Summary Plan Description

for

METROMONT CORPORATION

Salaried Employees Group Health Benefit Plan

Revision and Restatement Date: January 1, 2020

TABLE OF CONTENTS

ADOPTION AGREEMENT

Metromont Corporation (the "Employer") hereby restates the health care benefits plan (the "Plan") for its Hourly Employees and their dependents effective as of January 1, 2020. The Employer has duly authorized the adoption of this document ("Summary Plan Description") and the execution thereof.

The benefits provided under this Plan and the general terms and conditions governing the same are contained in this Summary Plan Description, a copy of which is provided to participants in the Plan, and may also be governed by the provisions of certain insurance contracts purchased on behalf of the Plan. The Summary Plan Description, Plan Document and all such insurance contracts, if any, as the same may be amended from time to time, are hereby incorporated herein by this reference and made a part of this Plan.

This Summary Plan Description contains a summary in English of the benefits available to Metromont Corporation employees. The Summary Plan Description/Plan Document Combination is available on the intranet, internet, and hard copy in your Human Resources Department. If you have difficulty understanding any part of this Summary Plan Description and you need assistance, please contact the Human Resources Department at:

Metromont Corporation
20 Two Notch Road
Greenville, SC 29605

Este folleto contiene un resumen en inglés de los beneficios disponibles en el Corporacion Metromont para los empleados. El resumen de todos los documentos Del plan también está disponible en el Intranet, Internet y puede también obtener una copia impresa en la oficina de Departmento de Recursos Humanos. Si usted tiene dificultad para entender cualquiera de estos documentos del plan, por favor póngase en contacto con el Departmento de Recursos Humanos en:

Metromont Corporation
20 Two Notch Road
Greenville, SC 29605

By affixing his signature and date to this document, the Plan Sponsor does hereby certify that the Plan Sponsor has reviewed the Summary Plan Description and that it represents the terms and conditions of the Plan adopted by the Plan Sponsor.

Authorized Signature of Health Plan

2/25/2020

Date

SCHEDULES OF BENEFITS

Group A: All SC Locations
Group B: Winchester, VA Location
Group C: All Other Metromont Locations

SCHEDULE OF BENEFITS
MEDICAL BENEFITS
PLUS PLAN OPTION: GROUPS A AND B ONLY

Note: The Covered Person is entitled to Medical Benefits only if (s)he has made application for such benefits and been enrolled for Coverage by the Plan Administrator under the Plan.

GENERAL INFORMATION		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
Calendar Year Deductible	Individual: $1,650 Family: $3,300	Individual: $3,300 Family: $6,600
	Eligible Expenses applied toward the Network Deductible are not applied toward the Non-Network Deductible, and vice versa. The Family Deductible must be met by one or more family members before benefits are payable.	
Coinsurance	Plan will pay 80% of Provider's Allowable Charge *Except as specified*	Plan will pay 60% of Provider's Allowable Charge *Except as specified*
Out-of-Pocket Limit *Includes Coinsurance and Deductible*	Individual: $3,300 Family: $6,600	Individual: $6,600 Family: $13,200
	Network Out-of-Pocket Limit is not used to satisfy the Non-Network Out-of-Pocket Limit, and vice versa. The Family Out-of-Pocket Limit will be met by one or more family members.	
Annual Maximum Benefit	Unlimited	
Lifetime Maximum Benefit	Unlimited	

COVERED SERVICES		
This listing of Covered Services appears in alphabetical order to better assist the Covered Person in locating the different benefit allowances for the specific Covered Services.		
Abortion Services *Only if mother's life in danger or pregnancy due to rape/incest*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Allergy Testing, Serum & Inhalers	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Allergy Injection	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Ambulance Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 80%
Anesthesia Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60% *Anesthesiologist services rendered in an In-Network Facility will be covered at the In-Network benefit level.*
Ambulatory Surgical Facility Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%

Birth Control Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Birthing Care Center *Dependent Child only covered for complications of pregnancy*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Cardiac Rehabilitation Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Chemotherapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Chiropractic Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a $500 Maximum Benefit per Benefit Period.	
Dental Services *Limited to treatment of accidental injury and treatment of certain dental surgical procedures (as described in Covered Services section)*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Diagnostic Tests	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	The following Non-Network services will be covered at the Network benefit level: 1. Reading of a Non-Network Radiologist when the x-ray was performed in an Network Facility; and 2. Reading of a Non-Network Laboratory or Pathologist when the lab sample was taken in or drawn by a Network Provider.	
Dialysis Treatment—Outpatient	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Durable Medical Equipment	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Precertification is required. Limited to a Maximum Benefit of 6-months rental or purchase price, whichever is less.	
Education Programs *Ostomy and diabetes only*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Emergency Room Care	After Deductible, Plan pays 80%	After Deductible, Plan pays 80%
Home Health Care Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Precertification is required. Limited to a 120-day Maximum Benefit per Benefit Period.	
Hospice Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 30-day lifetime Maximum Benefit for Inpatient services and a $3,000 lifetime Maximum Benefit for Outpatient services. Bereavement counseling subject to a $3,000 lifetime Maximum Benefit.	
Hospital Services During Inpatient Confinement • *Room, board, general nursing* *Ancillary services*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Medical and Surgical Supplies	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%

Obstetrical Care *Dependent Children covered for complications of pregnancy and certain prenatal preventive services*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Occupational Therapy Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period. Does not include: recreational programs, maintenance therapy or supplies.	
Orthotic Devices	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Physical Therapy Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period.	
Physician Office Visits for Non-Routine Care	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Podiatry Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Physician Consultations During Inpatient Hospital Confinement	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Pre-admission Testing Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Preventive Care *See page 33 for a list of preventive services.*	Deductible waived, Plan pays 100%	Not Covered
Prosthetic Appliances	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Psychiatric Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Radiation Therapy Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Reconstructive Surgery *As limited in Covered Services section.*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Respiratory Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Routine Nursery Care for Newborn	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Second & Third Surgical Opinion	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Skilled Nursing/Rehabilitation Facility	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 90-day Maximum Benefit per Benefit Period	
Speech Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period.	
Sterilization Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Substance Abuse Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Supplemental Accident Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Surgical Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%

TMJ Treatment	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Transplant Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Travel expenses are limited to $10,000 per lifetime. Includes one companion at any time or both parents when recipient is a minor. Note: Travel expenses are not covered for kidney or bone marrow transplants.	
Urgent Care Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Wigs	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a $250 lifetime Maximum Benefit.	

Group A: All SC Locations
Group B: Winchester, VA Location
Group C: All Other Metromont Locations

SCHEDULE OF BENEFITS
MEDICAL BENEFITS
BASIC PLAN OPTION: GROUPS A AND B ONLY

Note: The Covered Person is entitled to Medical Benefits only if (s)he has made application for such benefits and been enrolled for Coverage by the Plan Administrator under the Plan.

GENERAL INFORMATION		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
Calendar Year Deductible	Individual: $3,150 Family: $5,300	Individual: $6,300 Family: $10,600
	Eligible Expenses applied toward the Network Deductible are not applied toward the Non-Network Deductible, and vice versa. The Family Deductible must be met by one or more family members before benefits are payable.	
Coinsurance	Plan will pay 80% of Provider's Allowable Charge *Except as specified*	Plan will pay 60% of Provider's Allowable Charge *Except as specified*
Out-of-Pocket Limit *Includes Coinsurance and Deductible*	Individual: $6,300 Family: $10,600	Individual: $12,600 Family: $21,200
	Network Out-of-Pocket Limit is not used to satisfy the Non-Network Out-of-Pocket Limit, and vice versa. The Family Out-of-Pocket Limit will be met by one or more family members. The Network Family Out-of-Pocket Limit contains an embedded Individual Out-of-Pocket Limit of $1,750.	
Annual Maximum Benefit	Unlimited	
Lifetime Maximum Benefit	Unlimited	

COVERED SERVICES		
This listing of Covered Services appears in alphabetical order to better assist the Covered Person in locating the different benefit allowances for the specific Covered Services.		
Abortion Services *Only if mother's life in danger or pregnancy due to rape/incest*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Allergy Testing, Serum & Inhalers	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Allergy Injection	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Ambulance Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 80%
Anesthesia Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60% *Anesthesiologist services rendered in an In-Network Facility will be covered at the In-Network benefit level.*
Ambulatory Surgical Facility Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Birth Control Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%

Birthing Care Center *Dependent Child only covered for complications of pregnancy*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Cardiac Rehabilitation Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Chemotherapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Chiropractic Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a $500 Maximum Benefit per Benefit Period.	
Dental Services *Limited to treatment of accidental injury and treatment of certain dental surgical procedures (as described in Covered Services section)*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Diagnostic Tests	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	The following Non-Network services will be covered at the Network benefit level: 3. Reading of a Non-Network Radiologist when the x-ray was performed in an Network Facility; and 4. Reading of a Non-Network Laboratory or Pathologist when the lab sample was taken in or drawn by a Network Provider.	
Dialysis Treatment—Outpatient	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Durable Medical Equipment	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Precertification is required. Limited to a Maximum Benefit of 6-months rental or purchase price, whichever is less	
Education Programs *Ostomy and diabetes only*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Emergency Room Care	After Deductible, Plan pays 80%	After Deductible, Plan pays 80%
Home Health Care Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Precertification is required. Limited to a 120-day Maximum Benefit per Benefit Period.	
Hospice Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 30-day lifetime Maximum Benefit for Inpatient services and a $3,000 lifetime Maximum Benefit for Outpatient services. Bereavement counseling subject to a $3,000 lifetime Maximum Benefit.	
Hospital Services During Inpatient Confinement • *Room, board, general nursing* *Ancillary services*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Medical and Surgical Supplies	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Obstetrical Care	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%

Dependent Children covered for complications of pregnancy and certain prenatal preventive services		
Occupational Therapy Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period. Does not include: recreational programs, maintenance therapy or supplies.	
Orthotic Devices	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Physical Therapy Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period.	
Physician Office Visits for Non-Routine Care	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Podiatry Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Physician Consultations During Inpatient Hospital Confinement	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Pre-admission Testing Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Preventive Care *See page 33 for a list of preventive services.*	Deductible waived, Plan pays 100%	Not Covered
Prosthetic Appliances	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Psychiatric Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Radiation Therapy Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Reconstructive Surgery *As limited in Covered Services section.*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Respiratory Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Routine Nursery Care for Newborn	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Second & Third Surgical Opinion	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Skilled Nursing/Rehabilitation Facility	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 90-day Maximum Benefit per Benefit Period	
Speech Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period.	
Sterilization Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Substance Abuse Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Supplemental Accident Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Surgical Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%

TMJ Treatment	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Transplant Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Travel expenses are limited to $10,000 per lifetime. Includes one companion at any time or both parents when recipient is a minor. Note: Travel expenses are not covered for kidney or bone marrow transplants.	
Urgent Care Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Wigs	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a $250 lifetime Maximum Benefit.	

Group A: All SC Locations
Group B: Winchester, VA Location
Group C: All Other Metromont Locations

SCHEDULE OF BENEFITS MEDICAL BENEFITS PLUS PLAN OPTION: GROUP C ONLY		
Note: The Covered Person is entitled to Medical Benefits only if (s)he has made application for such benefits and been enrolled for Coverage by the Plan Administrator under the Plan.		
COVERED SERVICE/PLAN CATEGORY	**NETWORK PROVIDERS AND ALL FACILITY AND HOSPITAL BENEFITS**	**NON-NETWORK PROVIDERS**
GENERAL INFORMATION		
Calendar Year Deductible	Individual: $1,650 Family: $3,300	Individual: $3,300 Family: $6,600
	Eligible Expenses applied toward the Network Deductible are **not** applied toward the Non-Network Deductible, and vice versa. The Family Deductible must be met by one or more family members before benefits are payable.	
Coinsurance	Plan will pay 80% of the Reasonable and Allowable Charge *Except as specified*	Plan will pay 60% of the Reasonable and Allowable Charge *Except as specified*
Out-of-Pocket Limit *Includes Coinsurance and Deductible*	Individual: $3,300 Family: $6,600	Individual: $6,600 Family: $13,200
	Network Out-of-Pocket Limit is **not** used to satisfy the Non-Network Out-of-Pocket Limit, and vice versa. The Family Out-of-Pocket Limit will be met by one or more family members.	
Annual Maximum Benefit	Unlimited	
Lifetime Maximum Benefit	Unlimited	

COVERED SERVICES – PROFESSIONAL SERVICE PROVIDERS		
This listing of Covered Services appears in alphabetical order to better assist the Covered Person in locating the different benefit allowances for the specific Covered Services.		
Abortion Services *Only if mother's life in danger or pregnancy due to rape/incest*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Allergy Testing, Serum & Inhalers	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Allergy Injection	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Anesthesia Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60% *Anesthesiologist services rendered in an In-Network Facility will be covered at the In-Network benefit level.*

