.

**If Precertification is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care will be reduced by $250 and such reduction will not go toward the Maximum Out-of-Pocket Amount.**

**ARTICLE IV**
**DENTAL BENEFITS SCHEDULE**

| **DEDUCTIBLE, PER CALENDAR YEAR** | |
|---|---|
| Per Plan Participant | **$50.00** |
| Per Family | **$150.00** |
| **The Deductible applies to the following services:**<br>• Class B Services - Basic<br>• Class C Services - Major<br>• Class D Services - Orthodontia | |
| **MAXIMUM BENEFIT AMOUNT, PER PERSON** | |
| Class A, B, and C Services (combined) | **$1,500.00 per Calendar Year** |
| Class D Services | **$2,000 Lifetime Maximum** |
| **BENEFITS** | **PERCENTAGE PAYABLE** |
| **Class A Services - Preventive** | No cost to Plan Participant.<br>Deductible does not apply. |
| ***Class A Services includes the following services:***<br>• One exam twice per Calendar Year;<br>• Cleaning of teeth twice per Calendar Year;<br>• Full-Mouth X-rays once every 36 months;<br>• Bite-wing X-rays twice per Calendar Year;<br>• Sealants to permanent molar teeth for dependents under age 19;<br>• Space Maintainers for Dependents under age 14; and<br>• Fluoride treatments twice per Calendar Year for Dependents under age 19. | |
| **Class B Services - Basic** | 80% Coinsurance |
| ***Class B Services include the following services:***<br>• Extractions;<br>• Oral surgery;<br>• Fillings;<br>• General and IV anesthetics;<br>• Periodontal treatment;<br>• Endodontics treatment;<br>• Injection of antibiotic drugs; and<br>• Root Canals. | |
| **Class C Services - Major** | 50% Coinsurance |
| ***Class C Services Include the following services:***<br>• Gold restorations;<br>• Crowns;<br>• Dentures;<br>• Bridges; and<br>• Pontics. | |
| **Class D Services - Orthodontia**<br>***Limited to Dependent Children up to age 19.*** | 50% Coinsurance |
| | |

**PRE-DETERMINATION OF DENTAL BENEFITS**

Before starting a dental treatment for which the charge is expected to be over **$400,** a predetermination of benefits form is requested but not required. The Dentist must itemize all recommended services and costs.
The Dentist should send the form to the Claims Processor at this Address:

**Rocky Mountain Administrators (RMA)**
**P.O. Box 788**
**809 South Railway Avenue**
**Worland, WY 82401**
**(307) 347-2606 or (800) 383-8808**

The Claims Processor will notify the Dentist of the benefits payable under the Plan. The Plan Participant and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

## ARTICLE V
## PRESCRIPTION DRUG BENEFIT SCHEDULE

**Not all Prescription Drugs are covered**

Please visit the following website to view covered Drugs:

**www.procarerx.com**
**(800) 699-3542**

If applicable, this Plan will make a retroactive adjustment to a claim based on a discount, coupon, Pharmacy discount program or similar arrangement provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.

| PRESCRIPTION DRUG BENEFIT | | |
|---|---|---|
| **Pharmacy Option (34 Day Supply)** | | **PATIENTS PARTICIPATING IN PROJECT SPUR** |
| Generic Drugs | $10 Copay/prescription | No Copay |
| Preferred Drugs | $20 Copay/prescription or 20% Coinsurance, whichever is greater. | 20% Copay |
| Non-Preferred Drugs | $30 Copay/prescription or 20% Coinsurance, whichever is greater. | $30 + 20% Copay |
| Specialty Drugs<br>*under $1250.00 per Month | 10% Coinsurance after $250 Calendar Year Deducitble is met.* | |
| **Mail Order Option (90 day supply)** | | |
| Generic Drugs | $20 Copay/prescription | No Copay |
| Preferred Drugs | $50 Copay/prescription or 20% Coinsurance, whichever is greater. | $20 Copay |
| Non-Preferred Drugs | $80 Copay/prescription or 20% Coinsurance, whichever is greater. | $60 + 20% Copay |
| **Refer to the Prescription Drug Section of the Summary Plan Description for details on the Prescriptiion Drug benefit.** | | |
| Plan Participants may need to obtain certain medications from a pharmacy designated by the Plan Administrator. | | |
| In order to obtain a 90-day supply through mail order contact ProCare RX at (800) 699-3542. | | |
| **Certain medications may require a Prior Authorization through ProCareRX.**<br>**If Prior Authorization is not obtained the Plan Participant may be responsible for a higher cost.** | | |
| ***Specialty Pharmaceutical Drugs and other drugs over $1,250 are excluded under this Plan.**<br>**Notwithstanding the foregoing, the Plan will cover the charges for a Specialty Pharmaceutical *if Prior Authorized* for the first thirty (30) day fill of any Specialty Pharmaceutical that is self-administered and filled at a licensed pharmacy or the first dose of any Specialty Pharmaceutical administered in a Hospital, facility or provider's office by a healthcare professional for each Specialty Pharmaceutical drug, unless otherwise excluded from the Plan.**<br><br>**If the Specialty Pharmaceutical is not purchased through the Specialty Pharmacy the Plan Participant will be fully responsible for the increased cost for the specialty drug.** | | |

## ARTICLE VI
## ELIGIBILITY, FUNDING AND ENROLLMENT PROVISIONS

### ELIGIBILITY

A Plan Participant should contact the Claims 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.

**Eligible Classes of Employees**

- All active Employees of the Employer.

**Active Employment Requirement.** An Employee must be an active Employee for this coverage to take effect.

**Eligibility Requirements for Employee Coverage.** A person is eligible for Employee coverage from the first day that he or she:

**(1)** is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.
An Employee's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). For Plan Years beginning before January 1, 2015, an Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the Employer's standard employment practices. For these purposes, a "look back measurement period" is defined as the period established by the Employer of at least 3 but not more than 12 consecutive months for purposes of determining an employee's initial or ongoing eligibility for coverage. The initial look back measurement period and the standard look back measurement period for ongoing eligibility are not required to be of the same length. The "stability period" means the period chosen by the Employer for purposes of establishing the period of eligibility that follows an initial or standard look back measurement period (including any administrative period established by the Employer which may follow those look back periods).

**(2)** is in a class eligible for coverage.

**(3)** completes the employment Waiting Period of 60 days as an Active Employee. A **"Waiting Period"** is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

Coverage will begin the first day of the calendar month following or coinciding with the completion of all Eligibility Requirements, Active Employment Requirement, and Enrollment Requirements as stated under this Plan.

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

**(1)** The term **"spouse"** means a person recognized as the covered Employee's husband or wife by the laws of the State in which the marriage was formalized. The Plan Administrator may require documentation proving a legal marital relationship.

The term **"Children"** shall include natural Children, adopted Children, Children placed with a covered Employee in anticipation of adoption and stepchildren. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the Calendar Year.

If a covered Employee is the **Legal Guardian** of a Child or Children, these Children may be enrolled in this Plan as covered Dependents.

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.

Any Child of a Plan Participant who is an Alternate Recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A Plan Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

**Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax free benefits. (i.e., non-IRC Section 152 Dependent). There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s). The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).**

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

**(2)** A covered Dependent Child who reaches the **limiting age** and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. 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.

**These persons are excluded as Dependents:** other individuals living in the covered Employee's home, but who are not eligible as defined; Domestic Partners (Unless allowed per state guidelines), the legally separated or divorced former spouse of the Employee; 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 mother and father are employees of the plan, coverage will be under one employee, as family coverage.

**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 or a Dependent Child qualifies or continues to qualify as a Dependent as defined by this Plan.

**EFFECTIVE DATE**

**Effective Date of Employee Coverage.** An Employee will be covered under this Plan as of the first day of the calendar month following or coinciding with the date that the Employee satisfies all of the following:

**(1)** The Eligibility Requirement.
**(2)** The Active Employment Requirement.
**(3)** The Enrollment Requirements of the Plan.

**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.

**FUNDING**

Cost of the Plan. **The Employer pays for the cost of Employee coverage and family coverage under this Plan.**

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

**ENROLLMENT**

**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application. If Dependent coverage is desired, the covered Employee will be required to enroll for Dependent coverage as well.

**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 newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs. If the child is required to be enrolled and is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

**TIMELY, LATE OR OPEN ENROLLMENT**

**(1) Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty-one (31) days after the person becomes eligible for the coverage either initially or under a Special Enrollment Period.

If two Employees (husband and wife) 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 open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment, a reduction of hours of 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 as specified in the Open Enrollment section.*

## 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).

In addition, if an Employee or his or her Dependents (including his or her Spouse) is losing coverage due to a loss of a government sponsored subsidy (due to ineligibility for coverage or cost of coverage) there may be a right to enroll in this Plan.

However, a request for enrollment must be made within thirty-one (31) after the coverage ends (or after the Employer stops contributing towards the other coverage).

In addition, in the case of a birth, adoption, placement for adoption, or marriage there may be a right to enroll in this Plan. However, a request for enrollment must be made within thirty-one (31) days of the date of birth, adoption, placement for adoption or of the date of marriage.

**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 Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

**(1) Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

- **a.** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- **b.** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
- **c.** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date of loss.
- **d.** The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date of loss.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

- **a.** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time Employees).
- **b.** The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
- **c.** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

**d.** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

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

**a.** The Employee is a Plan Participant under this Plan (or has met the Waiting Period applicable to becoming a Plan 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, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. 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. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of thirty-one (31) days and begins on the date of birth, adoption or placement for adoption, or thirty-one (31) days and begins on the date of the marriage. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this time period as stated above.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

**a.** In the case of marriage, as of the date of marriage;
**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.

**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:

**(1)** The date the Plan is terminated.

**(2)** The last day of the calendar month in which 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 section entitled

COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

**(3)** If an Employee neglects to make the required premium payment, 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; or

**(4)** As otherwise specified in the Eligibility section under this Plan.

**Note:** 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 Coverage.

**Continuation During Periods of Employer-Approved Leave(s) of Absence** A person may remain eligible under the terms of this Plan during an Employer-approved leave of absence. 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 covered Employee. The Employer has sole discretion to determine the length of the Employer-approved leave of absence.

**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 (FMLA) as promulgated in regulations issued by the Department of Labor, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations.

This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, 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, 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 and/or other State leave law. 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.

**COVID-19 Leave.** Leave taken in accordance with the Families First Coronavirus Response Act "FFCRA," including the Emergency Family and Medical Leave Expansion Act and Emergency Paid Sick Leave Act: coverage will continue for the duration of the permitted leave under the FFCRA, as amended.

The above-noted leave(s) do not run concurrently with FMLA, USERRA, or any state-mandated family or medical leave, and/or any other applicable leaves of absence. At the end of the period(s) listed above, the Plan Participant's coverage will be deemed to have terminated for purposes of Continuation of Coverage under COBRA.

**Rehiring a Terminated Employee by an Applicable Large Employer.** A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by applicable law. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period.

**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 (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

**(1)** The maximum period of coverage of a person and the person's Dependents 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 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.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the earliest of these dates:

**(1)** The date the Plan is terminated.

**(2)** The last day of the calendar month that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.)

**(3)** The last day of the month in which a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled COBRA Continuation Coverage.)

**(4)** The last day of the Calendar Year in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled COBRA Continuation Coverage.)

**(5)** 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; or

**(6)** As otherwise specified in the Eligibility section under this Plan.

**Note:** 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 Coverage.

## ARTICLE VII
## OPEN ENROLLMENT

Each **August**, during open enrollment, covered Employees may change their benefit elections under the Plan, and Employees and their Dependents, who are late enrollees, will be able to enroll in the Plan.

Benefit choices for late enrollees made during the open enrollment period will become effective **September 1**. Plan Participants will receive detailed information regarding open enrollment from the covered Employee's Employer.

Benefit choices made during the open enrollment period will remain in effect until the next open enrollment period 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. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

If an Employee drops a spouse during Open Enrollment in anticipation of divorce it is their responsibility to notify the Plan Administrator of such.

## ARTICLE VIII
## MEDICAL BENEFITS

Medical Benefits apply when Covered Expenses are Incurred by a Plan Participant for care of an Injury or Illness and while the person is covered for these benefits under the Plan.

### DEDUCTIBLE

**Deductible Amount.** This is an amount of Covered Expenses for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Plan Participant must meet the Deductible shown in the Medical Benefits Schedule.

*The Deductible will apply to the Maximum Out-of-Pocket Amount.*

**Embedded Deductible.** This Plan has an "embedded" Deductible, which means a covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to the Plan paying benefits for that individual. However, the Deductible amount for all members of that Family Unit will only be satisfied when the family deductible has been met for that Calendar Year, or each individual member has satisfied his/her individual deductible amount.

**Family Unit Limit.** When the maximum amount shown in the Medical Benefits Schedule has been Incurred by members of a Family Unit toward their Calendar Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

### PAYMENT OF BENEFITS

All benefits under this Plan are payable, in U.S. Dollars, to the Plan Participant whose Illness or Injury is the basis of a claim, unless the Plan Participant, in accordance with the terms of this Plan, compensates Hospital or Physician of medical care with an Assignment of Benefits. Payment of benefits from the Plan to a health care Hospital or Physician pursuant to written direction of the Plan Participant is subject to the approval of the Plan Administrator, and shall be made as consideration in full for services rendered. In the event of the death or incapacity of a Plan Participant and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Plan Participant.

### COVERED EXPENSES

Charges for Covered Services are not to exceed the Maximum Allowable Charge that are Incurred for the following items of services and supplies when Medically Necessary to diagnose or treat a Plan Participant or specifically for Preventive Care. These charges are subject to all benefit limits, Exclusions, and other provisions of this Plan. Covered Services, Medically Necessary, and Preventive Care are defined terms; see Article XI for definitions of capitalized terms.

**(1) Abortion.** Covered Expenses are included only when the life of the mother is endangered by the continued Pregnancy, if it is determined that the fetus is nonviable or does not have a reasonable chance of survival, or the Pregnancy is the result of rape or incest.

**(2) Allergy Services.** Covered Expenses include allergy testing, evaluations and injections, including serum costs.

**(3) Ambulance.** Local Medically Necessary professional land or air ambulance service that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support or advanced life support.

In a medical Emergency, coverage will be provided to the nearest medical facility that can provide medical Emergency care. Ambulance transfers between facilities must be approved in advance by the Plan Administrator as Medically Necessary.

**(4) Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided.

**(5) Anesthesia Services.** Anesthesia services provided by a Physician (other than the attending Physician) or nurse anesthetist including the administration of spinal anesthesia, the injection or inhalation of a drug or other anesthetic agent.

**(6) Birthing Center.** Services of a birthing center for Medically Necessary care provided within the scope of its license.

**(7) Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank.

**(8) Cardiac Rehabilitation.** Cardiac rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a Hospital as defined by this Plan.

**(9) Chemotherapy or Radiation and Treatment with Radioactive Substances**. The materials and services of technicians are included.

**(10) Clinical Trials.** Covered Expenses will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

- The clinical trial is registered on the National Institute of Health (NIH) maintained web site www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial for cancer treatment;
- The Plan Participant meets all inclusion criteria for the clinical trial and is not treated "off-protocol.";
- The Plan Participant has signed an informed consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent;
- The trial is approved by the Institutional Review Board of the Institution administering the treatment; and
- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Plan Participant would receive whether or not he or she were participating in a clinical trial.

**Routine patient services do not include, and reimbursement will not be provided for:**

- The investigational service, supply, or drug itself;
- Services or supplies listed herein as Plan Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Plan Participant; or
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g. device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial Plan Participant.

**(11) Contraceptive Methods.** All Food and Drug Administration approved contraceptive methods when prescribed by a Physician, including but not limited to, intrauterine devices (IUDs), implants, and injections, and any related Physician and facility charges, including complications, and will be payable under the Preventive Care benefits as shown in the Medical Benefits Schedule section.

Refer to the separate Prescription Drug Benefit of this Plan regarding prescription coverage of oral

contraceptive medications, devices, transdermal, vaginal contraceptives, implantable and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Plan Participants.

**(12) Dental.** Emergency repair due to Injury to sound natural teeth, if the repair is made within twelve (12) months from the date of the Injury unless otherwise required by applicable law.

**(13) Diagnostic Testing.** Charges for X-rays and Advanced Imaging.

**(14) Dialysis Treatment - Outpatient.** This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

- Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:
    - The concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services.
    - The potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members.
    - Evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers,
    - The fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.
- Dialysis Program Components. The components of the Dialysis Program are as follows:
    - Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").
    - Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after **August 1, 2012**, regardless of when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.
    - Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination, the Plan Administrator shall consider factors including:
        1. Market concentration. The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
        2. Discrimination in charges. The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

- In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis- related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:
    1. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.
    2. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.
    3. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.
    4. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.
    5. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.
    6. All charges must be billed by a provider in accordance with generally accepted industry standards.
- Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.
- Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

**(15) Durable Medical Equipment (DME).** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for any of the following:

- Any purchases without its advance written approval.
- Replacements or repairs.
- The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment."

**(16) Emergency Care Services.** An Emergency medical condition is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or part.

If you are confined in a hospital after a medical Emergency, you (or someone on your behalf) must let the Plan Administrator know about your confinement as soon as it is reasonably possible to provide that notice. If you are receiving intensive treatment for mental health services, including Inpatient hospitalization and partial hospitalization, you must notify the Plan Administrator as soon as possible

**(17) Glaucoma.** Treatment of glaucoma, cataract surgery and one set of lenses (contacts or frame-type).

**(18) 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 Illness. The Diagnosis, care and treatment must be certified by the attending Physician and be contained in a home health care plan.

Benefit payment for nursing, home health aide and therapy services are subject to the home health care limit shown in the Medical Benefits Schedule.

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.

The following will not be a Covered Expense under this Plan: Maintenance or Custodial Care visits; domestic or housekeeping services; "Meals-on-Wheels" or similar food arrangements; visits, services, medical equipment or supplies not approved or included as part of the Plan Participant's treatment plan; services for Mental or Nervous Disorders; or services provided in a nursing home or Skilled Nursing Facility.

Note: Transportation services are not covered under this benefit.

**(19) Hospice Care Services and Supplies.** Charges relating to hospice care, provided the Plan Participant has a life expectancy of six months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered hospice expenses are limited to:

- Room and Board for confinement in a hospice.
- Ancillary charges furnished by the hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness.
- Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
- Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
- Home health aide services.
- Home care furnished by a Hospital or Home Health Care Agency, under the direction of a hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.

- Medical social services by licensed or trained social workers, psychologists or counselors.
- Nutrition services provided by a licensed dietitian.
- Bereavement Counseling.
- Respite care.

The hospice care program must be renewed in writing by the attending Physician every 30 days. Hospice care ceases if the terminal Illness enters remission.

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

Room charges made by a Hospital having only private rooms will be payable at the average private room rate of that facility.

**(21) Infertility Services.** Only the care, supplies and services for the **DIAGNOSIS** of infertility are covered.

**(22) Laboratory Studies.** Covered Expenses for diagnostic lab testing and services.

**(23) Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy or Lumpectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction surgery and prostheses following Mastectomy or Lumpectomy.

As required by law, the Plan Participant is being provided this notice to inform him or her about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy or Lumpectomy will also receive coverage for:

- Reconstruction of the breast on which the Mastectomy or Lumpectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications from all stages of Mastectomy or Lumpectomy, including lymphedemas.

The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the Plan Participant.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage and will be provided in consultation with the Plan Participant and his or her attending Physician.

**(24) Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy Diagnosis, and lancets and Chemstrips for diabetics.

**(25) Mental or Nervous Disorders and Substance Abuse Treatment.** Covered Expenses will be payable for care, supplies and treatment of Mental or Nervous Disorders and Substance Abuse. Benefits are available for Residential Treatment Facility, partial hospitalization, and intensive Outpatient services.

**(26) Morbid Obesity Surgery.** Covered Expenses includes the following surgical procedures if those procedures are determined to be Medically Necessary and appropriate for an individual's Morbid Obesity condition. Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Plan Participant.

- Bariatric surgery, including, but not limited to:

- Gastric or intestinal bypasses
- Stomach stapling (vertical banded gastroplasty, gastric banding, and gastric stapling).
- Lap band (laparoscopic adjustable gastric banding).
- Gastric sleeve procedure (laparoscopic vertical gastrectomy, and laparoscopic sleeve gastrectomy).

- Charges for Diagnostic Services.

This Plan does not cover diet supplements, exercise equipment or any other items listed in the Medical Plan Exclusions section of this Plan. (See benefit limitations in Schedule of Benefits Section)

**Complications of Morbid Obesity Surgery are NOT COVERED under The Plan**

**(27) Novel Coronavirus (COVID-19).** Covered Expenses associated with testing for and treatment of COVID-19 include the following:

- **Diagnostic Tests.**
  - In vitro diagnostic products for the detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized by the FDA, including all costs relating to the administration of such in vitro diagnostic products.
  - Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.

The following items will be covered under the Plan:

- **Inpatient Hospital Quarantines.** There may be times when Plan Participants with the virus need to be quarantined in a Hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the Hospital for public health reasons. Such charges will not be denied solely because otherwise-applicable Medically Necessary requirements would not indicate a need for a private room.
- **Telehealth and Other Communication-Based Technology Services.** Plan Participants can communicate with their doctors or certain other practitioners without going to the doctor's office in person. This is recommended if a Plan Participant believes he or she has COVID-19 symptoms.
- **Requests for Prescription Refills.** When considering whether to cover more than 34-day supply of drugs, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request and make decisions based on the circumstances of the patient.

The above benefits are specific to Diagnosis and treatment of COVID-19. Plan Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

**(28) Nursing Services.** Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN).

**(29) Occupational Therapy.** Services provided by a licensed occupational therapist, payable up to the limits as stated in the Medical Benefits Schedule. Therapy must be ordered by a Physician, result from an Injury or Illness and improve a body function. Covered Expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

**(30) Oral Surgery.** Oral surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist. Removal of bony impacted wisdom teeth is covered.

**(31) Orthotics.** Charges for orthotics.

**(32) Osseous Surgery.** Charges for osseous surgery.

**(33) Pathology Services.** Charges for pathology services.

**(34) Physical Therapy.** Services provided by a licensed physical therapist, payable up to the limits as stated in the Medical Benefits Schedule. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

**(35) Physician Care.** Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

**(36) Pregnancy Care.** The Maximum Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Illness and will be payable as stated in the Medical Benefits Schedule. Pregnancy expenses of the Employee, Spouse, and Dependent daughter(s) are covered.

Note: Routine prenatal office visits will be payable as stated under the Pregnancy benefit as shown in the Medical Benefits Schedule section. The following services will continue to be payable per normal Plan provisions:

Pregnancy-related ultrasounds, lab screenings (not otherwise specified), complications of Pregnancy (as defined under this Plan), delivery, and post-partum 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).

**(37) Prescription Drugs** (as defined). Outpatient Prescription Drugs will be payable under the separate Prescription Drug Benefit section of this Plan. Not all prescriptions are covered under this Plan, see below for further information. Drug purchases by a Plan Participant at an on-line pharmacy outside of the United States will not be covered.

**(38) Preventive Care.** Covered Expenses under Medical Benefits are payable for routine Preventive Care as described in the Medical Benefits Schedule. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force or as otherwise identified in applicable law. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    - Breastfeeding support, supplies, and counseling.
    - Gestational diabetes screening.

Standard Preventive Care includes women's contraceptives sterilization procedures, and counseling.

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:

- https://www.healthcare.gov/preventive-care-adults/

**Charges for Routine Well Adult Care.** Routine well adult care is care by a Physician that is not for an Injury or Illness.

**Charges for Routine Well Child Care.** Routine well childcare is routine care by a Physician that is not for an Injury or Illness. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for Children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

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

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:

- https://www.healthcare.gob/preventive-care-children/ https://www.healthcare.gov/preventive-care-children/https://www.healthcare.gov/preventive-care-children/

**(39) Private Duty Nursing.** Private duty nursing (Inpatient only).

**(40) Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes.

**(41) Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan.

**(42) Second Surgical Opinions.** Charges for second surgical opinions.

**(43) Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a convalescent care facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, intellectual disability or other Mental or Nervous Disorders) for which the Plan Participant is confined.

**(44) Smoking Addiction.** Nicotine withdrawal programs and facilities.

**(45) Speech Therapy.** Covered Expenses will be allowed for rehabilitation purposes, by a Physician or qualified speech therapist, when needed due to an Illness or Injury (other than a functional Nervous Disorder) or due to surgery performed as the result of an Illness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders.

**(46) Spinal Manipulation/Chiropractic.** Services provided by a licensed M.D., D.O. or D.C. and will be subject to Medical Necessity and non-maintenance care and will be payable up to the limits as stated in the Medical Benefits Schedule.

**(47) Sterilization Procedures.** Charges for male and female sterilization procedures. Benefits for all Food and Drug Administration (FDA) approved charges related to sterilization procedures for women are covered under Preventive Care, to the extent required by the Affordable Care Act (ACA).

**(48) Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

- Charges for multiple surgical procedures will be a Covered Expense subject to the following provisions:
    - If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Customary Charge that is allowed for the primary procedures; 50% of the Usual and Customary Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the Diagnosis will be considered "incidental" and no benefits will be provided for such procedures. If bi-lateral or multiple procedures through separate incisions are performed, no more than 75% of Usual and Customary will be allowed. If the procedure being performed is exempt from “multiple procedure guidelines” according to the CPT guidelines, procedures will be payable at the normal rate based on Usual and Customary Charges.
    - If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed 125% of the Usual and Customary percentage allowed for that procedure. Each surgeon will receive 50% of the 125% allowed; and
    - For Tubal Ligation performed at the same time as a cesarean section, the procedure will be allowed at 50% of the Usual and Customary fee allowance, payable as allowed in the Medical Benefits Schedule.
    - For tubal ligation performed at the same time as a vaginal delivery, the procedure will be allowed at 100% of the Usual and Customary fee allowance, payable as allowed in the Medical Benefits Schedule.
    - If an M.D. Assistant surgeon is required; the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Customary allowance.
    - If a P.A., R.N. or N.P. Assistant surgeon is required; the assistant surgeon's covered charge will not exceed 12% of the surgeon's Usual and Customary allowance.

**(49) Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist.

**(50) Telehealth and Other Communication-Based Technology Services**. Participants can communicate with their doctors or ce1iain other practitioners without going to the doctor's office in person. This is recommended if a Participant believes he or she has COVID-19 symptoms.

**(51) Temporomandibular Joint Disorder.** Charges for the surgery of Temporomandibular Joint Disorder are covered under this Plan.

**(52) Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

- Bone marrow.
- Heart.
- Lung.
- Heart and lung.
- Liver.
- Pancreas.
- Kidney.
- Cornea.

In addition, the Plan will cover any other transplant that is not Experimental.