Allergy Injection	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Birth Control Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Cardiac Rehabilitation Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Chemotherapy Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Chiropractic Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a $500 Maximum Benefit per Benefit Period.	
Dental Services *Limited to treatment of accidental injury and treatment of certain dental surgical procedures (as described in Covered Services section)*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Diagnostic Tests in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	The following Non-Network services will be covered at the Network benefit level: 1. Reading of a Non-Network Radiologist when the x-ray was performed in an Network Facility; and 2. Reading of a Non-Network Laboratory or Pathologist when the lab sample was taken in or drawn by a Network Provider.	
Durable Medical Equipment	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Precertification is required. Limited to a Maximum Benefit of 6-months rental or purchase price, whichever is less.	
Education Programs *Ostomy and diabetes only*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Emergency Room Care (Professional Services)	After Deductible, Plan pays 80%	After Deductible, Plan pays 80%
Home Health Care Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Precertification is required. Limited to a 120-day Maximum Benefit per Benefit Period.	
Hospice Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 30-day lifetime Maximum Benefit for Inpatient services and a $3,000 lifetime Maximum Benefit for Outpatient services. Bereavement counseling subject to a $3,000 lifetime Maximum Benefit.	
Home Health Care Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 120-day Maximum Benefit per Benefit Period.	
Hospice Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 30-day lifetime Maximum Benefit for Inpatient services and a $3,000 lifetime Maximum Benefit for Outpatient services. Bereavement counseling subject to a $3,000 lifetime Maximum Benefit.	
Medical and Surgical Supplies	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Obstetrical Care *Dependent Children covered for complications of pregnancy and certain prenatal preventive services*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%

Occupational Therapy Services Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period. Does not include: recreational programs, maintenance therapy or supplies.	
Orthotic Devices	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Physical Therapy Services Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period.	
Physician Office Visits for Non-Routine Care	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Podiatry Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Physician Consultations During Inpatient Hospital Confinement	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Pre-admission Testing Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Preventive Care *See page 33 for a list of preventive services.*	Deductible waived, Plan pays 100%	Not Covered
Prosthetic Appliances	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Psychiatric Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Radiation Therapy Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Reconstructive Surgery *As limited in Covered Services section.*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Respiratory Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Routine Nursery Care for Newborn	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Second & Third Surgical Opinion	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Speech Therapy Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period.	
Sterilization Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Substance Abuse Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Supplemental Accident Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Surgical Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
TMJ Treatment	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Transplant Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Travel expenses are limited to $10,000 per lifetime. Includes one companion at any time or both parents when recipient is a minor. Note: Travel expenses are not covered for kidney or bone marrow transplants.	
Wigs	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a $250 lifetime Maximum Benefit.	

COVERED SERVICES – FACILITY AND HOSPITAL BENEFITS	
This Plan does not use a PPO Network for services and supplies provided by a Facility and/or Hospital, or a Provider billing as a Facility. Instead, the Plan will calculate the Plan's responsibility for payment, the "Reasonable and Allowed Amount" as defined in the Definitions section.	
Ambulance Services	After Deductible, Plan pays 80%
Ambulatory Surgical Facility Services	After Deductible, Plan pays 80%
Birthing Care Center *Dependent Child only covered for complications of pregnancy*	After Deductible, Plan pays 80%
Cardiac Rehabilitation Therapy	After Deductible, Plan pays 80%
Chemotherapy (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
Diagnostic Tests	After Deductible, Plan pays 80%
	The following Non-Network services will be covered at the Network benefit level: 1. Reading of a Non-Network Radiologist when the x-ray was performed in a Network Facility; and 2. Reading of a Non-Network Laboratory or Pathologist when the lab sample was taken in or drawn by a Network Provider.
Dialysis Treatment - Outpatient	After Deductible, Plan pays 80%
Emergency Room Care (Facility Covered Services)	After Deductible, Plan pays 80%
Hospice Services	After Deductible, Plan pays 80%
	Limited to a 30-day lifetime Maximum Benefit for Inpatient services and a $3,000 lifetime Maximum Benefit for Outpatient services. Bereavement counseling subject to a $3,000 lifetime Maximum Benefit.
Hospital Services During Inpatient Confinement • *Room, board, general nursing* • *Ancillary services*	After Deductible, Plan pays 80%
Obstetrical Care (Inpatient Facility Expenses) *Dependent Children covered for complications of pregnancy and certain prenatal preventive services*	After Deductible, Plan pays 80%
Occupational Therapy (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
	Limited to a 20-visit Maximum Benefit per Benefit Period. Does not include: recreational programs, maintenance therapy or supplies.
Physical Therapy (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
	Limited to a 20-visit Maximum Benefit per Benefit Period.
Radiation Therapy (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%

Reconstructive Surgery (Facility Covered Services and Supplies) *As limited in Covered Services section.*	After Deductible, Plan pays 80%
Respiratory Therapy (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
Routine Nursery Care for Newborn (Facility Covered Services)	After Deductible, Plan pays 80%
Skilled Nursing Facility/Rehabilitation Facility Services	After Deductible, Plan pays 80%
	Limited to a 90-day Maximum Benefit per Benefit Period.
Speech Therapy (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
	Limited to a 20-visit Maximum Benefit per Benefit Period.
Sterilization Services (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
Substance Abuse Services (Facility Covered Services)	After Deductible, Plan pays 80%
Supplemental Accident Services (Facility Covered Services)	After Deductible, Plan pays 80%
Surgical Services (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
Transplant Services (Facility Covered Services)	After Deductible, Plan pays 80%
	Travel expenses are limited to $10,000 per lifetime. Includes one companion at any time or both parents when recipient is a minor. Note: Travel expenses are not covered for kidney or bone marrow transplants.
Urgent Care Services in Urgent Care Facility	After Deductible, Plan pays 80%
	Limited to a $250 lifetime Maximum Benefit.

Group A: All SC Locations
Group B: Winchester, VA Location
Group C: All Other Metromont Locations

SCHEDULE OF BENEFITS MEDICAL BENEFITS BASIC PLAN OPTION: GROUP C ONLY		
Note: The Covered Person is entitled to Medical Benefits only if (s)he has made application for such benefits and been enrolled for Coverage by the Plan Administrator under the Plan.		
COVERED SERVICE/PLAN CATEGORY	**NETWORK PROVIDERS AND ALL FACILITY AND HOSPITAL BENEFITS**	**NON-NETWORK PROVIDERS**
GENERAL INFORMATION		
Calendar Year Deductible	Individual: $3,150 Family: $5,300	Individual: $6,300 Family: $10,600
	Eligible Expenses applied toward the Network Deductible are **not** applied toward the Non-Network Deductible, and vice versa. The Family Deductible must be met by one or more family members before benefits are payable.	
Coinsurance	Plan will pay 80% of the Reasonable and Allowable Charge *Except as specified*	Plan will pay 60% of the Reasonable and Allowable Charge *Except as specified*
Out-of-Pocket Limit *Includes Coinsurance and Deductible*	Individual: $6,300 Family: $10,600	Individual: $12,600 Family: $21,200
	Network Out-of-Pocket Limit is **not** used to satisfy the Non-Network Out-of-Pocket Limit, and vice versa. The Non-Network Family Out-of-Pocket Limit will be met by one or more family members. The Network Family Out-of-Pocket Limit contains an embedded Individual Out-of-Pocket Limit of $7,150.	
Annual Maximum Benefit	Unlimited	
Lifetime Maximum Benefit	Unlimited	

COVERED SERVICES – PROFESSIONAL SERVICE PROVIDERS		
This listing of Covered Services appears in alphabetical order to better assist the Covered Person in locating the different benefit allowances for the specific Covered Services.		
Abortion Services *Only if mother's life in danger or pregnancy due to rape/incest*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Allergy Testing, Serum & Inhalers	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Allergy Injection	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%

Anesthesia Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60% *Anesthesiologist services rendered in a Network Facility will be covered at the In-Network benefit level.*
Birth Control Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Cardiac Rehabilitation Therapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Chemotherapy	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Chiropractic Services Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a $500 Maximum Benefit per Benefit Period.	
Dental Services *Limited to treatment of accidental injury and treatment of certain dental surgical procedures (as described in Covered Services section)*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Diagnostic Tests in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	The following Non-Network services will be covered at the Network benefit level: 1. Reading of a Non-Network Radiologist when the x-ray was performed in a Network Facility; and 2. Reading of a Non-Network Laboratory or Pathologist when the lab sample was taken in or drawn by a Network Provider.	
Durable Medical Equipment	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Precertification is required. Limited to a Maximum Benefit of 6-months rental or purchase price, whichever is less.	
Education Programs *Ostomy and diabetes only*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Emergency Room Care (Professional Services)	After Deductible, Plan pays 80%	After Deductible, Plan pays 80%
Home Health Care Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Precertification is required.Limited to a 120-day Maximum Benefit per Benefit Period.	
Hospice Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 30-day lifetime Maximum Benefit for Inpatient services and a $3,000 lifetime Maximum Benefit for Outpatient services. Bereavement counseling subject to a $3,000 lifetime Maximum Benefit.	
Medical and Surgical Supplies	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Obstetrical Care *Dependent Children covered for complications of pregnancy and certain prenatal preventive services*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Occupational Therapy Services Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period. Does not include: recreational programs, maintenance therapy or supplies.	

Orthotic Devices	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Physical Therapy Services in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period.	
Physician Office Visits for Non-Routine Care	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Podiatry Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Physician Consultations During Inpatient Hospital Confinement	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Pre-admission Testing Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Preventive Care *See page 33 for a list of preventive services.*	Deductible waived, plan pays 100%	Not Covered
Prosthetic Appliances	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Psychiatric Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Radiation Therapy Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Reconstructive Surgery Performed in a Physician's Office *As limited in Covered Services section.*	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Respiratory Therapy Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Second & Third Surgical Opinion	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Speech Therapy Performed in a Physician's Office	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a 20-visit Maximum Benefit per Benefit Period.	
Sterilization Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Substance Abuse Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Supplemental Accident Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Surgical Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
TMJ Treatment	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
Transplant Services	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Travel expenses are limited to $10,000 per lifetime. Includes one companion at any time or both parents when recipient is a minor. Note: Travel expenses are not covered for kidney or bone marrow transplants.	
Wigs	After Deductible, Plan pays 80%	After Deductible, Plan pays 60%
	Limited to a $250 lifetime Maximum Benefit.	

COVERED SERVICES – FACILITY AND HOSPITAL BENEFITS	
This Plan does not use a PPO Network for services and supplies provided by a Facility and/or Hospital, or a Provider billing as a Facility. Instead, the Plan will calculate the Plan's responsibility for payment, the "Reasonable and Allowed Amount" as defined in the Definitions section.	
Ambulance Services	After Deductible, Plan pays 80%
Ambulatory Surgical Facility Services	After Deductible, Plan pays 80%
Birthing Care Center *Dependent Child only covered for complications of pregnancy*	After Deductible, Plan pays 80%
Cardiac Rehabilitation Therapy	After Deductible, Plan pays 80%
Chemotherapy (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
Diagnostic Tests (Outpatient)	After Deductible, Plan pays 80% The following Non-Network services will be covered at the Network benefit level: 1. Reading of a Non-Network Radiologist when the x-ray was performed in a Network Facility; and 2. Reading of a Non-Network Laboratory or Pathologist when the lab sample was taken in or drawn by a Network Provider.
Dialysis Treatment – Outpatient	After Deductible, Plan pays 80%
Emergency Room Care (Facility Covered Services)	After Deductible, Plan pays 80%
Hospice Services	After Deductible, Plan pays 80% Limited to a 30-day lifetime Maximum Benefit for Inpatient services and a $3,000 lifetime Maximum Benefit for Outpatient services. Bereavement counseling subject to a $3,000 lifetime Maximum Benefit.
Hospital Services During Inpatient Confinement • *Room, board, general nursing* • *Ancillary services*	After Deductible, Plan pays 80%
Obstetrical Care *Dependent Children covered for complications of pregnancy and certain prenatal preventive services*	After Deductible, Plan pays 80%
Occupational Therapy Services (Facility Covered Services and Supplies)	After Deductible, Plan pays 80% Limited to a 20-visit Maximum Benefit per Benefit Period. Does not include: recreational programs, maintenance therapy or supplies.
Physical Therapy Services (Facility Covered Services and Supplies)	After Deductible, Plan pays 80% Limited to a 20-visit Maximum Benefit per Benefit Period.
Reconstructive Surgery (Facility Covered Services and Supplies) *As limited in Covered Services section.*	After Deductible, Plan pays 80%

Respiratory Therapy (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
Routine Nursery Care for Newborn (Facility Covered Services)	After Deductible, Plan pays 80%
Skilled Nursing Facility/Rehabilitation Facility Services	After Deductible, Plan pays 80% Limited to a 90-day Maximum Benefit per Benefit Period.
Speech Therapy (Facility Covered Services and Supplies)	After Deductible, Plan pays 80% Limited to a 20-visit Maximum Benefit per Benefit Period.
Sterilization Services (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
Substance Abuse Services (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
Supplemental Accident Services (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
Surgical Services (Facility Covered Services and Supplies)	After Deductible, Plan pays 80%
Transplant Services (Facility Covered Services)	After Deductible, Plan pays 80% Travel expenses are limited to $10,000 per lifetime. Includes one companion at any time or both parents when recipient is a minor. Note: Travel expenses are not covered for kidney or bone marrow transplants.
Urgent Care Services in Urgent Care Facility	After Deductible, Plan pays 80%

CERTIFICATION AND HEALTH MANAGEMENT PROVISIONS
Group A: All SC Locations
Group B: Winchester, VA Location
Group C: All Other Metromont Locations

I. Services Requiring Pre-Certification (All Groups):
The following services must be pre-certified:

1. All scheduled Hospital admissions
2. All non-scheduled Hospital admissions, including weekend Hospital admissions. Notification must take place within 48 hours after the admission date.
3. All admissions to a Skilled Nursing Facility or Rehabilitation Facility.
4. All home health care.
5. Durable medical equipment.:
   - $500 for rental
   - $1,500 for purchase
   - $1,000 for prosthetics
6. Outpatient Surgeries not performed in a Physician's office.
7. The following non-emergency diagnostic tests performed in the Outpatient Department of a Hospital: (a) PET scans; (b) CT angiogram; (c) CT calcium screening; (d) CT of the heart; and (e) MRI of the heart.
8. Non-emergent Air Ambulance transports.
9. Specialty Injectables covered under the medical plan. Please visit https://fhs.umr.com/print/UM1428.pdf for a list of Specialty Injectable drugs. To request a copy of the Specialty Injectable list, call the toll-free number on the back of the Participant's identification card and the list will be provided free of charge.

SPECIAL NOTE ABOUT OBSTETRICAL ADMISSIONS:
Pre-certification of Hospital admissions for an obstetrical delivery is not required for any Hospital Confinement for such services unless the Confinement exceeds 48 hours for a routine vaginal delivery and 96 hours for a cesarean section delivery. If the Hospital Confinement exceeds this time period, the medical management company must be notified 48 hours following the date of admission (or 5 business days prior to the admission date if there is a reasonable expectation that the Covered Person's Hospital stay will extend beyond the 48 hour/96-hour Hospital stay).

II. Pre-Certification Requirements: Group B Only
Care Management
Procedures
Benefit amounts payable might be affected if Utilization Management requirements are not satisfied. Participants should call the phone number on the back of the Plan identification card to request pre-certification at least two weeks prior to a scheduled procedure in order to allow for fact-gathering and independent medical review, if necessary. If the Plan is a secondary payor, pre-certification will be required unless the primary payor is Medicare.

Note: The Participant will not be penalized for failure to obtain pre-certification if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Participants who have received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**
866-494-4502

DEFINITIONS
The following terms are used for the purpose of the Care Management section of this Plan Document. Refer to the Definitions section for additional definitions.

Pre-certification is the process of determining benefit coverage prior to a service being rendered to an individual Plan Participant. A determination is made based on Medical Necessity criteria for services, tests, or procedures that are appropriate and cost-effective for the Participant. This Participant-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

The phone number to call for pre-certification is listed on the back of the Plan identification card.
The fact that a Participant receives pre-certification from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Participant must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this Plan Document, including additional information obtained that was not available at the time of the pre-certification.

Medical Director Oversight. A UMR Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Case Management Referrals. During the pre-certification review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Case management opportunities are identified by using a system-integrated, automated and manual trigger lists during the pre-certification review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals.

The Plan's goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to the Plan's (or its designee's) standard pre-certification policies and procedures and a final determination will be made no later than 30 days after the request for review.

Case Management services are designed to identify catastrophic and complex Illnesses, transplants, and trauma cases. UMR Care Management's nurse case managers identify, coordinate, and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified by using a system-integrated, automated and manual, trigger lists during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating Physician, and the facility to mobilize appropriate resources for the Participant's care. The Plan's philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future.

Penalties for Not Obtaining Pre-Certification

A non-pre-certification penalty is the amount that must be paid by a Participant who does not call for pre-certification prior to receiving certain services. A penalty of $500 may be applied to applicable claims if a Participant receives services but does not obtain the required pre-certification.

III. Pre-Certification Requirements: Groups A and C

Under the Plan, there are a number of certification requirements in connection with certain services. The purpose of these requirements is to assist the Plan in determining the Medical Necessity of the services or procedures and the appropriateness of the planned course of treatment (e.g., appropriate length of stay or the appropriate number of visits or treatments). Compliance with the certification requirements is not a guarantee of benefit payment. Failure to comply with the certification requirements will result in a penalty as described below.

All services requiring pre-certification, as noted on the Summary Plan Description are to be certified in advance, except for emergencies. The Covered Person or their representative is required to call the phone number for pre-certification located on the back of their ID card for the services specified below at least seven (7) business days prior to services being rendered. The Covered Person or their representative must identify the services to be rendered and the associated diagnosis and procedure codes necessary for pre-certification determinations and service pre-pricing.

NON-COMPLIANCE PENALTY:

Failure to comply with the pre-certification and notification requirements described in this section will result in a $500 penalty on all Eligible Expenses in connection with admission or procedure for which the Covered Person failed to pre-certify or notify the medical management company.

Utilization review is the process of evaluating if services, supplies or treatment are Medically Necessary, appropriate and priced at the prevailing rates to help ensure cost-effective care. Utilization review can eliminate unnecessary services, hospitalizations, and shorten confinements while improving quality of care and reducing costs to the Covered Person and the Plan.

Pre-certification establishes the Medical Necessity of certain care and services covered under the Plan. It ensures that the pre-certified care and services will not be denied on the basis of Medical Necessity (as defined by this Plan). The Pre-certification process will also establish the reference prices for requested services. However, pre-certification does not guarantee the payment of benefits. Coverage and benefits are always subject to other requirements and provisions of the Plan, such as, Plan limitations, exclusions, and eligibility at the time care and services are provided.

Under the Plan, a medical management company will conduct and manage the certification process. This means that the Covered Person should contact the medical management company at the telephone number appearing on the identification card to facilitate this process. In each instance, the Covered Person may satisfy this requirement by having the Hospital, Physician or other Provider or a family member contact the medical management company to provide the required pre-certification or notification.

CONTINUED STAY REVIEW AND DISCHARGE PLANNING

During a Covered Person's Hospital stay, a continued stay review will be conducted. This review applies to all Hospital admissions. The purpose of continued stay review is to re-evaluate the Medical Necessity of a continued Hospital stay. It may be necessary to obtain additional information concerning the Covered Person's Hospital stay in order to conduct a continued stay review. During this process and prior to the Covered Person being discharged, the medical management company will also review the Covered Person's progress for purposes of discharge planning. The purpose of discharge planning is to identify patients requiring extended care following discharge and to determine the most appropriate setting for continued care.

HEALTH MANAGEMENT PROGRAMS

The Plan offers a health management program to all Covered Persons. This program is known as Healthy Lifestyle Partnership. The goal of the healthy management program is to help the Covered Person achieve a healthy lifestyle by providing information concerning the prevention and management of chronic conditions.

There are several ways to participate in the Plan's health management program. A Covered Person may refer himself/herself or a family member into the program by calling 1-877-608-2200. In addition, a Physician may refer a Covered Person into the program. An individual may also receive information from time to time if it seems that (s)he or a family member would benefit from participating in the Healthy Lifestyle Partnership program.

Upon entering the program, a care manager will be assigned to the Covered Person. The care manager, who is a trained Registered Nurse, will contact the Covered Person to explain the program and answer any questions. The care manager will also work closely with the Covered Person's Physician to coordinate care and do everything possible to assist in making informed health care decisions. All information discussed with a care manager will be kept private and confidential

The following services are provided under this disease management program:

1. A health assessment performed by a Registered Nurse;
2. Information about diet, exercise and other important health-related topics; and
3. A personalized contact schedule with a care manager to discuss medication and other health needs or concerns.

AMBULANCE (AIR/FLIGHT) SERVICES: GROUPS A & C ONLY (All Locations Except Winchester, VA)

All flight-based inter-Facility patient transport services require pre-certification from the Plan Administrator via Sentinel Air Medical Alliance, LLC. Please contact Sentinel Air Medical Alliance, LLC at (877) 542-8828. Sentinel Air Medical Alliance, LLC may discuss with the Physician and/or Hospital/Facility the Diagnosis and the need for inter-Facility patient transport versus alternatives.

Failure to notify Sentinel Air Medical Alliance, LLC and subsequently obtain a pre-certification number from Sentinel Air Medical Alliance, LLC may, solely in the Plan Administrator's discretion, result in a reduction or denial of benefits for charges arising from or related to flight-based inter-Facility patient transport. Non-compliance penalties imposed for failure to notify Sentinel Air Medical Alliance, LLC will not be included as part of the annual out of pocket maximum.

The Plan Administrator retains the discretionary authority to limit benefit availability to alternative Providers of inter-Facility patient transport if and when a Provider fails to comply with the terms of the Plan, or proposed charges exceed the Maximum Benefit in accordance with the terms of the Plan.

MEDICAL BENEFITS

This section describes the Covered Person's Medical Benefits. All payments will be subject to any applicable Copayments, Deductible, Coinsurance, Maximum Benefits and other provisions and limitations in this Summary Plan Description.

HOW PAYMENT IS DETERMINED

I. Group B (Winchester, VA Location): United Healthcare ChoicePlus Network

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out-of-pocket Deductible has been satisfied. Benefits for Pregnancy expenses, which are covered for Employee and Spouse only, are paid the same as any other Sickness. Some services related to Dependent Children's Pregnancy expenses may be covered. See the Preventive Care section for more information.

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Participant and the Plan. The Utilization Management procedures include certain pre-certification requirements.

The benefit amounts payable under the Summary of Benefits of this Plan Document may be affected if the requirements described for Utilization Management are not satisfied.

Plan Network

The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. To find out to which Network a Provider belongs, please refer to the online Provider Directory, or call the toll-free number listed on the back of the Plan's identification card. The participation status of Providers may change from time to time.

- If a Provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the Network benefit levels that are listed on the Summary of Benefits:

  UnitedHealthcare Choice Plus Network

- For services received from any other Provider, claims for Covered Expenses will normally be processed in accordance with the Non-Network benefit levels that are listed on the Summary of Benefits unless one of the following exceptions applies:

  a. In the event a Participant receives services from a Non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia at a Network facility, the charges of the non-Network Provider will be paid as though the services were provided by a Network Provider.
  b. The Network Provider level of benefits is payable when a Participant receives emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.
  c. In the event a Participate has no choice of Network Provider in the specialty that he or she is seeking within the Network service area, the charges of the Non-Network Provider will be paid as though the services were provided by a Network Provider.
  d. If there is no In-Network provider, or no In-Network provider is willing or able to provide the necessary service(s) to the Covered Person within a 50-mile radius of the Covered Person's residence, the Covered Person may be eligible to receive In-Network benefits from an Out-of-Network provider. In this situation, Your In-Network Physician will notify the Claims Administrator, who will work with You and Your In-Network Physician to coordinate care through an Out-of-Network provider.

II. Group C: Reference Based Pricing Plan Design (All Metromont Locations Other Than SC Locations and Winchester, VA Location)

This Plan is structured to provide Participants with access to high quality care at an affordable cost. As such, the Plan calculates benefits differently depending on the type of Provider, the service or supply provided, and the location where a Participant receives services or supplies.

For Covered Expenses performed by a Facility or Hospital, as defined in Article IV, the Plan provides open access to any Facility or Hospital of the Participant's choosing. This means the Plan does not provide access to a Preferred Provider Organization ("PPO") Network for Facilities or Hospitals.

For Covered Expenses performed by a Provider, as defined in Article IV, which includes but is not limited to a Physician, a licensed speech or occupational therapist, physical therapist, the Plan provides access to a PPO Network, subject to any applicable Deductibles, copays, and/or coinsurance. Please see Section 3.05 below for more details.

Facilities and Providers Billing as Facilities

The Plan provides Participants with open access to any Facility or Hospital of the Participant's choosing. The following are examples of Facilities:

- Hospitals (Inpatient and Outpatient treatment);
- Inpatient Facilities (such as Skilled Nursing Facilities or Hospice Facilities);
- Outpatient Facilities (such as Rehabilitation Hospitals, Infusion Therapy Centers, or Hospice Facilities)
- Inpatient and Outpatient Facilities for treatment of Mental or Nervous Disorders, or Substance Abuse Disorders;
- Air/ground ambulance;
- Ambulatory Surgery Centers; or
- Dialysis clinics.

Payment for Covered Expenses at Facilities, or for Providers billing as a Facility, will be the Reasonable and Allowable Amount. Please see the Summary of Benefits for additional information on benefits and limitations.

Professional Services Providers

The Plan offers access to a PPO Network to access discounted fees for services for Participants. A list of the PPO Network Providers can be accessed at www.healthscopebenefits.com. Where a full complement of PPO Network Providers is unavailable, then the Plan Administrator may grant an exception and reimburse a Non-Network Provider at the PPO Network Provider benefit level. In order for the Plan Administrator to grant an exception, the Provider must accept the Reasonable and Allowed Amount as payment in full, less any applicable Deductible, copay, or coinsurance amounts.

Otherwise, if your Provider is not in the PPO Network, then your Provider is considered Non-Network and will be reimbursed at the Non-Network benefit level listed in the Summary of Medical Benefits. Payment for Covered Expenses by a Non-Network will be calculated using the Reasonable and Allowable Amount.
Please note that the PPO Network does not include services and supplies provided by Hospitals, Ambulatory Surgery Centers, infusion therapy centers, dialysis clinics, or Facilities. For these services and supplies, the Plan will calculate payment based on the Reasonable and Allowable Amount for Facilities.