Recipient Benefits

Covered Expenses will be considered the same as any other Sickness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered Expenses include:

a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part.
b. Services and supplies furnished by a Provider.
c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant described herein will be covered. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

When both the person donating the organ and the person receiving the organ are Plan Participants, each will receive benefits under the Plan.

Donor Benefits

The Plan covers donation-related services for actual or potential donors, whether or not they are Plan Participants, as long as the transplant recipient is a Plan Participant. The Plan will cover these costs, provided such costs are not covered in whole or in part by any other source other than the donor's family or estate. This includes, but is not limited to, other insurance, including self-funded medical plans, grants, foundations, and government programs. If a Plan Participant is donating the organ to a person who is not a Plan participant under this Plan, Benefits are not available under this Plan. Benefits provided to the donor will be charged against the Plan Participant's coverage.

**(53) Urgent Care Center Services.** Services and supplies provided at an urgent care center.

**(54) Coverage of Well Newborn Nursery/Physician Care.** Hospital and Physician nursery care for newborns who are Children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the Child's coverage, and the Child's own Deductible and Coinsurance provisions will apply:

- Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.

- The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:
    - The initial newborn examination and a second examination performed prior to discharge from the Hospital.
    - Circumcision.

***NOTE:*** *The Plan will cover Hospital and Physician nursery care for an ill newborn as any other medical condition, provided the newborn is properly enrolled in the Plan. These benefits are provided under the baby's separate coverage.*

## ARTICLE IX
## CARE MANAGEMENT SERVICES

Neiman Enterprises, Inc. Employee Benefit Plan has contracted with CRITIQUE in order to assist the Plan Participant in determining whether or not proposed services are appropriate. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

**CRITIQUE**
**(888) 272-4002**

A CRITIQUE nurse will assist/contact the Plan Participant to provide:

- Health education
- Individualized support to the patient
- Contacting the family to offer assistance for coordination of medical care needs
- Assisting in obtaining any necessary equipment and services
- Monitoring the response to treatment
- Pre-surgical counseling
- Inpatient care coordination
- Evaluating outcomes

### UTILIZATION REVIEW

Utilization Review is a program designed to help ensure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses. The program consists of:

*Precertification of the* Medical Necessity *for the following listed non-Emergency Services before medical and/or surgical services are provided:*

**If Precertification is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care will be *reduced by $250* and such reduction will not go toward the Maximum Out-of-Pocket Amount.**

The following services require Precertification:

- All Inpatient Stays;
- Chemotherapy and Radiation;
- Clinical Trials;
- Colonoscopies;
- Home Health Care Services;
- Hospice Services;
- Outpatient Surgical Procedures;
- Rehabilitation program (not limited to cardiac, chemical dependency, pain management or pulmonary);
- Skilled Nursing Care; and
- Transplant Services.

The purpose of the program is to determine Medical Necessity, appropriateness, health care setting, and level of care. All services requiring Precertification, as noted in the Summary Plan Description are to be certified in advance by the Utilization Review Department, except for emergencies. The Plan Participant or their representative is required to call the phone number for Precertification located on the back of their ID card for the services specified above at least five (5) working days prior to the services being rendered. The Plan Participant or their representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Precertification determinations.

**If Precertification is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care will be *reduced by $250* and such reduction will not go toward the Maximum Out-of-Pocket Amount.**

If a particular course of treatment or medical service is not certified as Medically Necessary before the Plan Participant receives the care or treatment, it means that the charges for the care or treatment may be subject to a penalty. The Plan Participant is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

**Any reduced reimbursement due to failure to follow Care Management procedures will not accrue toward the Maximum Out-of-Pocket Amount.**

The attending Physician does not have to obtain Precertification 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.

**In order to maximize Plan reimbursements, please read the following provisions carefully.**

**HOW THE UTILIZATION REVIEW PROGRAM WORKS**

**Precertification.** Before a Plan Participant enters a Hospital on a non-Emergency basis or receives other listed medical services, CRITIQUE will, in conjunction with the attending Physician, certify the care as Medically Necessary. A non-Emergency stay in a Hospital is one that can be scheduled in advance.

The Utilization Review program is set in motion by a telephone call from, or on behalf of, the Plan Participant or the treating Provider. Contact CRITIQUE at the number listed above at least five (5) working days before services are scheduled to be provided with the following information.

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an Emergency admission to the Hospital, the patient, patient's family member, Hospital or attending Physician must contact CRITIQUE **as soon as reasonably possible** after the admission.

CRITIQUE will review and make a determination on the Medical Necessity of the care, treatment or service.

**Note:** *Precertification does not guarantee payment of the Claim(s) Incurred during the period of certification. Whether an individual is a Plan Participant, whether a charge is eligible for payment, and how much of a charge is paid are determined after the Claim for the care, treatment or service is received by the Claims Administrator. All Claims are subject to all Plan terms and conditions, limitations, and Exclusions at the time the charges are Incurred. Providers and Plan Participants are informed at the time the Hospital stay is certified that certification from* CRITIQUE *does not guarantee payment of Claims for the same.*

**If Precertification is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care will be *reduced by $250* and such reduction will not go toward the Maximum Out-of-Pocket Amount.**

**Concurrent Review and Discharge Planning.** Concurrent review of a course of treatment and discharge planning from a Hospital are parts of the Utilization Review. CRITIQUE will monitor the Plan Participant's Hospital stay or use

of other medical services and coordinate with the attending Physician, Hospital and Plan Participant either the scheduled discharge or extension of the Hospital stay or extension or cessation of other medical services.

If the attending Physician believes it Medically Necessary for a Plan Participant to receive additional services or to stay in the Hospital for a greater length of time than has been Precertified, the attending Physician must request the additional services or days.

**CASE MANAGEMENT AND ALTERNATIVE BENEFIT**

If a Plan Participant has an ongoing medical condition or catastrophic Illness, a Case Manager may be assigned to monitor this Plan Participant, and to coordinate with the attending Physician and Plan Participant to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the Plan Participant, the family, and the attending Physician to assist in coordinating a Plan of Care approved by the Plan Participant's attending Physician and the Plan Participant.

Case Management is a voluntary program of the Plan. If the Plan Participant chooses not to participate in the Case Management program, there will be no reductions of benefits or penalties.

Each treatment plan is individualized to a specific Plan Participant and is not appropriate or recommended for any other patient, even one with the same Diagnosis. All treatment and care decisions will be the sole determination of the Plan Participant and the attending Physician.

**Alternative Benefit.** The Plan may elect, in its sole discretion, to allow for alternative benefits that are otherwise excluded under the Plan. The Plan's decision to allow alternative benefits shall be determined on a case-by-case basis in conjunction with the treating Provider and the Plan Participant. The Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Plan Participant, nor shall it be deemed to waive the right of the Plan Administrator to strictly enforce the provisions of the Plan

**The Alternative Benefit must be beneficial to both the Plan Participant and the Plan.** Alternative benefits, if approved by the Plan Administrator, are subject to all applicable Plan terms and conditions, limitations and Exclusions at the time the charges are Incurred. Once agreement has been reached, the Plan Administrator or its delegate will direct the Claims Administrator to reimburse for Medically Necessary expenses as stated in the alternative treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses Incurred in connections with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

## ARTICLE X
## DENTAL BENEFITS

The Deductible amount, if any, which is listed above, is the amount each Plan Participant must pay each Calendar Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and exclusions set forth in this section. Dental and orthodontic expense benefits are separate from and in addition to the medical benefits of this Plan. These benefits are available to all eligible Employees and Dependents.

COVERED EXPENSES

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Dental Benefits Schedule. Charges must be for services and supplies customarily employed for treatment of the dental condition and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary fees.

**(1) Class 1 Services (Preventative)**

- **a.** Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), twice per Calendar Year.
- **b.** Periapical x-rays, as required, and bitewing x-rays twice per Calendar Year.
- **c.** Sealants for Dependent Children under age nineteen (19), on the occlusal surface of a permanent posterior tooth, once per tooth.
- **d.** Topical application of fluoride for Dependent Children under age nineteen (19), but not more than twice per Calendar Year.
- **e.** Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children under age fourteen (14). No payment will be made for duplicate space maintainers.
- **f.** Full mouth x-rays, but not more than once in any period of thirty-six (36) consecutive months.
- **g.** Panoramic x-rays, but not more than once in any period of thirty-six (36) consecutive months.

**(2) Class 2 Services (Basic)**

- **a.** All Medically Necessary x-rays.
- **b.** Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible.
- **c.** Simple extractions.
- **d.** Endodontics, including pulpotomy, direct pulp capping and root canal treatment.
- **e.** Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant.
- **f.** Periodontal examinations, treatment and surgery.
- **g.** Consultations.
- **h.** Repair or re-cementing of crowns, inlays, bridgework or dentures and relining of dentures.
- **i.** Oral surgery.
- **j.** Extractions in connection with orthodontic services.
- k. Fillings, other than gold.
- **l.** Palliative Emergency treatment of an acute condition requiring immediate care.
- **m.** Periodontal scaling and root planing.
- **n.** Antibiotic drugs.

**(3) Class 3 Services (Major)**

Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered only when a Plan Participant has been covered continuously for at least twelve (12) months, unless otherwise required by applicable law.

- **a.** Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth.
- **b.** Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
  - **i.** Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable.
  - **ii.** Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months.
- **c.** Stainless steel crowns.

**(4) Class 4 Services (Orthodontia)**

Orthodontic services will be eligible only when provided to covered Dependents who are under age nineteen (19) when treatment is received.

- **a.** Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan.
- **b.** Interceptive, interventive or preventive orthodontic services.
- **c.** Fixed and removable appliance placement, and active treatment per month after the first month.

**EXCLUSIONS AND LIMITATIONS**

The following exclusions and limitations are in addition to others outlined within this Plan.

**(1) Adjustments.** Charges arising from alteration of dimension or occlusion; to address damage arising from abrasion or attrition; splinting and/or temporomandibular joint disturbances.

**(2) Administrative Costs.** For administrative costs of completing claim forms or reports or for providing dental records.

**(3) After the Termination Date.** The Plan will not pay for services or supplies furnished after the date coverage terminates. Predetermination of an allowable course of treatment and eligible services (claims for which coverage would be in effect had coverage not terminated) will not extend coverage beyond termination. The Plan will pay for a prosthetic device, crown, such as full or partial dentures, if the preparatory steps (such as an impression) had already initiated and/or been prepared for said device or crown, while the patient was a Participant in the Plan; so long as the device or crown is delivered and installed within two months following termination of coverage, as well as root canal therapy if the Dentist opened the tooth while the patient was a Participant, and treatment is completed within two months of coverage termination.

**(4) Anesthetic**. Local infiltration anesthetic when billed for separately by a Dentist.

**(5) Broken Appointments.** For charges for broken or missed dental appointments.

**(6) Cosmetic.** Charges for cosmetic dental work, exclusive of orthodontic treatment if otherwise eligible for coverage, but inclusive of personalization or characterization of dentures or veneers or any cosmetic procedures or supplies.

**(7) Crowns.** Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.

**(8) Education.** Charges solely arising from instruction provided regarding oral health and/or diet, including a plaque control program.

**(9) Experimental.** That are Experimental or Investigational, based upon standards set by the American Dental Association.

**(10) Hygiene.** For oral hygiene, plaque control programs or dietary instructions.

**(11) Implants.** For implants, including any appliances and/or crowns and the surgical insertion or removal of implants except, first-time non-cosmetic dental implants.

**(12) Late Enrollee.** Charges Incurred during the first twenty-four (24) months of coverage applicable to a late enrollee. This exclusion shall not apply to such claims arising from or due to an Accidental Injury sustained by the Plan Participant. "Late enrollee" means a person who enrolls for coverage during an annual enrollment period because he or she failed to enroll when first eligible for coverage or during a special enrollment period.

**(13) Medical Benefits.** For charges covered under the "Medical Benefits" section of the Plan.

**(14) Miscellaneous.** The Plan does not cover any dental charge, service or supply not provided by a Dentist or Physician unless it is: (1) specifically for non-Experimental services performed at a dental school under the supervision of a Dentist, and only if the school customarily charges patients for its services, or (2) specifically for cleaning, scaling and/or application of fluoride, and is performed by a licensed dental hygienist under the supervision of a Dentist.

**(15) Missing Appliances.** The cost of replacing lost, missing or stolen supplies, including implants, appliances, and prosthetics.

**(16) More Expensive Course of Treatment.** The aforementioned rules regarding Medical Necessity, Usual and Customary, and the least costly yet equally effective treatments shall apply here as well.

**(17) No Listing.** For services which are not included in the list of covered dental services.

**(18) Not Recommended.** Charges for services or supplies not administered in accordance with a Dentist or Physician's approval.

**(19) Orthognathic Surgery.** For surgery to correct malposition's in the bones of the jaw.

**(20) Personalization.** For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.

**(21) Replacements.** Charges for replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge, made within five years after the last placement, exclusive of replacement necessitated by damages caused by an Accidental Injury sustained by the Plan Participant, resulting in damages that are beyond repair.

**(22) Single Provider Care.** Charges arising from solely the transfer from one Provider's care to another, that would not have been Incurred had one Provider been utilized, and thereby in accordance with the Usual and Customary fee.

**(23) Splinting.** For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

**PRE-DETERMINATION OF DENTAL BENEFITS**

If a planned dental service or Plan Participant's proposed course of treatment can be reasonably expected to involve dental charges of $400 or more, a Plan Participant may submit a description of the procedures to be performed and an estimate of the charges therefore may be filed with the Plan Administrator or Claims Administrator prior to the commencement of the course of treatment. **However, approval is not required prior to treatment.** Any pre-determination of dental benefits is provided only as a convenience to the Plan Participant.