III. Group A: Cigna PPO (All SC Locations)

Covered Services Rendered by Preferred Provider
The Plan offers a broad network of providers within the network(s) selected by the Plan Sponsor. Preferred Providers are those who/that are contracted with the network(s) indicated on the identification card. For all Covered Services (other than Outpatient dialysis related services and products), Preferred Providers must accept a reduced rate ("Negotiated Rate") as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate. The Covered Person may obtain a directory of Preferred Providers by accessing the PPO Network's website. If, for some reason, the Covered Person is unable to obtain information concerning the Network's Preferred Providers via the website, (s)he may obtain information about the Preferred Providers by contacting the Plan Administrator.

Covered Services Rendered by a Non-Preferred Provider
Payment for Covered Services (other than Outpatient dialysis related services and products) rendered by a Non-Preferred Provider will be based on the Provider's Reasonable and Customary Charge. The Non-Preferred Provider may bill for charges in excess of such charge. Covered Services provided by Non-Preferred Providers will generally be covered at a lower benefit level except that services rendered by a Non-Preferred Provider to a Covered Person who resides outside of the PPO Network Service Area or who otherwise does not have access to a Preferred Provider will be covered at the In-Network benefit level. There may be additional exceptions which are shown in the Schedule of Benefits.

IV. Dialysis

Outpatient Dialysis Covered Services: Group C
Dialysis Services, diagnostic testing, laboratory tests, equipment and supplies are a Covered Service under the Plan only to the extent they are Medically Necessary and only insofar as their cost does not exceed the Reasonable and Allowable Charge specified on the Schedule of Benefits, specific to Dialysis Services.

Dialysis Services, diagnostic testing, laboratory tests, equipment and supplies are those services and items used in the dialysis treatment for acute renal failure or chronic irreversible renal insufficiency (treatment of anemia and other diagnoses related to renal failure). This also includes injectable and intravenous medication including, but not limited to, Heparin, Epogen, Procrit, and other medications administered directly before, during or after a dialysis procedure. Dialysis procedures are for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis regardless of whether they are provided on an Inpatient or Outpatient basis.

Dialysis: Groups A and B
Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same for any other Illness.

IV. Oncology Program: Groups A & C

This provision describes a specialty case management program designed for certain aspects of care received by cancer patients who are beneficiaries under the Plan. Your Plan has entered into an arrangement with American Health Holding, a company specializing in oncology case management, to assist you and your oncologist during the course of cancer treatment when administered either in an outpatient setting (e.g., in the physician's office or other covered outpatient setting) or an inpatient setting. The program applies to the plan of treatment for all cancer types and stages and begins with a treatment planning phase (including drug and/or radiation treatment) and continues through active treatment and transitional care.

A Registered Nurse will be assigned to you and will contact you to provide support, education, and answer any

questions you might have about your disease and your treatment plan and will remain in contact with you and your oncologist for the duration of your cancer journey.

Unless your oncologist has entered into an agreement with HealthSCOPE Benefits to accept other reimbursement rates, the payment for all drugs used in the treatment of cancer will be limited to the rate of Average Sales Price plus 10%. Average Sales Price is the price calculated by pharmaceutical manufacturers and submitted to the Centers for Medicare and Medicaid Services (CMS) on a quarterly basis.

MEDICAL COVERED SERVICES

The following is a list of those Covered Services under the Plan. The list of services appears in alphabetical order.

Abortion Services
The Plan will cover surgical services for a Covered Employee or Covered Spouse in relation to the performance of an abortion when such services are rendered and billed by a Physician when the mother's life would be in danger if the mother carried the pregnancy to term or when the abortion is performed to terminate a pregnancy that is the result of rape or incest.

Allergy Injections and Tests
The Plan will cover allergy testing and allergy serum and inhalers dispensed in the Physician's office at the time of the testing. The Plan will also cover allergy injections injection. When a Covered Person receives an allergy injection from a Primary Care Physician, the Covered Person is only required to pay one Copayment.

Ambulance Service: Group B (Winchester, VA) Only
Ambulance Transportation. Medically Necessary ground and air transportation by a vehicle designed, equipped and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary ambulance transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.

Ambulance Service: All Metromont Locations Except Winchester, VA
Transportation by professional ambulance, including approved available train transportation, to a local Hospital or transfer to the nearest Facility having the capability to treat the condition, if the transportation is connected with an Inpatient Confinement. Inter-Facility patient transport by air transport, for Participants if there is a life threatening situation or it is deemed to be Medically Necessary.

For a Participant who is in a Hospital or other health care Facility under the care or supervision of a licensed health care Provider pre-certification is required before transport of the Participant via air transport / any form of flight to another Hospital or Facility. Failure to notify Sentinel Air Medical Alliance, LLC and subsequently obtain a pre-certification number from Sentinel Air Medical Alliance, LLC may, solely in the Plan Administrator's discretion, result in a reduction or denial of benefits for charges arising from or related to inter-Facility patient transport via air/flight. Non-compliance penalties imposed for failure to notify Sentinel Air Medical Alliance, LLC will not be included as part of the annual out of pocket maximum.

The Plan Administrator retains the discretionary authority to limit benefit availability to alternative Providers of flight-based inter-Facility patient transport if and when a Provider fails to comply with the terms of the Plan, or proposed charges exceed the Maximum Benefit in accordance with the terms of the Plan.

Ambulatory Surgical Facility Services
The Plan will cover services rendered and billed by an Ambulatory Surgical Facility in connection with the performance of a covered surgical procedure performed in such Facility.

Anesthesia Services
The Plan will cover the administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist who is not the surgeon or assistant at surgery.

Birth Control
The Plan will cover the administration and removal of Intrauterine Devices (IUDs), injectable contraceptives (e.g. Depo Provera), and contraceptive devices.

Birthing Care Center Services
The Plan will cover the following services for a Covered Employee or Covered Spouse in connection with normal pregnancy, complications of a pregnancy or miscarriage when such services are provided to a Covered Person and rendered and billed by a Birthing Care Center. Services provided for a covered Dependent Child will only be covered for complications of a pregnancy. Birthing Care Center services include general nursing services, the use of the delivery room and equipment, prescribed drugs, anesthesia and medical/surgical dressings.

Cardiac Rehabilitation Therapy
The Plan will cover Cardiac Rehabilitation Therapy in connection with the rehabilitation of a Covered Person following a myocardial infarction or coronary occlusion or coronary bypass surgery when such rehabilitation services are rendered under the supervision of a Physician. Therapy must be initiated within 12 weeks after the initial treatment for the medical condition ends and services must be rendered in a Medical Facility.

Chemotherapy
The Plan will cover charges for chemotherapy. The Plan shall refer to the Centers for Medicare & Medicaid Services (CMS) authoritative compendia, including the NCCN Drugs and Biologics Compendium and Thomson Micromedex, in the determination of medically accepted drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen;

Chiropractic Services
The Plan will cover chiropractic treatment when rendered by a Physician or a Chiropractor on an Outpatient basis. As used herein, chiropractic treatment means treatment of the spine by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease or injury. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or a Chiropractor are required.

Clinical Trial Routine Patient Costs
The Plan will cover Routine Patient Costs for an Approved Clinical Trial. This benefit does not include: the investigational item, device or service itself; items and services solely for data collection and analysis purposes and not for direct clinical management of the Participant; or any service inconsistent with the established standard of care for the Participant's diagnosis. Routine Patient Costs services, treatment or items provided by a Non-Network Provider are covered only if the Approved Clinical Trial is only offered outside the Participant's state of residence.

Dental Services
The Plan will cover charges for Injury or care to the mouth, teeth or gums and alveolar processes when that care is for the following oral surgical procedures, when rendered and billed by a Physician or Other Medical Professional:

1. Treatment of an accidental injury;
2. Reduction of fractures of facial bones;
3. Excision of mandibular joints or lesions;
4. Incision of accessory sinus, mouth, salivary glands, or ducts;
5. Surgical removal of all impacted teeth.

Charges will not be covered under the Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Diagnostic Services
The Plan will cover Outpatient diagnostic services when the Covered Person has specific symptoms and such tests and procedures are needed to detect and diagnose an Illness or Injury. Specific services covered under this benefit include laboratory and pathology examinations, x-ray services, EKGs, EEGs, and MRIs, MRAs, CT scans and other tests using nuclear medicine.

Durable Medical Equipment
The Plan will cover the rental (or, if the charges would be less than the rental cost, the purchase) of durable medical equipment prescribed by a Physician. Rental costs must not be more than the purchase price. The durable medical equipment must serve only a medical purpose and be able to withstand repeated use.

Education Programs
The Plan will cover patient education programs for diabetic education programs (e.g., home blood sugar management, diabetes management, meal planning, insulin preparation and injection counseling) and ostomy care (i.e., care of the ostomy bag and the skin).

Emergency Room Services
The Plan will cover treatment of an Illness or Injury when such services are rendered in the emergency department of a Hospital. Covered Services include those Medically Necessary services and supplies provided by the Hospital following the Covered Person's admission to the emergency department for an Illness or Injury and include the services provided by the emergency room Physician and the Hospital's other emergency room staff (e.g. emergency room nursing staff, technicians, etc.).

Home Health Care Services
The Plan will cover home health care services rendered by a Home Health Care Agency when such services are provided to a Covered Person in the Covered Person's home and certified by a Physician to be in lieu of Inpatient care. Covered Services include the following:

1. Periodic visits by an R.N. or L.P.N.;
2. Non-custodial home health aide services, limited to 4-hour periods for each visit; and
3. Periodic visits for therapy by a licensed therapist (e.g. physical, occupational and speech therapy).

Hospice Services
The Plan will cover hospice services rendered by a Hospice Provider to a terminally ill patient with a life expectancy of 6 months or less. Hospice services are most often provided in the home but may also be provided on an Inpatient basis in a Hospice Facility. Hospice services must be agreed to by the Covered Person. Covered Services include the following:

1. 24-hour continuous nursing care and medical social services;
2. Physical, speech, occupational and respiratory therapy;
3. Home health aide services;
4. Dietary counseling;
5. Medical/surgical supplies and equipment;
6. Lab services;
7. Bereavement counseling - Must be furnished by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children) within 12 months following the patient's death; and
8. Respite care.

Hospital Services During an Inpatient Confinement
The Plan will cover certain Hospital services when the Covered Person is hospitalized as an Inpatient in a Hospital. The following room and board expenses and ancillary services are considered covered Inpatient Hospital services:

1. **Room and Board and General Nursing Services**. Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services, unless it is determined that private duty nursing services are needed because there is no available space in the Hospital's intensive care unit ("ICU") or the Hospital has no ICU. If the Covered Person uses a private room because the Hospital has only private rooms, payment for the room will be based on the Hospital's private room rate.

2. **Ancillary Services**. Ancillary Services received during a Hospital Confinement include, but are not limited to:

    a. Operating room and equipment;
    b. Delivery room and equipment;
    c. Other treatment rooms and equipment;
    d. Prescribed drugs;
    e. Anesthesia, anesthesia supplies and services provided by an employee of the Hospital;
    f. Medical and surgical dressings, supplies, casts and splints;
    g. Blood, blood transfusions and other blood-related services;
    h. Diagnostic services;
    i. Radiation therapy and intravenous chemotherapy;
    j. Kidney dialysis;
    k. Inhalation, physical, occupational and speech therapy.

Medical and Surgical Supplies
The Plan will cover medical and surgical supplies that serve a specific medical purpose and are purchased by the Covered Person for use in the home. Covered medical and surgical supplies include, but are not limited to, the following: Syringes and needles; oxygen; surgical dressings; casts and splints; braces; catheters; colostomy and ileostomy bags and supplies required for their use; and soft lenses and sclera shells intended for use in the treatment of an Illness or Injury of the eye. Covered Services do not include items usually stocked in the home for general use like adhesive bandages, thermometers and petroleum jelly.

Obstetrical Care
The Plan will cover services for a Covered Employee and Covered Spouse in connection with a normal pregnancy, complications of a pregnancy or miscarriage for the Covered Person when such services are rendered by a Physician, Certified Nurse Midwife or Physician Assistant. Coverage for a Dependent Child will only limited to complications from pregnancy and required prenatal preventive services.

Coverage will be provided for office visits in connection with pre-natal and post-natal care and treatment of the mother, including but not limited to routine examination of the mother and the infant, weight checks, blood pressure checks and one routine ultrasound. Pre and post-natal office visits will be covered as part of the overall obstetrical bill.

The Plan will also cover services rendered by a Hospital or Birthing Care Center in connection with a pregnancy, complications thereof or a miscarriage. The Plan may not restrict benefits for any length of stay in connection with childbirth for the mother or newborn Dependent Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Provider (e.g. the Covered Person's Physician, Certified Nurse Midwife, or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, the Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not require that a Physician or other Provider obtain authorization for prescribing a length of stay unless the length of stay will exceed 48 hours for a vaginal delivery or 96 hours for a cesarean section.

Occupational Therapy Services
The Plan will cover occupational therapy when rendered and billed by a Physician, Occupational Therapist or Physical Therapist. As used herein, occupational therapy means treatment rendered on an Inpatient or Outpatient basis as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts).