If requested, the Plan Administrator or Claims Administrator will notify the Employee, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post service claim, which will be subject to all applicable Plan provisions.**

## ARTICLE XI
## DEFINED TERMS

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

**Accident** means a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

**Accidental Bodily Injury** or **Accidental Injury** means an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

**Active Employment** means an Employee who on any day performs in the customary manner all of the regular duties of employment. An Employee will be deemed active on each day of a regular paid vacation or on a regular non-working day on which the covered Employee is not Totally Disabled, provided the covered Employee was working on the last preceding regular workday. An Employee shall be deemed active if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan's leave of absence provisions. An Employee will not be considered under any circumstances active if he or she has effectively terminated employment.

**ADA** shall mean the American Dental Association.

**Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a Claim that is based on any: (a) determination of an individual's eligibility to participate in a Plan or health insurance coverage; (b) determination that a claimed benefit is not a Covered Expense; (c) imposition of a source-of-injury Exclusion, or other limitation on otherwise Covered Expenses; (d) determination that a claimed benefit is Experimental, Investigational, or not Reasonable, Medically Necessary or appropriate; (e) invalid charges; or (f) improper balance, or (g) as otherwise defined in the Plan Document..

**Affordable Care Act (ACA)** means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

**AHA** shall mean the American Hospital Association.

**Allowable Expense(s)** means the Maximum Allowable Charge for any Medically Necessary, Reasonable eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the Reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, means the allowable benefit. Benefits payable under any Other Plan include the benefits that would have been payable had a claim been made.

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

**AMA** shall mean the American Medical Association.

**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.

**Approved Clinical Trial** means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an Approved Clinical Trial, the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an Approved Clinical Trial and either the individual's Physician has concluded that participation is appropriate or the Plan Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include: 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Plan Participant; 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis; 4) and/or items and/or services to be paid for and or provided at no cost from a third party (including but not limited to a manufacturer.)

**Assignment of Benefits** shall mean an arrangement whereby the Participant, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less Deductibles, co-payments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and Deductibles, co-payments and the coinsurance percentage that is the responsibility of the Participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Participant as the sole beneficiary.

**Authorized Representative** is a person designated by the Claimant to act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be made in writing, signed and dated by the Claimant, and include all information required in the Authorized Representative form.

**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 Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific Drug manufacturer; or (2) that the PBM identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify Drugs as either brand or Generic based on a number of factors. You should know that all products identified as a Brand Name by the manufacturer, Pharmacy, or your Physician may not be classified as Brand-name by the PBM.

**Calendar Year** is the 12-month period beginning on January 1st and ending the following December 31st.

**Cardiac Care Unit** shall mean a separate, clearly designated service area which is maintained within a Hospital, and which meets all the following requirements:

**(1)** It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.

**(2)** It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.

**(3)** It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.

**(4)** It contains at least two beds for the accommodation of critically ill patients.

**(5)** It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

**(6)** The ICU is staffed by a multidisciplinary continuously overseen by an intensivist, a board-certified physician with specialized training and expertise in critical care medicine.

**(7)** The intensivist provides 24/7 onsite supervision, ensuring immediate clinical decision-making, coordination of care, and utilization of advanced life-support technologies to optimize patient outcomes.

**CDC** shall mean Centers for Disease Control and Prevention.

**Centers of Excellence** are defined under this Plan as those Hospitals participating in a Transplant Centers of Excellence network. Contact the Claims Administrator, Rocky Mountain Administrators (RMA) at (307) 347-2606 or (800) 383-8808 immediately upon learning you are a candidate for a transplant for complete details on the Transplant Centers of Excellence, second opinion, Precertification, etc.

**Child and/or Children** means the Employee's natural Child, any stepchild, legally adopted Child, or any other Child for whom the Employee has been named Legal Guardian, or an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

**CHIP** refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

**CHIPRA** refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

**Chiropractic Care** shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

**Claim Determination Period** shall mean each Calendar Year.

**Claimant** means a Plan Participant or an Authorized Representative of a Plan Participant making a claim or for whom a claim is made.

**Claims Administrator** is Rocky Mountain Administrators (RMA).

**Clean Claim** means one that can be processed in accordance with the terms of this Plan without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this Plan, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this Plan, and only as permitted by this Plan, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity, or fees under review for Maximum Allowable Charge or any other

matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this Plan.

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

**CMS** shall mean Centers for Medicare and Medicaid Services.

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

**Coinsurance** means a cost sharing feature of many plans. It requires a Plan Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Plan Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for Covered Services.

**Copayment or Copay** means the specified dollar amount that a Plan Participant must pay each time certain medical care is provided, as specified in the Medical Benefits Schedule.

**Cosmetic Dentistry** means dentally unnecessary procedures.

**Cosmetic Surgery** Charges for any treatment for cosmetic purposes or for cosmetic surgery are not a covered expense. Except that the Plan will pay for cosmetic treatment or surgery if:

- **(1)** due solely to an accidental bodily injury which occurred while the individual was continuously covered under a medical Plan at the time the injury occurred: or
- **(2)** due solely to a birth defect of an individual who was continuously covered under a medical Plan from the date of his or her birth: or
- **(3)** due solely to surgical removal of all or part of the breast tissue as a result of an illness.

If services are in connection with a mastectomy and breast reconstruction is elected, coverage will be provided for the following:

- **(1)** reconstruction of the breast on which the mastectomy has been performed;
- **(2)** surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- **(3)** prostheses and physical complications for all stages of mastectomy, including lymphedemas;

**Covered Expense(s)/Covered Service(s)** are Provider charges for Covered Services. Covered Expenses are billed charges minus non-Covered Expenses and invalid charges. Covered Expenses also means a Reasonable fee for an appropriate, Medically Necessary service, treatment or supply, meant to improve a condition or Plan Participant's health, which is specified in this Plan as a Covered Expense. Covered Expenses will be determined based upon all other Plan provisions.

All treatment is subject to benefit payment maximums shown in the Medical Benefits Schedule (Article III) and as determined elsewhere in this Plan.

**Custodial Care** means 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.

**Deductible** means an amount of money that is paid once a Calendar Year per Plan Participant and Family Unit.

Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any medical care.

**Dentist** means a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

**Dependent(s)** means the covered Employee's eligible family members as outlined in Article VI.

**Diagnosis** means the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of Plan Participant history, examination, and review of laboratory data.

**Diagnostic Service** shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a Disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

**Disease** means any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any worker's compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness or Disease.

**Drug** shall mean a Food and Drug Administration (FDA) approved drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

**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.

**Emergency** means a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn Child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

**Emergency Medical Condition** shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

**Emergency Services** means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a medical emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

**Employee** shall mean a person who is employed by the Employer on a full-time basis and regularly scheduled to work at least Thirty (30) hours per week hours per week (i.e. Non-variable Hour Employee) or a Variable Hour Employee who has averaged at least Thirty (30) hours per week for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Patient Protection and Affordable Care Act (as amended).

**The following definitions are associated with the Code Section 4980H (Employer Shared Responsibility) as enacted under the Affordable Care Act:**

**Full-time Employee** or Full-time Employment shall mean, with respect to a calendar month, an Employee who is employed an average of at least Thirty (30) hours per week hours per week with the Employer.

**Hour of Service** shall mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the employer; and each hour for which an Employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

**Measurement Period** shall mean a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's Hours of Service are tracked to determine his or her employment status for benefit purposes.

- Initial Measurement Period - for a newly hired Variable Hour Employee, this Measurement Period will start from the date of hire and ends after consecutive months of service.

**New Employee** shall mean an Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero Hours of Service.

**Non-variable Hour Employee** shall mean an Employee reasonably expected at the time of hire to work Thirty (30) hours per week.

**Ongoing Employee** shall mean an Employee who has been employed by the Employer for at least one complete Measurement Period.

**Stability Period** shall mean a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period, and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is a period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

**Variable Hour Employee** shall mean an Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined.

**Employer** is each participating Employer associated with Neiman Enterprises, Inc.

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

**Errors** mean any billing mistakes or improprieties including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or medical care not actually rendered or performed, or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard.

**Essential Health Benefits** shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse

disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Excess Charges** means a charge or portion thereof billed for care and/or treatment of an Illness or Injury that is not payable under the terms of the Plan because it exceeds the Maximum Allowable Charge, or is determined by the Plan Administrator to be based on Invalid Charges or Errors as defined by this Plan Document. Also, charges for a service or supply furnished by a direct contract Provider in excess of the applicable negotiated rate.

**Exclusion** means conditions or services that this Plan does not cover.

**Experimental and/or Investigational** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

**(1)** If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

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

**(3)** *Except as provided under the Clinical Trial benefit in the Medical Benefits section of the Covered Expenses section*, if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or Diagnosis; or

**(4)** If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or Diagnosis.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

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

**FDA** means the Food and Drug Administration.

**Final Internal Adverse Benefit Determination** means an Adverse Benefit Determination that has been upheld by the

Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

**FMLA** means the Family and Medical leave Act of 1993, as amended.

**FMLA Leave** means an unpaid, job protected leave of absence for certain specified family and medical reasons, which an Employer may be required to extend to an eligible Employee under the provisions of the FMLA.

**GINA** shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information. Genetic Information Nondiscrimination Act – is an Act of Congress in the United States designed to prohibit the improper use of genetic information in health insurance and employment. The Act prohibits group health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individuals' genetic information when making, hiring, firing, job placement, or promotion decisions.

**Habilitation/Habilitative Services** shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**HIPAA** shall mean the Health Insurance Portability and Accountability Act of 1996, as amended. A Federal law that restricts access to individual's private medical information.

**Home Health Care** shall mean the continual care and treatment of an individual if all of the requirements are met:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician.
3. The Home Health Care is the result of an Illness or Injury.

**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.

**Home Health Care Agency** shall mean an agency or organization which provides a program of Home Health Care, and which meets one of the following requirements:

**(1)** Is a Federally Certified Home Health Care Agency and approved as such under Medicare.
**(2)** Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.
**(3)** Meets all of the following requirements. a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home.
    a. It has a full-time administrator.
    b. It maintains written records of services provided to the patient.
    c. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available.
    d. Its employees are bonded, and it provides malpractice insurance.

**Hospital** means an Institution that meets all of the following requirements:

**(1)** It provides medical and surgical facilities for the treatment and care of injured or sick persons on an Inpatient

basis;

**(2)** It is under the supervision of a staff of Physicians;

**(3)** It provides 24-hour nursing service by Registered Nurses (R.N.);

**(4)** It is duly licensed as a Hospital, except that this requirement will not apply in the case of a State tax supported Institution;

**(5)** It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training type Institution, or an Institution which is supported in whole or in part by a Federal government fund;

**(6)** It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA;

**(7)** The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA; and

**(8)** In addition to those facilities that meet all of the requirements above, the definition of "Hospital" for purposes of this document, unless otherwise specifically stated, shall also include any facility that solely provides medical care on an Outpatient basis whether affiliated with a Hospital as defined above or not ("independent facilities"), including but not limited to an Ambulatory Surgical Center.

**HRSA** shall mean Health Resources and Services Administration.

**Illness** means a bodily disorder, Disease, physical sickness or Mental or Nervous Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

**Impregnation and Infertility Treatment** shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

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

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

**Inpatient** means a Plan Participant who receives medical care at a Hospital and is admitted as a registered overnight bed patient.

**Institution** means a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse treatment center, alternative birthing center, or any other such facility that the Plan approves.

**Intensive Care Unit shall have the same meaning set forth in the definition of "Cardiac Care Unit."**

**Lawfully Married Spouse** shall mean the legally and formally recognized union of a man and a woman, or two people of the same sex, as partners in a relationship.

**Leave of Absence** shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer's rules, policies, procedures and practices where applicable.

**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.

**Legal Separation** shall mean an arrangement to remain married but live apart, following a court order.

**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.

**Lumpectomy** means the surgical removal of a small tumor, which may be benign or cancerous.

**Mastectomy** means the surgical removal of all or part of a breast.

**Maximum Allowable Charge** will be a negotiated rate, if one exists. In the absence of a negotiated rate, the Maximum Allowable will be calculated by the Plan Administrator taking into account any or all of the following:

**(1)** The Usual and Customary amount.
**(2)** The Reasonable charge specified under the terms of the Plan.
**(3)** The allowable charge specified under the terms of the Plan.
**(4)** The actual billed charges for the covered services.

The Plan has the discretionary authority to decide if a charge is Usual and Customary and for Medically Necessary and Reasonable service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

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

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

**Medically Necessary/Medical Necessity** refers to medical care ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, Diagnosis or treatment of that Plan Participant's Illness or Injury. For such medical care to be considered Medically Necessary, it must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Plan Participant's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. For such medical care to be considered Medically Necessary it must be no more costly than alternative interventions and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Plan Participant's Illness or Injury without adversely affecting the Plan Participant's medical condition. In order for a service to be considered Medically Necessary: (a) it must not be maintenance therapy or maintenance treatment; (b) its purpose must be to restore health; (c) it must not be primarily custodial in nature.

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

To be Medically Necessary, all of these criteria must be met. The determination of whether medical care, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors or medical advisors to the Claims Administrator. The Plan Administrator has the ultimate discretionary authority to determine whether care or treatment is or was Medically Necessary.