Orthotic Devices and Orthopedic Shoes
The Plan will cover the acquisition, replacement and adjustment of orthotic devices. Charges in connection with replacement will only be covered if necessary due to the Covered Person's growth and development. Under the Plan, orthotic devices are rigid or semi-rigid supportive devices which limit or stop motion of a weak or diseased body part.

In addition, the Plan will cover charges in connection with orthopedic shoes or corrective shoes provided such shoes are an integral part of a leg brace, and other supportive devices. All charges in connection with the adjustment of orthopedic or corrective shoes will not be covered.

Physical Therapy Services
The Plan will cover physical therapy when rendered by a Physician or Physical Therapist in a covered Outpatient setting. As used herein, physical therapy means treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Physical Therapist are required.

Physician's Office Visit for Non-Routine Care
The Plan will cover charges incurred during a visit to the Covered Person's Physician for non-routine care in connection with a specific Injury or Illness. Covered Services include screening examinations, evaluation procedures, medical care, treatment or services directly related to assist in the diagnosis or treatment of a specific Injury or Illness which is known or reasonably suspected.

Physician Consultations During Inpatient Confinement
The Plan will cover Physician visits and certain other consultation services for a Covered Person who is hospitalized as an Inpatient in a Hospital. Services under this benefit include services such as Physician visits from the treating Physician and Physician consultations with other Physicians. Staff consultations required by Hospital rules are excluded from Coverage.

Podiatry Services
The Plan will cover podiatry services rendered by a Podiatrist or a Physician. Covered Services include capsular or bone surgery for treatment of bunions, complete or partial removal of the nail or nail matrix affected by disease, infection or fungus, surgical procedures or injections involving the bones, nerves, muscles or tendons of the foot or ankle, and cutting or removal of corns, calluses or toenails if done in connection with

underlying medical conditions, such as diabetes or peripheral vascular disease.

Pre-admission Testing Services
The Plan will cover diagnostic services in connection with a scheduled surgical procedure.

Preventive Care
The Plan will cover charges for Preventive Care services. Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/preventive-care-benefits/ for more details.

Important Note: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered;

Preventive and Wellness Services for Adults and Children – In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/preventive-care-benefits/.

Women's Preventive Services – With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling

A description of Women's Preventive Services can be found at:
http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/preventive-care-benefits/.

For information about breastfeeding support and supplies, including breast pumps, please contact the customer service number on the back of the member ID card.

Prosthetic Appliances
The Plan will cover the purchase, fitting, needed adjustment, repairs, and replacements of prosthetic appliances and supplies that replace all or part of a missing body part and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body organ. Covered prosthetic appliances include prostheses in connection with breast reconstruction following a covered mastectomy procedure.

Psychiatric Services
The Plan will cover services for the treatment of a psychiatric condition and includes treatment of behavioral disorders, Autism, Attention Deficit Hyperactivity Disorders (ADHD) and Attention Deficit Disorders (ADD). A psychiatric condition will be treated the same as any other Illness for purposes of determining available Covered Services. In addition, the Plan will also cover individual and group psychotherapy and psychological testing. Covered Services include services rendered by:

1. Physician, Psychologist, or a Licensed Clinical Social Worker under the supervision of a Physician or Psychologist;
2. Hospital (Inpatient, Partial Hospitalization, acute Outpatient and Outpatient)
3. Specialized Hospital (Inpatient, Partial Hospitalization, acute Outpatient and Outpatient); or
4. Community Mental Health Facility (Inpatient, Partial Hospitalization, acute Outpatient and Outpatient).

The Plan will provide benefits for intermediate levels of care for mental health conditions and substance abuse disorders in parity with medical or surgical care of the same level. For instance, if the Plan provides benefits for a skilled nursing or rehabilitation Facility for medical or surgical treatment, the Plan will provide equal benefits for intensive outpatient therapy, partial hospitalization or residential treatment. Contact the customer service number on the back of the member ID card for more information.

Radiation Therapy
The Plan will cover the treatment of disease by x-ray, radium or radioactive isotopes.

Reconstructive Surgery
The Plan will cover reconstructive surgery to correct a deformity visible at birth or for treatment to restored bodily function as the result of an accidental injury. Such surgical procedure will be treated the same as any other surgical procedure. In addition, Coverage will be provided for the following services in connection with a mastectomy:

1. All stages of 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. Physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Respiratory Therapy
The Plan will cover respiratory therapy when such services are rendered and billed by a Physician or Other Medical Professional who is qualified and licensed to render such services. Respiratory therapy is a type of therapy that involves the introduction of oxygen and other dry or moist gases into the lungs in order to maintain the breathing capacity of individuals with impaired lung function.

Routine Nursery Care
The Plan will cover the routine nursery care of the newborn infant and the first Inpatient visit to examine the infant provided the infant has been enrolled for Coverage in accordance with the enrollment requirements of the Plan.

Second and Third Surgical Opinion
When the Covered Person's Physician recommends that a surgical procedure be performed, the Plan will cover

a consultation with a Physician in order to obtain a second option in connection with the recommended surgery. The Physician providing the second opinion must be a Physician who is qualified to perform the surgery that has been recommended by the first Physician and cannot be a Physician whose practice is associated with the first Physician. Charges incurred for a second surgical opinion must be billed as a second surgical opinion. Otherwise, the consultation with the Physician will be treated the same as any other Physician consultation in connection with an Illness. If the second opinion differs from the first opinion obtained, the Plan will cover a consultation with a third Physician.

Skilled Nursing Facility Services
The Plan will cover a Confinement in a Skilled Nursing Facility when the Covered Person is admitted to the Skilled Nursing Facility immediately following discharge from the Hospital. The condition being treated in the Skilled Nursing Facility must be the same as that which was being treated during the previous Hospital Confinement. The following services will be covered during the Skilled Nursing Facility Confinement:

1. **Room and Board.** Room and board in a semi-private room, including meals, special diets and nursing services. Coverage includes a bed in a special care unit approved by the Plan.

2. **Ancillary Services.** Ancillary services received during a Confinement include treatment rooms, prescription drugs, medical dressings and supplies, diagnostic services and therapy services, such as physical, occupational and speech therapy.

The Plan will also pay for Confinements in a Rehabilitation Facility, subject to the same conditions and limitations described above.

Speech Therapy
The Plan will cover speech therapy when rendered and billed by a Physician or Speech Therapist. As used herein, speech therapy means active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an active Illness or disease.

Substance Abuse Services
The Plan will cover Substance Abuse Services for the care and treatment of alcoholism and drug addiction. Substance Abuse Services will be covered on an Inpatient and Outpatient basis. In addition, Partial Hospitalization is also covered. Covered Services include those services that would be covered for any other Illness, as set forth in this Summary Plan Description, and also include individual and group psychotherapy and psychological testing. Substance Abuse Services does not include dependence on tobacco and ordinary caffeine-containing beverages.

Covered Services include services rendered by:

1. Physician, Psychologist, or a Licensed Clinical Social Worker under the supervision of a Physician or Psychologist;
2. Hospital (Inpatient, Partial Hospitalization, acute Outpatient and Outpatient)
3. Specialized Hospital (Inpatient, Partial Hospitalization, acute Outpatient and Outpatient);
4. Community Mental Health Facility (Inpatient, Partial Hospitalization, acute Outpatient and Outpatient);
5. Substance Abuse Treatment Facility (Inpatient, Partial Hospitalization, acute Outpatient and Outpatient).

The Plan will provide benefits for intermediate levels of care for mental health conditions and substance abuse disorders in parity with medical or surgical care of the same level. For instance, if the Plan provides benefits for a skilled nursing or rehabilitation Facility for medical or surgical treatment, the Plan will provide equal benefits for intensive outpatient therapy, partial hospitalization or residential treatment. Contact the customer service number on the back of the member ID card for more information.

Sterilization Services
The Plan will cover surgical services in connection with a voluntary sterilization procedure when such services are rendered and billed by a Physician.

Surgical Services
Surgery performed by a Physician is covered on an Inpatient or Outpatient basis (e.g. in a Physician's office or Ambulatory Surgical Facility). Surgical services also include:

1. **Surgical Assistance**. Services of a Physician who helps the Covered Person's surgeon in performing covered major surgery when a house staff member, intern or resident cannot be present. In this instance, the Reasonable and Allowable/Customary and Reasonable Charge for services of a Physician who assists the surgeon in performing a covered surgery will be determined as 20% of the surgeon's charge for the surgery; and

2. **Multiple Surgical Procedures**. When more than one surgical procedure is performed through the same body opening during one operation, the Covered Person is covered only for the most complex procedure. If more than one body system is involved or the procedures are needed for the handling of multiple traumas, then the Plan will base payment on 100% of the Reasonable and Allowable/Customary and Reasonable Charge for the most complex procedure and 50% of the Reasonable and Allowable/Customary and Reasonable Charge for each additional procedure performed.

   When more than one surgical procedure is performed through more than one body opening during one operation, then the Plan will base payment on 100% of the Reasonable and Allowable/Customary and Reasonable Charge for the most complex procedure and 50% of the Reasonable and Allowable/Customary and Reasonable Charge for each additional procedure performed.

TMJ Treatment
The Plan will cover the diagnosis Temporomandibular Joint (TMJ) disorders. In addition, Coverage will be provided for the therapeutic IM injection into the Temporomandibular Joint and orthodontic devices and the adjustment to such devices that are deemed to be Medically Necessary for the treatment of the TMJ disorder.

Transplant Services: Groups A & C (All Metromont Locations Except Winchester, VA)
The Plan will cover services in connection with sectional Medically Necessary and non-Experimental/Investigational transplant procedures. Covered transplant services include all Covered Services described in this Summary Plan Description as such services would be available for the treatment of any other Illness. In addition, the Plan will cover expenses for the acquisition of the organ or tissue and travel and lodging expenses in connection with the Covered Person receiving a covered transplant procedure. Travel and lodging expenses will be limited to the travel expenses of the Covered Person receiving the transplant procedure and, if the Covered Person is a minor, the travel and lodging expenses of 2 adult companions (e.g., the Covered Person's parents). If the Covered Person is an adult, the Plan will cover the travel and lodging expenses of one adult companion. Note: Travel and lodging expenses will only be covered if the distance being traveled is more than 60 miles from the Covered Person's place of residence. In addition, travel and lodging expenses will not be covered in connection with a kidney or bone marrow transplant.

Transplant Benefits: Group B (Winchester, VA)
Refer to the Care Management section of this Plan Document for pre-certification requirements. The program for Transplant Services at Designated Transplant Facilities is:

Optum

This coverage provides Participants with a choice for transplant care. The Plan provides incentives to

Participants by giving the option of using a Designated Transplant Facility. While the Plan does not require Participants to use a Designated Transplant Facility in order to receive benefits, Participants may receive better benefits if they do so. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes that include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

1. Definitions

The following terms are used for the purpose of the Transplant Benefits section of this Plan Document.

"Approved Transplant Services" means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing, and Ancillary Services.

"Designated Transplant Facility" means a facility that has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

"Non-Designated Transplant Facility" means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a Participating Provider.

"Organ and Tissue Acquisition / Procurement" means the harvesting, preparation, transportation, and storage of human organ and tissue that is transplanted to a Covered Person. This includes related medical expenses of a living donor.

"Stem Cell Transplant" includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and includes chimeric antigen receptor T-cell therapy (CAR-T).

2. Benefits

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-Designated Transplant Facility due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Summary of Benefits. Benefits are based on the Customary and Reasonable Charge/Reasonable and Allowable Amount.

It will be the Covered Person's responsibility to obtain pre-certification for all transplant-related services. If pre-certification is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be an individual Plan exclusion.

3. Covered Expenses

The Plan will pay for Approved Transplant Services at Designated or Non-Designated Transplant Facility for Organ and Tissue Acquisition / Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition / Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition / Procurement. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor-related complications during the transplant period, per the transplant contract, if the recipient is a Covered Person under this Plan.

The Plan will provide donor services at a Non-Designated Transplant Facility for initial acquisition/procurement only, up to the maximum listed on the Summary of Benefits, if any. Complications, side effects, or Injuries are not covered unless the donor is a Covered Person.

4. Second Opinion

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the transplant facility, the Plan will allow him or her to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant-related services or supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

5. Travel Benefit

If the Covered Person lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to the maximum of_$10,000 per lifetime. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility, including:
  - Airfare.
  - Tolls and parking fees.
  - Gas/mileage.

- Lodging at or near the transplant facility, including:
  - Apartment rental.
  - Hotel rental.

Lodging for purposes of this Plan does not include private residences. Lodging reimbursement that is greater than $50 per person per day may be subject to IRS codes for taxable income. Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will pay travel and housing benefits for a non-covered living donor only after any other coverage that the living donor has is exhausted.

6. Transplant Exclusions

In addition to the exclusions listed in this Plan Document, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition / Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.