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

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

**(1)** The drug is approved by the Food and Drug Administration (FDA).

**(2)** The prescribed drug use is supported by one of the following standard reference sources:

a. Micromedex® DRUGDEX®.

b. The American Hospital Formulary Service Drug Information.

c. Medicare approved compendia.

d. Scientific evidence is supported in well-designed Approved Clinical Trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

**(3)** The drug is otherwise Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

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

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

**Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA** shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

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

**Mental or Nervous Disorder** means any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**Morbid Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person. The term "Morbid Obesity" shall mean a condition in which the presence of excess weight causes physical trauma; where pulmonary and circulatory insufficiencies are present; where complications related to the treatment of conditions such as arteriosclerosis, diabetes, coronary disease, etc. are present.

**National Medical Support Notice (NMSN)** means a notice that contains all of the following information:

**(1)** The name of an issuing State child support enforcement agency.
**(2)** The name and mailing address (if any) of the Employee who is a Plan Participant under the Plan or eligible for enrollment.
**(3)** The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Plan Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
**(4)** Identity of an underlying child support order.

**Network** shall mean the facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms they have agreed to accept Assignment of Benefits, and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant's identification card.

**No-Fault** Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile Accidents.

**Nurse** shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

**Open Enrollment Period** shall mean the period of August 1st through August 31st.

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

**Out-Of-Pocket Expense** means the cost to the covered person for deductibles, coinsurance, co-payments, penalties and non-covered expenses. Out-of-pocket expenses do not include amounts which are in excess of the allowable claim limits as defined in the section, "Claim Review and Audit Program.

**Outpatient** means a Plan Participant who receives medical care at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than 24 hours.

**Partial Hospitalization** is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

**Patient Protection and Affordable Care Act (PPACA)** means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

**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.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Naturopathic Doctor (N.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means the Neiman Enterprises, Inc. Employee Benefit Plan which is a benefits plan for certain Employees, and Dependents of Neiman Enterprises, Inc.

**Plan Administrator or Plan Sponsor** means Neiman Enterprises, Inc.

**Plan of Care** is a written plan that describes the services being provided and any applicable short term and long-term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Participant's condition changes.

**Plan Participant** means an Employee, a Dependent, a COBRA Qualified Beneficiary, a COBRA Qualified Beneficiary's Dependent or other person meeting the eligibility requirements for coverage as specified in the Plan, and who is properly enrolled in the Plan.

**Plan Year** means starting August 1st and ending the following July 31st.

**Pre-admission Tests** shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that all of the following requirements are met:

**(1)** The Participant obtains a written order from the Physician.
**(2)** The tests are approved by both the Hospital and the Physician.
**(3)** The tests are performed on an outpatient basis prior to Hospital admission.
**(4)** The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

**Precertification** means a decision by the Plan that a health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary. The Plan may require Precertification for certain services before the Plan Participant receives them, except in an Emergency.

**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 an Illness or Injury.

**Prior Plan** shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

**Prior to Effective Date or After Termination Date** are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless continuation of benefits applies.

**Privacy Standards** shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

**Provider** shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

**Psychiatric Hospital** shall mean an Institution, appropriately licensed as a Psychiatric Hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. As such, to be deemed a "Psychiatric Hospital," the Institution must ensure every patient is under the care of a Physician and their staffing pattern must ensure the availability of a Registered Nurse 24 hours each day. Should the Institution fail to maintain clinical medical records on all patients permitting the determination of the degree and intensity of treatment to be provided, that Institution will not be deemed to be a "Psychiatric Hospital."

To be deemed a "Psychiatric Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

**Reasonable and/or Reasonableness** means in the Plan Administrator's discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider's error or mistake. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) the national medical associations, societies, and organizations; (b) the Centers for Medicare and Medicaid Services (CMS) and (c) the Food and Drug Administration. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

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

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

**Rehabilitation Hospital** shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Sickness and/or Injury. To be deemed a "Rehabilitation Hospital," the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a "Rehabilitation Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

**Room and Board** shall mean a Hospital's charge for any of the following:

**(1)** Room and complete linen service.
**(2)** Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation.
**(3)** All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
**(4)** Other conditions of occupancy which are Medically Necessary.

**Scheduled Benefit or Scheduled Benefit Amount** shall mean a specified dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled Benefits are based upon Covered Expenses not otherwise limited or excluded under the terms of the Plan.

**Security Standards** shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

**Service Waiting Period** shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

**Sickness** shall have the meaning set forth in the definition of "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 Illness. 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, mentally disabled, Custodial or educational care or care of Mental or Nervous Disorders; and

**(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, long-term acute care facility or any other similar nomenclature.

**Specialty Pharmaceuticals** are those federal legend drugs that are any drug, regardless of route of administration which are classified by the pharmacy benefit manager as "Specialty" Medications. A drug is considered a "Specialty" medication if it includes one or more of the following characteristics:

- Requires patient participation in a medication management program that includes review of medication use, patient training, coordination of care and management for successful use.
- Continual monitoring and training is needed.
- An FDA-mandated Risk Evaluation and Mitigation Strategy program is utilized in order to approve medication.
- Medication has particular handling, distribution and/or administration requirements.

- Medication has a high cost.
- Medication is administered orally, inhaled, infused or injected.
- Medication is used to target chronic or complex diseases.
- Medication can be produced through biological processes.
- Medication is used to treat rare diseases and is referred to as orphan drugs

**Substance Abuse** means any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

**(1)** A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
   a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
   b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
   c. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
   d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

**(2)** The symptoms have never met the criteria for Substance Dependence for this class of substance.

**Substance Abuse Treatment Center** shall mean an Institution whose facility is licensed, certified or approved as a Substance Abuse treatment center by a Federal, State, or other agency having legal authority to so license; which is affiliated with a Hospital and whose primary purpose is providing diagnostic and therapeutic services for treatment of Substance Abuse. To be deemed a "Substance Abuse Treatment Center," the Institution must have a contractual agreement with the affiliated Hospital by which a system for patient referral is established, and implement treatment by means of a written treatment plan approved and monitored by a Physician. Where applicable, the "Substance Abuse Treatment Center" must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

**Substance Dependence** shall mean substance use history which includes the following: (1) Substance Abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

**Surgery** shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.

**Surgical Procedure** shall have the same meaning set forth in the definition of "Surgery."

**Third Party Administrator** shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

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

**Urgent Care Claim** means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination could seriously jeopardize the life or health of the Plan Participant or the Plan Participant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Plan Participant's medical condition, would subject the Plan Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

**Uniformed Services** shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

**USERRA** shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

**Waiting Period** means the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

**All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear**.

## ARTICLE XII
## MEDICAL PLAN EXCLUSIONS

**Note: All Exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.**

**For all Medical Benefits shown in the Medical Benefits Schedule, a charge for the following is not covered:**

**(1) Abortion.** Services, supplies, care or treatment in connection with an elective abortion except as outlined under Covered Expenses.

**(2) Acupuncture.** Charges related directly or indirectly to acupuncture.

**(3) Adoption Expenses.** Expenses not covered include, but are not limited to court costs, expenses related to the natural mother and expenses for the child prior to the placement for adoption.

**(4) Administrative Costs.** Charges for completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.

**(5) Alcohol.** Involving a Plan Participant who has taken part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Plan Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

**(6) Biofeedback.** Care, services, supplies and treatment in connection with biofeedback.

**(7) Complications of Non-Covered Services.** That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

**(8) Confined Persons.** That are for services, supplies, and/or treatment of any Plan Participant that were Incurred while confined and/or arising from confinement in a prison, jail or other penal Institution.

**(9) Consultations.** Charges for consultations.

**(10) Cosmetic Surgery.** That are incurred in connection with the care and/or treatment of surgical procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

**(11) Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except as specifically stated as a benefit under this Plan.

**(12) Education or Training Program.** Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

**(13) Educational or Vocational Testing.** Services for educational or vocational testing, training or care for learning disorders or behavioral problems whether or not associated with a manifest mental disorder or other disturbance will not be covered.

**(14) Excess Charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Maximum Allowable Charge.

**(15) Exercise Programs.** Exercise programs for treatment of any condition, except as a part of an approved Physician-supervised rehabilitation therapy program.

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

**(17) Eye Care.** Radial keratotomy, Lasik surgery, or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting except as specifically stated as a benefit under this Plan or for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease of Injury.

**(18) Foreign Travel.** Charges for services that are received outside of the United States if travel is for the sole purpose of obtaining medical services.

**(19) Genetic Counseling.** Charges for genetic counseling or tests to determine the sex or characteristics of an unborn Child are not covered, except if one of the following conditions applies, the testing only would be covered, if:

- **a.** Mother is age 35 or older at delivery;
- **b.** Close relative with a neural tube defect;
- **c.** Fetal sex for x-linked disease;
- **d.** Family history of metabolic disorders and disorders for which Restriction Fragment Length Polymorphism (RFLP) diagnostic testing is available;
- **e.** Previous trisomic infant;
- **f.** Parental translocations;
- **g.** Hemoglobinopathics;
- **h.** Significant abnormality suspected in ultrasound examination;
- **i.** Elevated or low maternal serum Alpha-Fetoprotein determination

**(20) Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This Exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

**(21) Hair Loss.** Services or supplies in connection with hair loss, including drugs or medications, hair transplants or wigs except as specifically stated as a benefit under this Plan.

**(22) Hazardous Pursuit, Hobby or Activity.** That is of an Injury or Illness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Plan Participant's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm **including but not limited to:** rock climbing, hang gliding, skydiving, bungee jumping, parasailing, motorized vehicle racing, use of explosives, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings. The Plan Administrator has the full discretionary authority to determine if a pursuit, hobby, and/or activity is considered hazardous.

**(23) Hearing Aids.** Charges for hearing aids or examination for the prescription, fitting, and/or repair of hearing aids.

**(24) 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.

**(25) Hypnosis.** Charges for hypnosis or hypnotherapy.

**(26) Illegal Acts.** Charges for services received as a result of Injury or Illness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this Exclusion, the term "Serious Illegal Act" means any act or series of acts that, if prosecuted as a criminal offense, could result in a crime being charged as a misdemeanor or felony under applicable state or federal law. It is not necessary that criminal charges be filed, or, if filed, that a conviction result be imposed for this Exclusion to apply. Proof beyond a reasonable doubt is not required. This Exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

**(27) Illegal Drugs or Medications.** Charges that are for services, supplies, care or treatment to a Plan Participant for Injury or Illness Incurred while the Plan Participant was voluntarily taking or was under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. This Exclusion will apply even if the Plan Participant has a prescription for the drug and the drug is legal in the state where the Plan Participant lives. Expenses will be covered for Injured Plan Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

**(28) Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence or sexual dysfunction.

**(29) Incurred by Other Persons.** Charges that are for Expenses actually Incurred by other persons.

**(30) Infertility.** Services and supplies relating to treatment for infertility including, among other things, artificial insemination; in-vitro fertilization; embryo or ovum transfer procedures; any other assisted reproduction procedure; surrogate parenting; prescription drugs designed to achieve pregnancy; ultrasounds for egg harvest and services to reverse voluntary sterilizations. Diagnosis and treatment of the underlying cause of infertility is covered.

**(31) Marital, Pre-marital or Family Counseling.** Treatment or services for marriage or pre-marital counseling and similar types of services which are defined as any act of providing psychotherapy to avoid or relieve family or marital discord, divorce, preparation for marriage, encounter groups, parental counseling, treatment for situational disturbances such as financial or environmental problems or other types of everyday stresses or strains.

**(32) Massage Therapy.** Massage Therapy will not be considered eligible unless when a part of an overall patient treatment.

**(33) Medicare.** Charges that are provided, or which would have been provided had the Plan Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled “Coordination of Benefits” and “Medicare.”

**(34) Military Service.** That are related to conditions determined by the Veteran’s Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

**(35) Missed Appointments.** Charges Incurred for failure to keep a scheduled appointment.

**(36) Negligence.** That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

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

**(38) Non-Compliance.** All charges in connection with treatments or medications where the patient either is in noncompliance with medical orders issued while an Inpatient at, or is discharged against medical advice from a Hospital or Skilled Nursing Facility against medical advice.

**(39) Non-Emergency Hospital Admissions.** Care and treatment billed by a Hospital for non-medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

**(40) Non-Prescription Drugs.** Charges for drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act.

**(41) No Obligation to Pay.** Charges Incurred for which the Plan has no legal obligation to pay.

**(42) No Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

**(43) Not Acceptable.** Charges that are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

**(44) Not Covered Provider.** Charges for services that are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

**(45) Not Specified as Covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

**(46) Nutritional Supplements and Nutritional Education.** Charges for nutritional supplements and Nutritional Education, except as specified under Preventive Care.

**(47) Obesity.** Care and treatment of obesity, weight loss or dietary control, unless related to morbid obesity (See Guidelines).

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

**(49) Orthopedic Shoes.** Charges for orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge.

**(50) Other than Attending Physician.** Charges that are other than those certified by a Physician who is attending the Plan Participant as being required for the treatment of Injury or Disease and performed by an appropriate Provider.

**(51) Penalties.** Charges that are related to failure to comply with any requirements for coverage under this Plan, or for any Copay amounts identified as a "penalty" in this Plan.

**(52) Personal Comfort Items.** Personal comfort items, patient convenience 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.

**(53) Plan Design Excludes.** Charges excluded by the Plan design as mentioned in this Plan.

**(54) Postage, Shipping, Handling Charges, Etc.** Charges that are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third-Party Administrator; including interest or financing charges.