- Transplants considered Experimental, Investigational, or not Medically Necessary.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

Urgent Care Facility Services
The Plan will cover services rendered by an Urgent Care Facility in connection with the treatment and diagnosis of an Illness or Injury. Covered Services include the services of the Physician on call in the Urgent Care Facility and all other medical staff of the Urgent Care Facility. Under this benefit, Coverage will be provided for screening examinations, evaluation procedures, medical and surgical care, and treatment or services directly related to a specific Injury or Illness that is known or reasonably suspected.

Wigs
The Plan will cover wigs when necessary as the result of hair loss due to chemotherapy treatment.

MEDICAL EXCLUSIONS AND LIMITATIONS

1. **Acupressure and/or Acupuncture.** The Plan will not cover charges in connection with acupressure and/or acupuncture;

2. **Admissions Primarily for Diagnostic Studies**. The Plan will not cover room, board and general nursing care for Hospital admissions mainly for diagnostic studies;

3. **Admissions Primarily for Physical Therapy**. The Plan will not cover room, board and general nursing care for Hospital admissions mainly for Physical Therapy;

4. **Braces and Artificial Limbs**. The Plan will not cover replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is a sufficient change in the Covered Person's physical condition to make the original device no longer functional;

5. **Certain Examinations and Services.** The Plan will not cover examinations or medical services the Covered Person receives specifically for the purpose of employment, recreation, insurance, school attendance or licensure;

6. **Complications of Non-Covered Treatments**. The Plan will not cover care, services or treatment required as a result of complications from treatment not covered under the Plan (not including Coverage of complications of a non-covered abortion);

7. **Contraceptives.** The Plan will not cover contraceptive drugs and devices under the Medical Benefits, except that the insertion of contraceptive devices will be covered. Certain contraceptives are covered under the Plan's Prescription Drug Benefits. Refer to the Prescription Drug Benefits section;

8. **Cosmetic Services**. The Plan will not cover expenses in connection with treatment only to improve appearance, except as specifically set forth herein. This exclusion does not include procedures to restore body function or correct deformity from disease, trauma, birth or growth defects or prior therapeutic processes;

9. **Custodial Services**. The Plan will not cover expenses or services for custodial care, custodial care counseling or for services not needed to diagnose or treat an Injury or Illness and will furthermore not cover Hospital Confinements for custodial care or for custodial treatment for a psychiatric or substance abuse disorder;

10. **Dental or Medical Department/Clinic**. The Plan will not cover expenses incurred or services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group;

11. **Dental Services**. The Plan will not cover expenses for dentistry or dental processes, except as specified;

12. **Drugs.** The Plan will not cover expenses for over-the-counter or prescription drugs purchased and administered on an Outpatient basis, except as specified herein. Prescription drugs administered while an Inpatient in a Hospital will be covered under the Plan;

13. **Ecological or Environmental Medicine.** The Plan will not cover ecological or environmental medicine;

14. **Educational or Training**. The Plan will not cover expenses or services or supplies primarily for educational, vocational or training purposes;

15. **Elective Abortion.** The Plan will not cover expenses or services for an elective abortion unless the abortion is performed when the mother's life would be in danger if the mother carried the pregnancy to term or when the abortion is performed to terminate a pregnancy that is the result of rape or incest. Coverage for such an abortion is limited to Covered Employees and Covered Spouses. Complications from an abortion are covered for Dependent Children;

16. **Exercise Program.** The Plan will not cover expenses for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by the Plan;

17. **Eye Glasses**. The Plan will not cover expenses for eye glasses, sunglasses, safety glasses, safety goggles, subnormal vision aids or contact. This exclusion does not apply to the first pair of contact lenses or eyeglasses following cataract surgery;

18. **Family Counseling.** The Plan will not cover family counseling or counseling with a patient's family members, except as set forth herein;

19. **Financial Counseling.** The Plan will not cover financial counseling services;

20. **Gender Determination.** The Plan will not cover services in order to determine the sex of an unborn child, unless Medically Necessary to determine a genetic disorder;

21. **Genetic Testing**. The Plan will not cover expenses related to Genetic Testing performed as a diagnostic tool; to predict the presence of a specific disease in those with a familial history; preconception or prenatal screening; or population screening.

    This exclusion does not apply to histological examination of tumor specimens from individual patients (such as HER2/NEU in breast cancer) to look for genetic markers associated with prognosis and likely treatment response that are part of a drug's FDA labeling and or has been recognized as safe and effective for a specific type cancer diagnosis in the National Comprehensive Cancer Drugs and Biologics Compendium, or as otherwise stated herein;

22. **Hearing Aids**. The Plan will not cover expenses for hearing aids or examinations for prescribing or fitting them;

23. **Holistic Medicine.** The Plan will not cover charges in connection with holistic treatment or therapy;

24. **Homeopathic Medicine or Drugs.** The Plan will not cover charges in connection with homeopathic treatment or drugs;

25. **Hypnotherapy or Hypnotic Anesthesia.** The Plan will not cover charges in connection with hypnosis, hypnotherapy or hypnotic anesthesia;

26. **Impotence Treatment**. The Plan will not cover charges for the care, treatment, services, supplies or medication in connection with treatment for impotence;

27. **Infertility Services**. The Plan will not cover expenses for assisted reproductive technologies, including but not limited to, in-vitro fertilization, artificial insemination, GIFT or ZIFT, and all other services in connection with an infertility condition;

28. **Legal Counseling Services.** The Plan will not cover charges in connection with legal counseling;

29. **Lifestyle Improvement Services**. The Plan will not cover lifestyle improvement services or charges, including but not limited to, physical fitness programs and equipment, spas, air conditioners, humidifiers, personal hygiene and convenience items, mineral baths, massage and dietary supplements;

30. **Marital or Pre-Marital Counseling**. The Plan will not cover services in connection with marital or pre-marital counseling;

31. **Massage Therapy.** The Plan will not cover charges in connection with massage or massage therapy;

32. **Megavitamin Therapy.** The Plan will not cover megavitamins or megavitamin therapy;

33. **Non-Emergency Hospital Admissions.** The Plan will not cover charges for care and treatment billed by a Hospital for non-medical emergency admissions on a Friday or Saturday. This does not apply if surgery is performed within 24 hours of admission;

34. **Podiatry Services.** The Plan will not cover expenses for foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular or bone surgery), calluses, toenails (unless needed in treatment of a metabolic or peripheral-vascular disease), and the like;

35. **Pregnancy of a Dependent Daughter**. Charges for a Dependent Daughter's pregnancy, with the exception of treatment for complications and services that may be covered under the Preventive Care benefit;

36. **Prior to Effective Date or After Termination Date**. The Plan will not cover expenses incurred prior to the Covered Person's Effective Date or after the termination date except as specified in this Summary Plan Description;

37. **Private Room Charges**. The Plan will not cover charges for a private room except as set forth herein;

38. **Preventive and Routine Services**. The Plan will not cover preventive services, routine office visits or routine periodical physical examinations for a Covered Person, except as specified in this Summary Plan Description;

39. **Replacement Braces.** The Plan will not cover charges for the replacement of braces of the leg, arm, back, neck or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional;

40. **Sleep Disorders.** The Plan will not cover charges for the care and treatment of sleep disorders unless deemed Medically Necessary;

41. **Smoking Cessation Programs**. The Plan will not cover expenses for care and treatment for smoking cessation, including smoking cessation programs and smoking deterrent patches, unless specified otherwise;
42. **Sterilization Reversal**. The Plan will not cover expenses for the reversal of a sterilization procedure;

43. **Telephone Consultations, Missed Appointments, Claim Form Completion**. The Plan will not cover expenses for telephone consultations, missed appointments, or completion of claim forms;

44. **TMJ Devices and Services.** The Plan will not cover services in connection with TMJ except as set forth herein;

45. **Transplant Services**. The Plan will not cover transplant services other than those specified herein;

46. **Transplant Travel Expenses**. The Plan will not cover charges for the following transplant travel expenses: (a) charges that are not pre-approved; (b) travel, including air ambulance travel, within 60 miles of the Covered Person's home; and (c) laundry telephone bills, alcohol, tobacco products, and transportation charges that exceed coach class rates;

47. **Transsexual Surgery**. The Plan will not cover expenses for transsexual surgery or any treatment leading to or in connection with transsexual surgery, including treatment for non-congenital transsexualism, gender dysphoria, or sexual reassignment or change. This exclusion includes, medications, implants, hormone therapy, surgery, medical or psychiatric treatment in connection with such surgery or treatment;

48. **Vision Services**. The Plan will not cover expenses for eye care, including radial keratotomy or other eye surgery to correct refractive disorders. In addition, eye examinations will not be covered, except as specified herein, including lenses for the eyes and examinations for the fitting of lenses. This includes eye examinations for any occupational condition, ailment or Injury arising out of or in the course of employment will not be covered. This exclusion does not apply to the first pair of contact lenses or eyeglasses following cataract surgery;

49. **Weight Control or Related Treatments**. The Plan will not cover counseling, services, dietary products or supplies or treatment for controlling or reducing weight, obesity treatments, including but not limited to any surgical procedures to correct obesity or morbid obesity, including complications of such surgical procedures, nor exercise programs; and

50. **Wigs.** The Plan will not cover expenses for care and treatment for hair loss including wigs (except that the first wig following chemotherapy treatment will be covered), hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

PRESCRIPTION DRUG BENEFITS

The Plan's nationwide prescription drug benefits are administered by EpiphanyRx.

Prescription Drug Covered Expenses
Covered prescription drugs include drugs approved by the Food and Drug Administration (FDA) and that are required to be labeled, "Caution – Federal Law prohibits dispensing without a prescription", insulin and some diabetic supplies when prescribed by a physician or other authorized licensed health professional and dispensed by a licensed pharmacist. This excludes "over-the-counter" medications unless coverage is required by the Affordable Care Act (ACA).

Some drugs may not be covered by the plan if they have over-the-counter (OTC) equivalents or provide low-value as compared to other drugs available on the plan's formulary. The formulary can be found at www.EpiphanyRx.com/Resources and is updated from time to time.

Prescription drug services, supplies, and medications not covered under the Plan include:

- Drugs not approved by the U.S. Food and Drug Administration (FDA), which may also include off-label use (meaning drugs that may be prescribed, but are not approved for that condition or age group);
- Drugs available without a prescription;
- Drugs labeled "Caution: Limited by federal law to investigational use";
- Any drug being used for cosmetic purposes, including those for hair growth;
- Medical devices or appliances;
- Prescription drugs not covered by a current prescription order;
- Drugs not listed on the Plan's Formulary;
- Any compounded drugs that contain products excluded by the Plan;
- Drugs of unproven clinical efficacy and/or value;
- Drugs that have less expensive, but clinically equivalent alternatives.
- Products for nutritional support, unless required for coverage by the Affordable Care Act
- Products recently approved by the FDA may not be covered upon release to the market
- Drugs to facilitate fertility
- Proton Pump Inhibitors (PPIs)
- Non-Sedating Antihistamines (NSAs)
- Nasal Corticosteroids
- Coverage may be changed and/or the amount you pay may vary based on the condition being treated

Pharmacy Network
Your prescription drug coverage has a retail pharmacy, specialty pharmacy, and a mail order component. Prescriptions must be obtained through an EpiphanyRx contracted network pharmacy. You will be responsible for 100% of the drug costs if prescriptions are obtained at out-of-network pharmacies. To identify an in-network pharmacy or enroll in the mail order service, go to https://www.epiphanyrx.com/resources/members/.

Specialty prescriptions must be obtained through AcariaHealth. In rare instances you may be required to use a different specialty pharmacy for limited distribution medications that are available only through select pharmacies. In those cases, you must use a pharmacy in the EpiphanyRx specialty

pharmacy network. You will be responsible for 100% of the drug costs if prescriptions are obtained at out-of-network pharmacies. Please call EpiphanyRx at 844-820-3260 if you have any questions about where to obtain your medications.

The Amount You Will Pay For Prescription Drug Coverage

Benefits are provided for the payment of the prescription charge, less the amount you pay, according your benefit design, for each prescription order or refill. You will NEVER pay more than the cost of the drug. The amount you pay for each prescription order or refill will be determined based on the applicable "tier" (or level) of the drug, and the day supply of the drug. Refills of prescriptions are allowed after 75% of the previous prescription has been used (e.g., 23 days in a 30-day supply).

If the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design or the amount determined by the manufacturer-funded copay assistance program. Once copay assistance is exhausted, the amount you pay will be no more than your benefit design. Dollars used from copay assistance programs will not be considered member out of pocket costs and will not count toward your deductible and/or out-of-pocket maximums. Your monthly contribution includes the cost of access to copay assistance services.

Drugs are classified in tiers generally by their cost to the plan, with Tier 1 drugs having the lowest cost to the plan and Tier 3 having the highest cost to the plan. To determine the Tier in which a drug is classified by your plan, log into https://www.epiphanyrx.com/resources/members/. The Tier drug classifications are updated periodically.

Basic Plan

Deductible	Deductible Type	Individual	Family
You pay 100% of the drug cost up to the amounts listed to the right.	Your deductible is non-embedded, meaning your family deductible must be met before anyone in your family can receive post-deductible benefits as outlined below.	$3,150	$5,300

Non-Maintenance prescription drugs	THE AMOUNT YOU PAY AT AN IN-NETWORK PHARMACY AFTER DEDUCTIBLE	THE AMOUNT YOU PAY AT AN OUT-OF-NETWORK PHARMACY AFTER DEDUCTIBLE
Tier 1 drugs	20% copayment	100%
Tier 2 drugs	20% copayment	100%
Tier 3 drugs	20% copayment	100%
Tier 4 (Specialty drugs)	20% copayment	100%
Compounds	20% copayment	100%
Maximum Day Supply	30 Days	N/A

Maintenance prescription drugs	THE AMOUNT YOUR PAY AT AN IN-NETWORK PHARMACY AFTER DEDUCTIBLE	THE AMOUNT YOUR PAY AT AN OUT-OF-NETWORK PHARMACY
Tier 1 drugs	20% copayment	100%
Tier 2 drugs	20% copayment	100%
Tier 3 drugs	20% copayment	100%
Maximum Day Supply	90 Days	N/A

Out-of-Pocket Maximum	Out-of-Pocket Type	Individual	Family
Your out-of-pocket maximum is the maximum amount you will pay in any plan year. This means any copay or coinsurance paid by you will apply to your out of pocket maximum	Your out-of-pocket maximum is non-embedded, meaning your family out-of-pocket maximum must be met before anyone in your family can receive post-out of-pocket benefits.	$6,300	$10,600 per family Or $7,150 individual limit on family plan

Plus Plan

Deductible	Deductible Type	Individual	Family
You pay 100% of the drug cost up to the amounts listed to the right.	Your deductible is non-embedded, meaning your family deductible must be met before anyone in your family can receive post-deductible benefits as outlined below.	$1,650	$3,300

Non-Maintenance prescription drugs	THE AMOUNT YOU PAY AT AN IN-NETWORK PHARMACY AFTER DEDUCTIBLE	THE AMOUNT YOU PAY AT AN OUT-OF-NETWORK PHARMACY AFTER DEDUCTIBLE
Tier 1 drugs	20% copayment	100%
Tier 2 drugs	20% copayment	100%
Tier 3 drugs	20% copayment	100%
Tier 4 (Specialty drugs)	20% copayment	100%
Compounds	20% copayment	100%
Maximum Day Supply	30 Days	N/A

Maintenance prescription drugs	THE AMOUNT YOUR PAY AT AN IN-NETWORK PHARMACY AFTER DEDUCTIBLE	THE AMOUNT YOUR PAY AT AN OUT-OF-NETWORK PHARMACY
Tier 1 drugs	20% copayment	100%
Tier 2 drugs	20% copayment	100%
Tier 3 drugs	20% copayment	100%
Maximum Day Supply	90 Days	N/A

Out-of-Pocket Maximum	Out-of-Pocket Type	Individual	Family
Your out-of-pocket maximum is the maximum amount you will pay in any plan year. This means any copay or coinsurance paid by you will apply to your out of pocket maximum	Your out-of-pocket maximum is non-embedded, meaning your family out-of-pocket maximum must be met before anyone in your family can receive post-out of-pocket benefits.	$3,300	$6,600

If you paid cash for a drug, the amount you paid for the drug may count toward the deductible and/or out-of-pocket maximum amounts, if you paid the same or lower price as what the drug would have cost through EpiphanyRx. For the amounts to be considered, you must submit the receipt using the Prescription Reimbursement Request Form. The form can be found at https://www.epiphanyrx.com/resources/members/.

Essential Health Benefits

The amount you pay for drugs designated as Essential Health Benefits counts toward your deductible and/or out of pocket maximum. Your plan covers select Non-Essential Health Benefits Drugs at the tiers outlined below. The amount you pay for Non-Essential Health Benefits Drugs will NOT count toward your deductible and/or out of pocket maximum.

Non-Essential Health Benefits Drugs	THE AMOUNT YOUR PAY AT AN IN-NETWORK PHARMACY	THE AMOUNT YOUR PAY AT AN OUT-OF-NETWORK PHARMACY
Tier 1 drugs	50% coinsurance	100%
Tier 2 drugs	70% coinsurance	100%
Tier 3 drugs	80% coinsurance	100%
Tier 4 drugs	90% coinsurance	100%
Maximum Day Supply	30 Days	N/A

Generic and Brand-Name Medications

Prescription drugs are dispensed under three names: the biosimilar name, generic name and the brand name. Biosimilar drugs are alternatives to brand specialty drugs and are almost an identical copy. A generic drug is chemically equivalent to a brand drug for which the patent has expired. By law, biosimilar, generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

If you choose a brand-name drug, when a generic or biosimilar is available, you may have to pay the copayment for the tier the drug is on that you are choosing plus the difference in cost between the brand drug and the generic or biosimilar drug. This cost difference will not apply to your deductible or out of pocket maximums.

Maintenance Drug List (MDL)

Maintenance drugs are certain drugs taken on an ongoing basis (three months or more), such as those used to treat high blood pressure or high cholesterol. The Plan has established a list of maintenance drugs that are available up to a 90-day supply at a network retail pharmacy or as a 90-day supply at a network mail order pharmacy. A complete MDL list is available at: https://www.epiphanyrx.com/resources/members/. This list is subject to change periodically.

Specialty medications

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis.

Not all specialty drugs are covered by the benefit, and some specialty drugs may be covered under the medical benefit. Up to a 30-day supply of specialty drugs will be covered at a time. Specialty drugs are only available through the approved EpiphanyRx specialty pharmacy network. To obtain a specialty medication, contact AcariaHealth at 844-484-6926. This pharmacy is subject to change.

Diabetic Products

Select insulin products, needles, syringes, test strips and glucose meters (non-continuous monitoring) are the only diabetic supplies available as prescription drug benefits under the plan and you will be responsible for your cost share based on your benefit design. All diabetic supplies, including glucose monitors, have a separate copayment for each prescription order or refill.

Compound medications

Compound drugs are defined as a drug product made or modified to have characteristics that are specifically prescribed for an individual patient when commercial drug products are not available or clinically appropriate. To be eligible for coverage, compounded drugs must contain at least one FDA-approved prescription ingredient and must not be a copy of a commercially available product. In addition, it must not include drugs excluded from plan coverage. All compounded drugs are subject to review and may require prior authorization. Drugs used in compounded prescriptions may be subject to additional coverage criteria and utilization management edits. Compounded prescriptions must be obtained from an in-network EpiphanyRx pharmacy.

Preventive Drugs Covered under the Affordable Care Act (ACA)

The following products will be covered at 100% without a copay if you have a prescription as a preventive service. If a generic product is available, only the generic will be covered at 100% without a copay.

- OTC aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
- Select generic Statin preventive medication for adults 40 to 75 at high risk
- FDA-approved contraceptives for women of child-bearing age;
- Generic fluoride supplements for children age 6-months to 5 years
- OTC Folic acid supplements for women who may become pregnant;
- Select Iron supplements for children 6 to 12 months at risk for anemia.
- OTC Vitamin D supplements for adults 65 or older at risk of falls
- Select smoking cessation products for adults age 18 and older
- Select breast cancer preventive drugs for adults age 35 years and older at increased risk for breast cancer
- Select bowel preparations for colonoscopy procedures for adults age 50 to 75 years

HSA Preventive Drug List

Your plan includes HSA Preventive Drug coverage as part of your prescription benefit plan. Preventive care medications are drugs that can help you prevent health problems or problems caused by a health condition. All Brand tier 2 and 3 drugs on the HSA Preventative list are covered prior to reaching your deductible with your tier 2 and 3 cost share applied until you meet your Out-of-Pocket Maximum. Once your Out-of-Pocket Maximum is met, you will no longer pay anything for these medications. Generic drugs on the HSA Preventative list are covered at a $0 cost share. You must purchase drugs listed on the HSA list at a network pharmacy and quantity limits, utilization management, Step Therapy, etc., will apply if applicable. The HSA Preventive list can be found at: https://www.epiphanyrx.com/resources/members/.

Drug Coverage Guidelines - Quality and Utilization Management

To promote safety and clinically appropriate care while controlling costs, prescription drug coverage may be restricted in quantity or require prior authorization and/or step therapy through Drug Coverage Guidelines. These guidelines can be found in the pharmacy section of our website. You may also call the Customer Service Department number on the back of your ID card for more information.

a. *Prior Authorization* - The Plan requires a review to determine if the drug qualifies for coverage under the benefit. If your physician prescribes a drug that requires a prior authorization, EpiphanyRx will work with your prescriber to complete the prior authorization review. Either you or the pharmacy can ask your doctor to call 844-820-3260 to initiate the prior authorization or appeal process. You can also contact EpiphanyRx via mail at:

EpiphanyRx
Prior Authorizations and Appeals
278 Franklin Rd Suite 242
Brentwood, TN 37027

Prior Authorization Forms can be found at:
https://www.epiphanyrx.com/resources/providers_pharmacies/

Once your prior authorization is reviewed, a clinician may contact your doctor to discuss your case and potential medication alternatives. Your doctor may change your prescription, when medically appropriate, to a different brand name or generic medication.

b. *Quantity Restrictions* - For certain drugs, the amount of the drug that will be covered by the plan is limited based on national standards and current scientific literature. These limits ensure the quantity of units supplied for each prescription remain consistent with clinical dosing guidelines and benefit plan design.

c. *Step Therapy* - In some cases, you are required to first try certain drugs to treat your medical condition before the Plan will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Plan may not cover Drug B unless you try Drug A first.

GENERAL PLAN EXCLUSIONS

The following exclusions and limitations are the General Exclusions under the Plan and apply to the entire Plan.

1. **Applicable Section**. The Plan will not cover expenses which are payable under one section of this Plan under any other section of this Plan;

2. **Charges Incurred Due to Non-Payment.** The Plan will not cover charges for sales tax, mailing fees and surcharges incurred due to nonpayment;

3. **Claims Time Frames.** The Plan will not cover charges for claims not received within the Plan's filing limit deadlines as specified under the section entitled Claims Information;

4. **Court Ordered Treatment.** The Plan will not cover charges for court ordered treatment (e.g. substance abuse) unless such treatment would be considered eligible for Coverage under this Plan;

5. **Criminal Act.** The Plan will not cover charges for services and supplies incurred as a result of an Illness or Injury caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance. However, the Plan may not deny charges for the care or treatment of an Injury which is sustained as the result of an act of domestic violence or a medical condition. As used herein, a medical condition includes a physical or mental condition;

6. **Effective and Termination Date.** The Plan will not cover charges for services and supplies for which a charge was incurred before the Covered Person was covered under this Plan or after their date of termination, except as specified herein;

7. **Exclusions.** The Plan will not cover charges for services and supplies which are specifically excluded under this Plan;

8. **Experimental or Investigative.** The Plan will not cover charges for services and supplies which are either experimental or investigational or not Medically Necessary, except as provided herein;

9. **Excess of Reasonable and Allowable/Customary and Reasonable Charge.** The Plan will not cover the part of an expense for services, supplies and/or treatment of an Injury or Illness that is in excess of the Reasonable and Allowable/Customary and Reasonable Charge. (except as otherwise stated herein);

10. **Family Member**. The Plan will not cover expenses or services received from a member of the Covered Person's household or from an Immediate Family Member. For the purposes of this exclusion, Immediate Family Member means the Covered Employee, his or her spouse, brother, sister, parent or the Dependent Child. Immediate Family Member also includes the brother sister, parent or Dependent Child of the Employee's spouse.