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

**(56) Provider Error.** Charges that are a result of unreasonable Provider error.

**(57) Radial Keratotomy.** Charges for radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.

**(58) Relative Giving Services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

**(59) Routine Care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the Diagnosis or treatment of a specific Injury, Illness or Pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically covered in the Medical Benefits Schedule or required by applicable law.

**(60) Sales Tax.** Charges for mailing or sales tax.

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

**(62) 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.

**(63) Sex Changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This Exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment, unless required by applicable law.

**(64) Sleep Disorders.** Charges in connection with treatment of sleep disorders unless deemed Medically Necessary.

**(65) Specialty Pharmaceuticals.** Specialty Pharmaceutical Drugs are excluded under this Plan. Notwithstanding the foregoing, the Plan will cover the charges for a Specialty Pharmaceutical Drug for the first 30 day fill of any Specialty Pharmaceutical that is self-administered and filled at a licensed pharmacy or the first dose of any Specialty Pharmaceutical administered in a hospital, facility or provider's office administered by a healthcare professional for each Specialty Pharmaceutical Drug, unless otherwise excluded elsewhere in the Plan.

**(66) Surgical Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.

**(67) Temporomandibular Joint Syndrome.** Charges for the treatment of Temporomandibular Joint Syndrome (TMJ) will not be a Covered Expense under this Plan. TMJ surgery is covered as outlined under the Covered Expenses section within this Plan.

**(68) Travel.** Charges for travel, whether or not recommended by a Physician, except as specifically provided herein.

**(69) Unreasonable.** Charges that are not "Reasonable" and are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

**(70) Vitamins.** Charges for vitamins.

**(71) War or Riot.** Services Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Plan Participant is a member of the armed forces of any Country, or during service by a Plan Participant in the armed forces of any Country. This Exclusion does not apply to any Plan Participant who is not a member of the armed forces and does not apply to victims of any act of war or aggression.

**(72) Workers' Compensation.** Expenses for which Payment is required under applicable Workers' Compensation Statutes are not eligible for Payment under this medical Plan. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance. However, work-related claims for Plan Participants for which Workers' Compensation is not required can be considered for benefits under this Plan.

## ARTICLE XIII
## PRESCRIPTION DRUG BENEFITS

**Participating Pharmacy.** Participating Pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. **ProCareRX** is the administrator of the Pharmacy Drug Plan.

**For prescription claims questions** or to obtain a claim form please call:

**ProCareRX**
**(800) 699-3542 or on the web at www.procarerx.com**

**Prescription Drug Coinsurance.** A Prescription Drug Coinsurance is applied to each covered Pharmacy drug, specialty medication or mail order drug charge after the medical Deductible (as shown in the Medical Benefits Schedule section) has been met. The Plan Participant's Deductible must be met before the Coinsurance amounts will apply.

- *Any one retail Pharmacy prescription is limited up to a 34-day supply.*

If a drug is purchased from a **Participating Pharmacy when the Plan Participant's ID card is not used**, the Plan Participant will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Plan Participant will be required to submit the prescription receipt to **ProCareRX** for reimbursement (less any applicable Copayments and medical Deductible as shown in the Medical Benefits Schedule section).

All specialty drug prescriptions paid for by the Plan through the appeals process must be dispensed/coordinated by **ProCareRX.**

For more information regarding the Specialty Pharmacy Program, please contact:

**ProCareRX**
**1267 Professional Parkway**
**Gainesville, GA 30507**
**(800) 699-3542**

**Specialty Pharmaceuticals.** Reimbursement for Specialty Pharmaceuticals is paid under the Pharmaceutical Benefit. Specialty Pharmaceuticals are those federal legend drugs that are any drug, regardless of route of administration which are classified by the pharmacy benefit manager as "Specialty" Medications. Any drug, regardless of classification, **with a prescription cost of $1250 or more will require clinical review and Prior Authorization.**

**Specialty Pharmaceutical Drugs are excluded under this Plan. Notwithstanding the foregoing, the Plan will cover the charges for a Specialty Pharmaceutical Drug for the first 30 day fill of any Specialty Pharmaceutical that is self-administered and filled at a licensed pharmacy or the first dose of any Specialty Pharmaceutical administered in a hospital, facility or provider's office administered by a healthcare professional for each Specialty Pharmaceutical Drug, unless otherwise excluded elsewhere in the Plan.**

**Mail Order Pharmacy.** The Mail Order Pharmacy benefit is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). For more information regarding the mail order drug benefit option contact **ProCareRX** toll-free at (800) 699-3542.

For more information on Mail Order Pharmacy please contact:

**ProCareRX**
**(800) 699-3542 or on the web at www.procarerx.com**

**Any one mail order prescription is limited up to a 90 day supply.**

Note: Some quantity limitations and/or Prior Authorization may apply.

**PRE-AUTHORIZATION REQUIREMENTS**

The following categories of Prescription Drugs require Prior Authorization.

**(1)** Compound Drugs
**(2)** Specialty Drugs

**COVERED PRESCRIPTION DRUGS**

**(1)** All drugs prescribed by a Physician that require a prescription either by federal or state law, excluding any drugs stated as not covered under this Plan.

**(2) Allergy Sera.** Charges for allergy sera.

**(3) Bee Sting Kits.** Charges for EPI PEN and Ana Kit.

**(4) Blood and Blood Plasma.** Charges for blood and blood plasma.

**(5) Compound Prescriptions.** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

**(6) Contraceptives.** All Food and Drug Administration (FDA)-approved contraceptives Drugs and methods, in accordance with the Health Resources and Services Administration (HRSA) guidelines.

**(7) Diabetes.** Insulin and other injectable **diabetic medications** and the following diabetic supplies, when prescribed by a Physician: lancets, lancet devices, alcohol swabs, blood glucose meters, blood glucose and test strips, blood test strips, and insulin syringes and needles.

**(8) Flonase.** Charges for Flonase Allergy Relief OTC will pay from Tier 2.

**(9) Gleevec.** Gleevec, for treatment of any of the following conditions:

**a.** CML myeloid blast crisis.
**b.** CML accelerated phase.
**c.** CML in chronic phase after failure of interferon treatment.

Prior Authorization is required. In order to obtain such authorization, information from the patients' Physician indicating the condition being treated must be submitted to the Plan.

**(10) Imitrex Injection.** Charges for Imitrex injections (migraine auto-injector).

**(11) Immunologicals.** Charges for immunologicals (vaccines).

**(12) Injectables.** A charge for injectables.

**(13) Legend Drugs.** Charges will be covered for:

**a.** Class V drugs.
**b.** Diabetic supplies.
**c.** Legend drugs with over the counter equivalents.
**d.** Pre-natal vitamins.

**(14) Nasacort.** Charges for Nasacort Allergy 24 Hour OTC.

**(15) Over-the-Counter (OTC) Drugs.** OTC Drugs related to Preventive and Wellness Services as specified by the Affordable Care Act of 2010. A description of these services can be found at:

https://www.healthcare.gov/coverage/preventive-care-benefits/

This includes Food and Drug Administration (FDA)-approved generic Drugs and Over-the-Counter (OTC) Drugs, devices and supplies related to Women's Preventive Services, as specified by the Affordable Care Act of 2010.

A description of FDA-approved contraceptive methods can be found at:

https://www.fda.gov/consumers/womens-health-topics/birth-control

**(16) Prescription Drugs** prescribed when not confined in a Hospital or other facility. Prescription Drugs must be:
- Prescribed on or after the date Coverage begins;
- Approved for use by the Food and Drug Administration (FDA);
- Dispensed by a licensed pharmacist or dispensing Physician;
- Listed on the Preferred formulary; and
- Not available for purchase without a Prescription.

**(17) Required by Law.** All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except the Drugs excluded below.

**(18) Steroids.** Charges for Anabolic steroids.

**LIMITS TO THIS BENEFIT**

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

**(1)** Refills only up to the number of times specified by a Physician.
**(2)** Refills up to one year from the date of order by a Physician.

Drugs that are newly introduced to the U.S. market are subject to the drug benefits Exclusions. Drugs that are approved by the FDA for indications not specifically excluded are generally covered but may be subject to higher Copayments in drug formulary plans and tier-copayment plans. Generally, a new drug approved for indications not specifically excluded is covered upon FDA approval but is subject to the higher Copayment tier until evaluated by the PBM, which may assign the drug to a lower Copayment tier.

**New to Market Drugs** that are newly introduced to the U.S. market are subject to the drug benefits Exclusions. Drugs that are approved by the FDA for indications not specifically excluded are generally covered but may be subject to higher Copayments in drug formulary plans and tier-copayment plans. Generally, a new drug approved for indications not specifically excluded is covered upon FDA approval but is subject to the higher Copayment tier until evaluated by the PBM, which may assign the drug to a lower Copayment tier.
Prescription drug use does not have unlimited coverage. As with all medical and hospitalization services, Prescription

Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug Utilization Review (DUR) may be retrospective, concurrent, or prospective. Retrospective review generally involves claim review and may include communication between the PBM and the prescriber in order to coordinate care and verify Diagnosis and Medical Necessity. Concurrent review generally occurs at the time of service and may include electronic claim edits to protect Plan Participants from potential drug interactions, drug-therapy conflicts, or over-use or underuse of medications. Prospective review may include drug or medical therapy guidelines, case management, disease management or Physician or Pharmacy assignment in which one Physician and/or Pharmacy is selected to service as the coordinator of Prescription Drug services and benefits for the Plan Participant.

**EXPENSES NOT COVERED**

This benefit will not cover a charge for any of the following:

**(1) Acne Control and Cosmetic Anti-Aging.** Accutane and Retin-A. (Except when Medically Necessary and Rx is provided and approved by ProCareRX).

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

**(3) Anorexiants.** Weight loss drugs.

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

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

**(6) Drug Efficacy Study Implementation (DESI) Drugs.** Charges for DESI drugs.

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

**(8) Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant. This Exclusion shall not apply to the extent that charges are for routine patient care associated with an Approved Clinical Trial. (See "Clinical Trials" within the Covered Expenses section of this Plan).

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

**(10) Growth Hormones.** Charges for growth hormones, unless Medically Necessary and approved by **ProCare RX.**

**(11) Immunizations.** Immunization agents or biological sera.

**(12) Impotence.** A charge for impotence and sexual dysfunction medication.

**(13) Infertility.** A charge for infertility medication or fertility agents.

**(14) Inpatient Medication.** A drug or medicine that is to be taken by the Plan Participant, 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.

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

**(16) Medical Exclusions.** A charge excluded for Prescription Drugs for procedures and services that are not covered under the Medical Plan.

**(17) No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs, including worker's compensation. In addition, discounts, coupons, Pharmacy discount programs or similar arrangements provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs will not be a Covered Expense under this Plan.

**(18) Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

**(19) No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

**(20) Over-the-Counter Medicines** unless required under the Patient Protection Affordable Care Act (PPACA), or otherwise covered within this Plan.

**(21) Prescription Orders Before or After Coverage.** Prescription orders filled before the effective date or after the termination date of the Plan Participant.

**(22) Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

**(23) Rogaine.** Charges for Rogaine (topical minoxidil).

**(24) Smoking Deterrents.** A charge for drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches unless required by applicable law.

**(25) Specialty Pharmaceuticals.** Specialty Pharmaceutical Drugs are excluded under this Plan. Notwithstanding the foregoing, the Plan will cover the charges for a Specialty Pharmaceutical Drug for the first 30 day fill of any Specialty Pharmaceutical that is self-administered and filled at a licensed pharmacy or the first dose of any Specialty Pharmaceutical administered in a hospital, facility or provider's office administered by a healthcare professional for each Specialty Pharmaceutical Drug, unless otherwise excluded elsewhere in the Plan.

**(26) Syringes or Needles.** Charges for syringes and needles that are not used for injectable medication that are deemed Medically Necessary for the Diagnosis.

**(27) Vitamins.** Vitamins, except pre-natal vitamins.

**(28) Weight Loss Drugs.** A charge for Prescription Drugs for any type of Weight Loss is not a covered benefit.

## HOW TO SUBMIT PHARMACY CLAIMS

When obtaining a prescription, a Plan Participant should show his or her **Rocky Mountain Administrators (RMA)/Neiman Enterprises, Inc. Employee Benefit Plan identification card** to the pharmacist. Participating Pharmacies may submit claims on a Plan Participant's behalf.

If the Pharmacy Provider is unable to submit the claim, the Plan Participant should request a receipt.

For more information regarding the Prescription Drug benefit section or to submit manual prescription receipts for reimbursement, please contact the Pharmacy Benefit Administrator at the following:

**ProCareRX**
**(800) 699-3542 or on the web at www.procarerx.com**

## ARTICLE XIV
## SHORT-TERM DISABILITY BENEFITS

The following benefit limits are per Participant:

**WEEKLY INCOME DISABILITY BENEFITS – Short Term Disability Definition of Disability**

You are disabled if you:

1. Cannot perform any of the material and substantial duties of your own occupation because of illness, accident or maternity. (if you can perform even one of the material and substantial duties, you may not be considered disabled);
2. Are under the direct care of a licensed physician other than yourself or a family member; and
3. Are not employed elsewhere for a salary or other income.

If you become unable to work due to a condition accommodated under the Americans with Disabilities Act that has not substantially changed since your most recent date of employment, or any permanent disability that can safely be accommodated, then you will not be considered disabled.

If you are on disability and develop an additional disability, it will not be treated as a new disability but will be a continuation of your current disability.

**Job-related disability**
Job-related injuries or illnesses are not eligible for benefits under this Plan. These situations are covered by Workers' Compensation benefits.

**When Your Short Term Disability Benefits Begins**
To initiate your request for a Short Term Disability (STD) benefit, see "Filing a Claim".
You must be disabled seven (7) continuous calendar days before you are eligible to receive a STD benefit. If your disability is approved, your benefit begins on the eighth (8th) calendar day of disability and will be paid on regularly scheduled payments.
If your disability is a continuation of a prior disability, your STD benefit will begin on the first day of missed work due to the continued disability, subject to: (1) submitting satisfactory proof of disability and (2) the initial maximum benefit period.

**Amount and Duration of Your STD Benefit**
Short Term Disability:

- Benefits begin after the eighth day of an accident, illness or maternity leave.
- Benefits are paid up to a Maximum of 26 weeks.
- 67% of weekly income up to $150 per week (before the appropriate taxes are taken out.)

**Coordination of Your STD Benefit with Other Income**
Benefits for which you are eligible from other income sources will be used as an offset when calculating your STD benefit. This does not include personal disability insurance policies, no-fault wage replacement benefits from an automobile insurance policy, or your savings program. Some sources of other income offsets are:

- Any federal, state or local disability, retirement or unemployment programs;
- Other group disability benefits; and
- Disability payments from insurance or other sources that result from an act or omission of another person who caused your disability.

## ARTICLE XV
## EMPLOYEE BASIC LIFE AND AD&D BENEFITS, SPOUSE AND CHILD BENEFIT

**Your Life Insurance:**

Basic Insurance Amount: 1.5 times Basic Annual Earnings, rounded up to the nearest $1,000; subject to a minimum of $1,000 and an overall maximum of $300,000.

**Your Dependent Insurance:**

Spouse or Life Partner

Basic Insurance Amount:

| Flat Dollar Options | Benefit Amount |
|---|---|
| Option 1: | $2,000 |

Child

Basic Insurance Amount (1 Days of Age or Older):

| Flat Dollar Options | Benefit Amount |
|---|---|
| Option 1: | $1,000 |

## ARTICLE XVI
## CLAIMS PROCEDURES

When services are received from a health care Provider, a Plan Participant should show his or her **identification card** to the Provider.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from his or her health care Provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the Provider of care
- Date of service(s)
- Place of service
- Amount billed
- CPT Codes
- Diagnostic (ICD) Codes

**Note:** A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at www.rockymountainadministrators.com/members/

### WHERE TO SUBMIT CLAIMS

Rocky Mountain Administrators (RMA) is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

**Rocky Mountain Administrators (RMA)**
**P.O. Box 788**
**809 S Railway**
**Worland, WY 82401**
**Email: Claims@rockymountainadministrators.com**
**(307) 347-2606 or (800) 383-8808**

### WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion. The Plan also encourages Plan Participants to obtain Second Opinions as outlined in the Covered Expenses section set forth above.

### TYPES OF CLAIMS

A **Claim** means a request for a Plan benefit, made by a Claimant (Plan Participant or by an Authorized Representative of a Plan Participant that complies with the Plan's Reasonable procedures for filing benefit Claims).

A Claimant may appoint an Authorized Representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an Authorized Representative will be considered an Authorized Representative. A healthcare Provider is not an Authorized Representative simply by virtue of an Assignment of Benefits; however, a healthcare Provider can represent the Claimant in claims involving Urgent Care. Contact the Claims Administrator for information on the Plan's procedures for Authorized Representatives. There are four types of Claims:

A **Pre-Service Claim** is a reduction in benefits for certain Covered Services because the Plan Participant did not obtain the required Plan approval before receiving the care or treatment. This Plan does require prior approval for certain Covered Services or treatments as a condition to receiving benefits under the Plan. This review program is known as Predetermination. See the Medical Benefits Schedule section for more information.

An **Urgent Care Claim** is any Pre-Service Claim where the application of the time periods for review and determination of the Pre-Service Claim could seriously jeopardize the life or health of the Plan Participant or the Plan Participant's ability to regain maximum function, or – in the opinion of the Plan Participant's treating Physician, would subject the Plan Participant to severe pain that cannot be managed without the proposed care or treatment.

If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-Service Claim, as herein described.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-Service Claim.

A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan Participant, Case Management is not considered a Concurrent Care Determination.*

A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

**INITIAL BENEFIT DETERMINATION**

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and Exclusions, and industry standard guidelines in effect at the time charges were Incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

The initial benefit determination will be made as follows:

**Pre-Service Claims for Urgent Care.** If your Pre-Service Claim is determined by the Claims Administrator to be a claim involving Urgent Care, notice of the Plan's decision will be provided to the Plan Participant as soon as possible but no later than 72 hours after receipt of the Pre-Service Claim by the Claims Administrator.

The exception is if the Plan Participant does not provide sufficient information to decide the Pre-Service Claim. In that case, notice requesting specific additional information will be provided to the Plan Participant within 24 hours of receipt of the Pre-Service Claim.

The Plan's decision regarding the Pre-Service Claim will be made as soon as possible but no later than 48 hours after the earlier of:

- The Plan's receipt of the requested information or
- The expiration of the time period set by the Plan for you to provide the requested information (at least 48 hours).

**Pre-Service Claims for non-Urgent Care.** If your Pre-Service Claim is not an Urgent Care Claim, written notice of the Plan's decision will generally be provided to the Plan Participant within a reasonable period of time, but no later than 15 days after receipt of the Pre-Service Claim by the Claims Administrator.

If matters beyond the control of the Claims Administrator so require, one 15-day extension of time for processing the Pre-Service Claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to the Plan Participant before the end of the initial 15-day period. If an extension is required because the Plan Participant did not provide the information necessary to decide your claim, the notice of extension will specifically describe the required information.

The time-period for processing your Pre-Service Claim will be deferred beginning on the date this extension notice is sent to you and ending on the earlier of:

- The date the Plan receives your response to the request for additional information, or
- The date set by the Plan for your response (which will be at least 45 days).

**Concurrent Care Determination.** The initial benefit determination on a Concurrent Care Determination will be made within 15 days of the Claim Administrator's notice of a Concurrent Care Claim. If additional information is necessary to process the Concurrent Care Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant or the healthcare Provider must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a Concurrent Care Claim is suspended until the earlier of:

- The date the Plan receives the Claimant's or healthcare Provider's response for additional information, or
- The date set by the Plan for the Claimant or healthcare Provider to respond (which will be at least 45 days).

A benefit determination on the Concurrent Care Claim will be made within 15 days of the Plan's receipt of the additional information.

**Post-Service Claim.** The initial benefit determination on a Post-Service Claim will be made within 30 days of the Claim Administrator's receipt of the Claim. If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a Post-Service Claim is suspended until the earlier of:

- The date the Plan receives the Claimant's additional information, or
- The date set by the Plan for the Claimant to respond (which will be at least 45 days)

A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

**NOTICE OF DETERMINATION**

**(1)** The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant. If a Claim is denied in whole or in part, notice will include the following:

**(2)** Specific reason(s) for the denial.

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

**(4)** Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

**(5)** Description of the Plan's Claims review procedures and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following a notice of the determination on final review.

**(6)** 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.

**If applicable:**

**(1)** Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the notice of the determination and that a copy will be provided free of charge to the Claimant upon request).

**(2)** If the notice of the determination is based on the Medical Necessity or Experimental or Investigational Exclusion or similar such Exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim, or a statement that such explanation will be provided free of charge, upon request.

**(3)** Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Plan Participant’s failure to timely pay required premiums.

**CLAIMS REVIEW PROCEDURE - GENERAL**

A Claimant may appeal an Adverse Benefit Determination as follows:

- The Plan offers a one-level internal review process for Pre-Service Claims for Urgent Care;
- The Plan offers a two-level internal review process for a Pre-Service Claim (non-Urgent Care), Concurrent Care Claim, and Post Service Claim.

The Plan Administrator will provide for a review that does not give deference to the previous benefit determination and that is conducted by either an appropriate Plan fiduciary or the Claims Administrator on the Plan’s behalf who was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final notice of the determination so that the Claimant has a reasonable amount of time to respond.
- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's benefit determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

**INTERNAL APPEAL PROCEDURE**

First Level of Internal Review. To appeal a denial of a Claim, the Claimant must submit in writing, a request for a review of the Claim. The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the denial. The Claimant may include any additional supporting information, even if not initially submitted with the Claim.

The written request for review must be submitted within 180 days of the Claimant's receipt of an Adverse Benefit Determination.

The written request for review should be addressed to:

**Claims Administrator**
**Attention: Appeals**
**Rocky Mountain Administrators (RMA)**
**P.O. Box 788**
**809 S Railway**
**Worland, WY 82401**

An appeal will not be deemed submitted until it is received by the Claims Administrator. Failure to appeal the initial denial within the prescribed time period will render that determination final. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on behalf of the Plan Administrator. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within:

- 72 hours of the receipt of the appeal for an Urgent Care Claim;
- 15 days of the receipt of the appeal for a Pre-Service Claim or a Concurrent Care Claim; or
- 30 days of the receipt of the appeal for a Post Service Claim.

**Second Level of Internal Review**

If the Claimant does not agree with the Claims Administrator's determination from the First Level of Internal Review, the Claimant may submit a second level appeal in writing. The Claimant may request a second level appeal on Pre-service Claims (non-Urgent Care) and Post-Service only along with any additional supporting information.

The written request for review of the First Level of Internal Review must be submitted within 60 days of the Claimant's receipt of the first level of internal review.

The written request for review should be addressed to:

**Claims Administrator**
**Attention: Appeals**
**Rocky Mountain Administrators (RMA)**
**P.O. Box 788**
**809 S Railway**
**Worland, WY 82401**

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. Failure to appeal the determination from the first level of review within the prescribed time period will render that determination final. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Plan Administrator, or its designee. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within:

- 15 days of the Plan's receipt of Claimant's second level appeal on a Pre-Service Claim (non-Urgent Care);
- 15 days of the Plan's receipt of Claimant's second level appeal on a Concurrent Care Determination;
- 30 days of the Plan's receipt of Claimant's second level appeal on a Post-Service Claim.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may be eligible for an External Review. The Claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review. In certain circumstances, the Claimant may also request an expedited External Review.

**Both the First Level of Internal Review Decision and Second Level of Internal Review Decision will contain the following, if applicable:**

**(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, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

**(2)** Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.

**(3)** A reference to the specific portion(s) of the Plan provisions on which the denial is based.

**(4)** The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request).

**(5)** A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.

**(6)** Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.

**(7)** A description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

**(8)** A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

**(9)** A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Plan Participant's right to bring civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.

**(10)** In the case of denials based upon medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant free of charge, upon request.

**EXTERNAL REVIEW PROCEDURE**

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within 4 months from the date of receipt of the notice of the Final Internal Adverse Benefit Determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or services is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.

For an Adverse Benefit Determination to be eligible for External Review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within 6 business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for External Review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law.

Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

Generally, a Claimant must exhaust the Plan's Claims 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.

**APPOINTMENT OF AUTHORIZED REPRESENTATIVE**

A Plan Participant may designate another individual to be an Authorized Representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Plan Participant, and include all the information required in the Authorized Representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator.

Should a Plan Participant designate an Authorized Representative, all future communications from the Plan will be conducted with the Authorized Representative instead of the Plan Participant, unless the Plan Administrator is otherwise notified in writing by the Plan Participant. A Plan Participant can revoke the Authorized Representative designation at any time. A Plan Participant may authorize only one person as an Authorized Representative at a time.

Recognition as an Authorized Representative is completely separate from a Provider accepting an Assignment of Benefits, requiring a release of information, or requesting completion a similar form. An Assignment of Benefits by a Plan Participant shall not be recognized as a designation of the Provider as an Authorized Representative.

**ASSIGNMENT OF BENEFITS**

The term “Assignment of Benefits” shall mean an arrangement whereby the Plan Participant assigns their right to seek and receive payment from the Plan for eligible Covered Expenses to a Provider, in strict accordance with the conditions and limitations of such rights provided under the terms of this Plan Document.

Conditions and Limitations of an Assignment of Benefits:

**(1)** The validity of an Assignment of Benefits by a Plan Participant to a Provider is limited by the terms of this Plan Document. An Assignment of Benefits is considered valid on the condition that Provider accepts the payment received from the Plan as consideration, in full, for Covered Expenses for services, supplies and/or treatment rendered. This amount does not include any cost sharing amounts (i.e. Copayments, Deductibles, or Coinsurance), or charges for non-Covered Services; the Provider may bill the Plan Participant directly for these amounts.

**(2)** An Assignment of Benefits cannot be inferred, implied or transferred. An Assignment of Benefits must be made by the Plan Participant to the Provider directly through a valid written instrument that is signed and dated by the Plan Participant.

**(3)** Unless specifically prohibited by a Plan Participant, a Provider with a valid Assignment of Benefits may exhaust, on behalf of the Plan Participant, any administrative remedies available under the terms of the Plan Document, including initiating an internal or external appeal of an Adverse Benefit Determination in accordance with the terms of the Plan Document. Notwithstanding the foregoing, the Plan Participant does not, under any circumstances, have the right to assign to any Provider (or their representative) through an Assignment of Benefits any right to initiate any cause of action against the Plan that the Plan Participant them self may be afforded under applicable law. This includes, but is not limited to, any right to bring suit as such is afforded to Plan Participants under ERISA section 502(a). The assignment of any right to initiate suit against the Plan to a Provider is strictly prohibited.

**(4)** An Assignment of Benefits does not grant the Provider any rights other than those specifically set forth herein.

**(5)** The Plan Administrator may disregard an Assignment of Benefits at its discretion and continue to treat the Plan Participant as the sole recipient of the benefits available under the terms of the Plan.

**(6)** An Assignment of Benefits by a Plan Participant to a Provider will not constitute the appointment of an Authorized Representative.

By submitting a claim to the Plan and accepting payment by the Plan, the Provider is expressly agreeing to the foregoing conditions and limitations of an Assignment of Benefits in addition to the terms of the Plan Document. The Provider further agrees that the payments received constitute an 'accord and satisfaction' and consideration, in full, for the Covered Expenses for services, supplies and/or treatment rendered. The Provider agrees that the conditions and limitations of an Assignment of Benefits as set forth herein shall supersede any previous terms and/or agreements. The Provider agrees to the specific condition that the patient not be balance billed for any amount beyond applicable cost sharing amounts (i.e. Copayments, Deductibles, or Coinsurance), or charges for non-Covered Services; the Provider may bill the Plan Participant directly for these amounts.

If a Provider refuses to accept an Assignment of Benefits under the conditions and limitations as set forth herein, any Covered Expenses payable under the terms of the Plan Document will be payable directly to the Plan Participant, and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Expense.

## ARTICLE XVII
## COORDINATION OF BENEFITS

### DEFINED TERMS

**Allowable Expense(s)** means the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in this section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

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

**Other Plan** includes, but is not limited to:

**(1)** Any primary payer besides the Plan.

**(2)** Any other group health plan.

**(3)** Any other coverage or policy covering the Plan Participant.

**(4)** Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

**(5)** Any policy of insurance from any insurance company or guarantor of a responsible party.

**(6)** Any policy of insurance from any insurance company or guarantor of a third party.

**(7)** Workers' compensation or other liability insurance company.

**(8)** Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

**Coordination of the Benefit Plans.** Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. When a Plan Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

**Standard Coordination of Benefits.** 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 due up to 100% of the total allowable charges.

**Benefits Subject to This Provision.** The following shall apply to the entirety of the Plan and all benefits described therein.

**Excess Insurance.** If at the time of Injury, Illness, Disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

**(1)** Any primary payer besides the Plan.

**(2)** Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

**(3)** Any policy of insurance from any insurance company or guarantor of a third party.
**(4)** Workers' compensation or other liability insurance company.
**(5)** Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

**Vehicle Limitation.** When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy Deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

**EFFECT ON BENEFITS**

**Application to Benefit Determinations.** The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

**(1)** The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.

**(2)** The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

**Order of Benefit Determination.** For the purposes of the provision entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

**(1)** A plan without a coordinating provision will always be the primary plan.

**(2)** The benefits of a plan which covers the person on whose expenses claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such person as a Dependent.

**(3)** If the person for whom a claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

**(4)** When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody.

**(5)** When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

**(6)** Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a Dependent Child.

**(7)** When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

**(8)** To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State Child health benefits or other applicable State health benefits program.

**Right to Receive and Release Necessary Information.** The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any Other Plan. Any Plan Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

**Facility of Payment.** A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

**Right of Recovery.** Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Plan Participant or his or her Dependents.

**Claims Determination Period.** Benefits will be coordinated on a Calendar Year basis. This is called the Claims Determination Period.

**Exception to Medicaid.** In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Plan Participant under the Plan

**Applicable to Active Employees and Spouses Ages 65 and Over.** An active Employee and his or her Spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

**Applicable to All Other Plan Participants Eligible for Medicare Benefits.** To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

**Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan.** If any Plan Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

## ARTICLE XVIII
## THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

### DEFINED TERMS

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

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

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

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

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

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

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in the Illness or Injury to the extent of such conditional payment by the Plan plus Reasonable costs of collection. The Plan Participant is obligated to notify the Plan or its Authorized Representative of any settlement prior to finalization of

the settlement, execution of a release, or receipt of applicable funds. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

If the Plan Participant(s) fails to file a claim or pursue damages against:

**(1)** The responsible party, its insurer, or any other source on behalf of that party.

**(2)** Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

**(3)** Any policy of insurance from any insurance company or guarantor of a third party.

**(4)** Workers' compensation or other liability insurance company.

**(5)** Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

**Right of Reimbursement.** The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Plan Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Plan Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Plan Participant's/Plan Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

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

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

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

**(1)** Notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

**(2)** Instruct his or her attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on all settlement drafts.

**(3)** In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its Authorized Representative as a payee on the settlement draft.

**(4)** Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

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

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

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

**(1)** The responsible party, its insurer, or any other source on behalf of that party.

**(2)** Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

**(3)** Any policy of insurance from any insurance company or guarantor of a third party.

**(4)** Workers' compensation or other liability insurance company.

**(5)** Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

**Reimbursement Due to Surrogacy Arrangement.** If a Plan Participant enters into a Surrogacy Arrangement, the Plan Participant must reimburse the Plan for Covered Expenses received related to conception, Pregnancy, delivery, or postpartum care in connection with that Surrogacy Arrangement. The reimbursed amount shall not exceed the payments or other compensation the Plan Participant or another person is entitled to receive under the Surrogacy Arrangement.

A "Surrogacy Arrangement" is one in which a Plan Participant agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the Child (or Children), whether or not the Plan Participant receives payment for being a surrogate.

A Surrogacy Arrangement does not affect a Plan Participant's obligation to pay any and all patient responsibility amounts for these services. These amounts will be taken into account at the time of reimbursement.

After a Plan Participant surrenders a baby to the legal parents, the Plan is not obligated to pay for any services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

As set forth above, as a condition precedent to the Plan Participant receiving benefits under the Plan, the Plan Participant automatically assigns to the Plan any right to receive payments that are payable to the Plan Participant or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy the Plan's lien.

Within 30 days after entering into a Surrogacy Arrangement, the Plan Participant must send written notice of the arrangement to the Plan, including all of the following information:

**(1)** Names, addresses and telephone numbers of all parties to the arrangement;

**(2)** Names, addresses and telephone numbers of any escrow or trustee;

**(3)** Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for the services of baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive;

**(4)** A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and

**(5)** Any other information the Plan requests in order to satisfy its rights.

The Plan Participant must complete and send all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for the Plan to determine the existence of any rights the Plan may have under this Surrogacy Arrangement and to satisfy those rights. The Plan Participant may not agree to waive, release, or reduce the Plan's rights without the Plan's prior, written consent.

If a Plan Participant's estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the Plan Participant had asserted the claim against the third party. The Plan may assign its rights to enforce its liens and/or other rights.

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

**Obligations.** It is the Plan Participant's/Plan Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

**(1)** To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

**(2)** To provide the Plan with pertinent information regarding the Illness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.

**(3)** To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights.

**(4)** To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

**(5)** To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

**(6)** To notify the Plan or its Authorized Representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

**(7)** To notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement.

**(8)** To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

**(9)** To instruct his or her attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on any settlement draft.

**(10)** In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement to include the Plan or its Authorized Representative as a payee on the settlement draft.

**(11)** To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Participant over settlement funds is resolved.

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

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

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

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

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

**Language Interpretation.** The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

**Severability.** In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

## ARTICLE XIX
## COBRA CONTINUATION COVERAGE

### INTRODUCTION

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

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

### WHAT IS COBRA CONTINUATION COVERAGE?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent Children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA. **A domestic partner is not a Qualified Beneficiary.**

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

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

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

**Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.**

Your Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child is no longer eligible for coverage under the plan as a "Dependent Child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent Children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?**

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

**Claims Administrator**
Rocky Mountain Administrators (RMA)
PO Box 788
809 S Railway
Worland, WY 82401
(307) 347-2606 or (800) 383-8808

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

**HOW IS COBRA CONTINUATION COVERAGE PROVIDED?**

Once the Plan Administrator receives 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 on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the COBRA Coordinator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Coordinator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

**HOW LONG DOES COBRA CONTINUATION COVERAGE LAST?**

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage can last for up to a total of 36 months.

## MEDICARE EXTENSION OF COBRA CONTINUATION COVERAGE

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18 month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent Children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18 month period.

## DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months.

The disability would have to have started at some time before the 60$^{th}$ day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

**Claims Administrator:**
Rocky Mountain Administrators (RMA)
PO Box 788
809 S Railway
Worland, WY 82401
(307) 347-2606 or (800) 383-8808

## SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

**You must provide this notice to:**

**Claims Administrator**
Rocky Mountain Administrators (RMA)
PO Box 788
809 S Railway
Worland, WY 82401
(307) 347-2606 or (800) 383-8808

## DOES COBRA CONTINUATION COVERAGE EVER END EARLIER THAN THE MAXIMUM PERIODS ABOVE?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Plan Participant.

**HOW DO I PAY FOR COBRA CONTINUATION COVERAGE?**

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

**ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?**

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.HealthCare.gov.

**CURRENT ADDRESSES**

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**ADDITIONAL INFORMATION**

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Coordinator:

**Plan Administrator**
Neiman Enterprises, Inc.
P.O. Box 218
Hulett, WY 82720
(307) 467-5252

**COBRA Coordinator /Claims Administrator**
Rocky Mountain Administrators (RMA)
PO Box 788
809 S Railway
Worland, WY 82401
(307) 347-2606 or (800) 383-8808

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

## ARTICLE XX
## RESPONSIBILITIES FOR PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible. The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a 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 as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator, in its discretion, that the Plan Participant is entitled to them.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, shall be considered ambiguous and shall be interested by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may amend retroactively to cure such ambiguity, notwithstanding anything in the Plan to the contrary.

### DUTIES OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following:

**(1)** To administer the Plan in accordance with its terms;

**(2)** To determine all questions of eligibility, status and coverage under the Plan;

**(3)** To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

**(4)** To make factual findings;

**(5)** To decide disputes which may arise relative to a Plan Participant's rights;

**(6)** To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

**(7)** To keep and maintain the Plan Documents and all other records pertaining to the Plan;

**(8)** To appoint and supervise a third party administrator to pay claims;

**(9)** To perform all necessary reporting as required by ERISA;

**(10)** To establish and communicate procedures to determine whether a Medical Child Support Order or National Medical Support Notice is a QMCSO

**(11)** To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

**(12)** To perform each and every function necessary for or related to the Plan's administration.

**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.

## ARTICLE XXI
## FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

**For Employee Coverage:** Funding is derived from contributions made to the Neiman Enterprises, Inc. Employee Benefit Plan.

**For Dependent Coverage:** Funding is derived from contributions made by the Employer.
Benefits are paid directly from the Plan through the Claims Administrator.

### 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 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, the amount of overpayment may 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 Plan Sponsor or Plan Administrator 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).**

### DISTRIBUTION OF ASSETS

Subject to the requirements of ERISA §402, in the event of a termination or partial termination of the Plan or Trust (if applicable), Neiman Enterprises, Inc. shall direct the disposition of Plan assets pursuant to applicable law and governing documents, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by an Employer.

## ARTICLE XXII
## HIPAA PRIVACY AND SECURITY

### STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

### DISCLOSURE OF SUMMARY HEALTH INFORMATION TO THE PLAN SPONSOR

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

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

### DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

**Protected Health Information (PHI)** means individually identifiable health information, created or received by a health care Provider, health plan, Employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

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

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

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

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

**(4)** Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

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

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

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

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

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

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

a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed: **Privacy Officer**
b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
c. In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non- compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.
"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, Claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

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

## DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

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

## DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

## OTHER DISCLOSURES AND USES OF PHI

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

## CONTACT INFORMATION

**Privacy Officer Contact Information:**
Privacy Officer
HIPAA Compliance Department
Neiman Enterprises, Inc.
P.O. Box 218
Hulett, WY 82720
(307) 467-5252

**STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)**

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

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

**(1)** Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

**(2)** Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by Reasonable and appropriate security measures.

**(3)** Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement Reasonable and appropriate security measures to protect the Electronic PHI; and

**(4)** Report to the Plan any security incident of which it becomes aware.

## ARTICLE XXIII
## 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 Employee Benefits Security 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 or 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 Plan 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 Plan 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, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## ARTICLE XXIV
## 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 contributions to the Neiman Enterprises, Inc. Employee Benefit Plan, made by the covered Employees. The Plan is not insured.

**PLAN NAME:** Neiman Enterprises, Inc. Employee Health Benefit Plan

**PLAN NUMBER: 501**

**TAX ID NUMBER:** 83-0303167

**PLAN EFFECTIVE DATE:** August 1, 2011

**PLAN YEAR:** August 1st through July 31st

### PLAN SPONSOR

Neiman Enterprises, Inc.
P.O. Box 218
Hulett, WY 82720
(307) 467-5252

### PLAN ADMINISTRATOR

Neiman Enterprises, Inc.
P.O. Box 218
Hulett, WY 82720
(307) 467-5252

### NAMED FIDUCIARY

Neiman Enterprises, Inc.
P.O. Box 218
Hulett, WY 82720
(307) 467-5252

### AGENT FOR SERVICE OF LEGAL PROCESS

Neiman Enterprises, Inc.
P.O. Box 218
Hulett, WY 82720
(307) 467-5252

### CLAIMS ADMINISTRATOR

Rocky Mountain Administrators (RMA)
P.O. Box 788
809 S Railway
Worland, WY 82401
(307) 347-2606 or (800) 383-8808
www.rockymountainadministrators.com

I,_____, certify that I am the _____
Name Title

of the Neiman Enterprises, Inc. for the above named Plan which has an initial effective date of_____, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms stated herein and am hereby authorizing the implementation of the Plan as of the effective date stated above.

Signature: _____

Print Name: _____

Date: _____