11. **Government Owned/Operated Facility**. The Plan will not cover charges for services and supplies in a hospital owned or operated by the United States government or any government outside the United States in which the Covered Person is entitled to receive benefits, except for the reasonable cost of services and supplies which are billed, pursuant to Federal Law, by the Veterans Administration or the Department of Defense of the United States for services and supplies which are eligible herein and which are not incurred during or from service in the Armed Forces of the United States or any other country;

12. **Governmental Agency or Program**: The Plan will not cover supplies and services that are furnished or rendered to a Covered Person, or for which the cost is payable, by a governmental agency or governmental

program;

13. **Hazardous Hobby.** The Plan will not cover charges for services and supplies due to an Illness or Injury that results from engaging in a hazardous hobby. A hazardous hobby is an activity that is characterized by a threat of danger or risk of bodily harm. Some examples of hazardous hobbies include, but are not limited to: any kind of organized vehicular speed or endurance contest in the air, on land or water, hang gliding, bungee jumping, stunt driving, ski jumping, snow boarding, jet skiing, scuba diving, snowmobiling without a helmet, motorcycling without a helmet, driving or riding in a motor vehicle without a seat belt, and participating in an aerobatics contest or demonstration. However, the Plan may not deny charges for the care or treatment of an Injury which is sustained as the result of an act of domestic violence or a medical condition. As used herein, a medical condition includes a physical and mental health condition;

14. **Hospital/Facility Employee.** The Plan will not cover charges for services billed by a Provider (Physician or nurse) who is an employee of a hospital or Facility and is paid by the hospital or Facility for the services rendered;

15. **Illegal Acts**. The Plan will not cover charges for services received as a result of an Injury or Illness occurring directly or indirectly, as a result of a Serious Illegal Act. For purposes of this exclusion, the term Serious Illegal Act shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. However, the Plan may not deny charges for the care or treatment of an Injury which is sustained as the result of an act of domestic violence or a medical condition. As used herein, a medical condition includes a physical or mental condition;

16. **Illegal Drugs, Medications or Alcohol**. The Plan will not charges incurred by a Covered Person for an Injury or Illness which occurred as a result of such person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotics not administered on the advice of a Physician. In addition, the Plan will not cover charges in connection with an Injury or Illness which occurred as a result of the covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for purposes of applying this exclusion. Expenses will be covered for the injured Covered Person other than the person using controlled substances or alcohol and expenses will covered for substance abuse treatment as specified in the Plan. However, the Plan may not deny charges for the care or treatment of an Injury which is sustained as the result of an act of domestic violence or a medical condition. As used herein, a medical condition includes a physical or mental condition;

17. **Legal Obligation.** The Plan will not cover charges for services and supplies for which the Covered Person has no legal obligation to pay or for which no charge has been made;

18. **Maximum Benefit.** The Plan will not cover charges for services and supplies which exceed the Maximum Benefit, as shown in the Schedule of Benefits;

19. **Medicare.** The Plan will not cover charges for which benefits are payable under Medicare Part A or would have been payable if a Covered Person had applied for Part A; and for which benefits are payable under Medicare Part B or would have been payable if a Covered Person had applied for Part B, except as specified in this Plan Document;

20. **Military Related Disability**. The Plan will not cover charges for services and supplies for any military service-related disability or condition;

21. **Non-Covered Services.** The Plan will not cover charges in connection with services that are not

specifically listed as a Covered Service in this Summary Plan Description;

22. **Non-Medical Charges.** The Plan will not cover charges for: telephone consultations; failure to keep a scheduled visit; completion of a claim form; attending Physician statements; or requests for information omitted from an itemized billing;

23. **Non-Medically Necessary Services.** The Plan will not cover any services that are not deemed to be Medically Necessary except as set forth herein. The Plan Administrator retains discretionary authority in determining Medical Necessity regarding inter-Facility patient transport, and will consider assessment by Sentinel Air Medical Alliance, LLC in determining Medical Necessity of such inter-Facility patient transport. The Plan Administrator retains the discretionary authority to limit benefit availability to alternative providers of inter-Facility air transport if and when a Provider fails to comply with the terms of the Plan, or proposed charges exceed the Maximum Benefit in accordance with the terms of the Plan;

24. **Non-Prescription Drugs**. The Plan will not cover charges for non-prescription drugs, except as otherwise stated herein;

25. **Not Under Care of Physician.** The Plan will not cover charges for services and supplies not recommended and approved by a Physician; or services and supplies when the Covered Person is not under the care of a Physician;

26. **Professional Medical Standards.** The Plan will not cover charges for services and supplies which are not provided in accordance with generally accepted professional medical standards or for experimental treatment;

27. **Subrogation Failure**. The Plan will not cover charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any party if the Covered Person fails to provide information as specified under Subrogation;

28. **Self-Inflicted Injury or Suicide.** The Plan will not cover expenses incurred in connection with a self-inflicted injury, suicide attempt, or suicide, while sane or insane. However, the Plan may not deny charges for the care or treatment of an Injury which is sustained as the result of an act of domestic violence or a medical condition. As used herein, a medical condition includes a physical and mental health condition (e.g. depression);

29. **Travel Outside United States.** The Plan will not cover charges for services and supplies obtained outside of the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;

30. **Travel Expenses.** The Plan will not cover charges for travel, whether or not recommended by a Physician, except as provided herein;

31. **War.** The Plan will not cover any charge for services, supplies or treatment related to Illness, Injury, or disability caused by or attributed to an act of war, act of terrorism, riot, civil disobedience, insurrection, nuclear explosion or nuclear accident. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized military forces; and

32. **Work-Related Illness or Injury**. The Plan will not cover charges for services and supplies for any condition, disease, defect, ailment, or accidental Injury arising out of and in the course of employment (for wage or profit) whether or not benefits are available under any Workers' Compensation Act or other similar law. This exclusion applies if the Covered Person receives the benefits in whole, part or even if there is no Workers' Compensation coverage in place. This exclusion also applies whether or not the Covered Person

claims the benefits or compensation. This exclusion shall not apply to Covered Persons who are also owners of Metromont Corporation.

APPLYING FOR COVERAGE AND EFFECTIVE DATES

ENROLLMENT PERIOD FOR NEW HIRES
The following classes of Employees will be eligible for coverage under the Plan:

1. **New Hires** -
    a. Regular Full-time Employees: Employees designated by the Employer as Regular Full-time Employees. Coverage for Regular Full-time Employees, if properly elected, will be effective on the date of hire.
    b. Qualifying Part-time Employee: Any other Employees, including but not limited to Seasonal Employees, who are not Regular Full-time Employees to the extent that such Employees average 30 hours of service per week over the employee's applicable Initial Measurement Period (as defined in the Plan Eligibility Appendix adopted by the Employer). Coverage for such Employees, if properly elected, will be effective on the first day of the Qualifying Part-time Employee's New Employee Stability Period (as defined by the Plan). A Qualifying Part-time Employee will remain eligible throughout the New Employee Stability Period to the extent that the employee remains employed, subject to the Plan's Break in Service (as defined by the Plan) rules.

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

If a Qualifying Part-time Employee transfers to a Regular Full-time Employee position prior to the start of the Qualifying Part-time Employee's New Employee Stability Period, the Employee will become eligible for coverage. If elected, coverage for such new Regular Full-time Employee will become eligible the date of transfer.

2. **"Ongoing" Employees** - Once an Employee has completed the Plan's Standard Measurement Period, eligibility will be based solely on the Employee's Hours of Service during the Plan's Standard Measurement Period. Any Employee who averages 30 Hours of Service per week during the Plan's Standard Measurement Period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next Ongoing Employee Stability Period to the extent that the Ongoing Employee remains employed, subject to the Plan's Break in Service rules. Such coverage, if elected, will be effective on the first day of the Plan's Ongoing Employee Stability Period.

Whether an Employee averages 30 Hours of Service per week will be determined in accordance with policies and procedures adopted by the Plan Administrator.

Impact of Breaks In Service
Any Employee who resumes Hours of Service following a Break in Service (as defined in the Plan Eligibility Appendix) will be treated as a New Hire and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. If, however, the Employee experiences a period without any Hours of Service, and resumes Hours of Service without experiencing a Break in Service, the Employee will be treated as a continuous employee. A continuous employee resuming Hours of Service after a period with no Hours of Service that does not constitute a Break in Service will be eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with No Hours of Service. Such coverage will be effective on the first day of the month that coincides with or follows the date you resume Hours of Service.

If you wish to review a copy of the Plan's Eligibility Appendix, please contact the Plan Administrator.

ENROLLMENT PERIOD FOLLOWING LOSS OF OTHER COVERAGE
Eligible Employees who are covered under another health plan and subsequently lose such coverage are eligible for Coverage following the loss of the other coverage provided they submit a completed application to the Employer within 31 days following termination of the other coverage. If an Employee submits the application within this 31-day enrollment period, Coverage will be effective on the date of the loss of other coverage. The Employee is eligible only if (s)he submitted a written declination of Coverage to the Employer when (s)he was initially eligible to enroll under the Plan.

As used herein, loss of the other coverage must be due to: (a) exhaustion of COBRA benefits; (b) Loss of Eligibility under the prior coverage; or (c) termination of contributions by the employer under the prior plan of coverage. The enrollment opportunity in connection with the loss of other coverage is considered to be a HIPAA Special Enrollment Period.

This HIPAA Special Enrollment Period also applies to Dependents of Eligible Employees who decline enrollment when initially eligible under the Plan due to existing medical benefits under another health plan and state in writing at such time that this is the reason for declining enrollment, provided the application is submitted within the time frame set forth above and loss coverage under the other plan was for one of the reasons set forth above.

ENROLLMENT PERIOD FOLLOWING MARRIAGE
An Eligible Employee may add his or her Spouse during the Employee's initial eligibility period (i.e., when (s)he is initially eligible to enroll for Coverage). However, in the event a Covered Employee marries after his or her Coverage has become effective, the Employee may add his or her spouse to the Coverage by submitting to the Employer a completed application within 31 days of the event. In this event, Coverage will be effective on the date of the marriage. In this instance, the Eligible Employee, the Spouse and any Dependent Children who are newly acquired as the result of the marriage, who did not enroll under the Plan when initially eligible or during a subsequent open enrollment period, if applicable, are permitted to enroll during this special enrollment period.

The enrollment opportunity in connection with the addition of a Spouse following marriage is considered to be a HIPAA Special Enrollment Period.

ENROLLMENT PERIOD FOLLOWING BIRTH OR ADOPTION
An Eligible Employee may add Dependent Coverage to his or her Coverage during the Employee's initial eligibility period (i.e., when (s)he is initially eligible to enroll for Coverage). However, in the event a child is born, adopted or placed for adoption after the Employee's Coverage is in effect, the Employee will be eligible to enroll the child by submitting an application to the Employer within 60 days following the child's birth date, adoption or placement for adoption. In the event the application is submitted within this enrollment period, Coverage shall be made effective on the birth date of the child, or on the date of adoption or the date the child has been placed for adoption. In addition, the Eligible Employee and Spouse, if not already covered, will also be eligible to enroll for Coverage.

The enrollment opportunity in connection with the addition of a Dependent Child following birth, adoption or placement for adoption is considered to be a HIPAA Special Enrollment Period.

ENROLLMENT PERIOD FOR OTHER MID-YEAR ELECTION CHANGES
This provision applies if the Employer offers a Section 125 plan, including but not limited to a Section 125 Premium Only Plan, in which the Employee is participating.

When the Covered Employee experiences an event that would allow him to make a mid-year election change

to his current premium payment elections under his Section 125 Plan, the Employee may also be permitted to make a corresponding change under this medical Plan provided such change is permitted by the Employer and is in accordance with the IRS regulations governing Section 125 Plans

The events that would allow such a revocation or change include, but are not limited to the following types of events: change in residence that effects an Employee's or dependent's eligibility; change in family status; increase in the employer's contributions; significant change in employee-cost for a benefit package; significant curtailment of benefits; addition or significant improvement in a benefit option; change in dependent eligibility as the result of a court order or decree; becoming eligible for Medicare or Medicaid; going on FMLA leave of absence; revocation due to a reduction in hours and revocation due to enrollment in a qualified health plan. Any change or revocation must be consistent with the events permitted as a mid-year change under the Section 125 Plan (as regulated by the IRS) to the extent that it is necessary or appropriate as the result of such change.

Contact the Employer for details concerning this provision.

SPECIAL ENROLLMENT RIGHTS UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2009

1. **Special Enrollment Right:** Employees and Dependents who are or become eligible under the State Children's Health Insurance Program (SCHIP) or Medicaid and then lose such eligibility, may enroll in the Plan (if they are otherwise eligible) within sixty (60) days of the date the Employee (or a Dependent) loses eligibility for the Medicaid or SCHIP program or within sixty (60) days of becoming eligible for premium assistance under Medicaid or SCHIP. This "special enrollment right" exists even though the timing may fall outside of a Plan's open enrollment period and the Employee previously refused Plan coverage. This enrollment allowance also applies to those who lose SCHIP or Medicaid coverage and then want to enroll in the Employer Plan.

2. **Premium Assistance:** The State may either: (1) reimburse the Employer directly for the cost differential to add family coverage (to add previously uncovered children to the Plan), or (2) require covered beneficiaries to pay the full family cost and reimburse the Employee. However, the Employer/Plan Sponsor can opt out of the first option, and require the full cost of coverage from the covered Employee. To qualify, residents and their Dependent(s) must be eligible for Plan coverage in which the Employer contributes at least 40% toward the coverage cost.

OPEN ENROLLMENT PERIOD

Open Enrollment Period is the period designated by the Employer during which the Employee may elect Coverage for himself and any eligible Dependents if (s)he is not covered under the Plan. For example, Late Enrollees are only permitted to enroll during the Plan's Open Enrollment Period. During the Open Enrollment Period, an Employee and his Dependents who are not covered under this Plan must complete and submit an application. The Open Enrollment Period under this Plan occurs in the fall months of each calendar year. Coverage for Employees and Dependents who enroll during this Open Enrollment Period will be effective the first day of January.

TERMINATION PROVISIONS

TERMINATION OF EMPLOYEE COVERAGE

Coverage will terminate for the Covered Employee and his/her Covered Dependents on the earliest of the following:

1. The date the Plan terminates;
2. The date the Covered Employee ceases to be an Eligible Employee;
3. The date the Covered Employee dies; or
4. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees have not been submitted when due;
5. For an Employee who is on a leave of absence as defined under the Family and Medical Leave Act ("FMLA"), at the end of the FMLA leave of absence provided the Employee does not return to work as an Actively Working Employee at the end of such leave of absence (see note below);
6. For an Employee who is on other Employer-approved leave of absence, at the end of the approved leave of absence provided the Employee does not return to work as an Actively Working Employee at the end of the such leave of absence (see note below).

The Employee may be eligible for COBRA Coverage "COBRA Coverage."

SPECIAL NOTE ABOUT LEAVE OF ABSENCE:

The Employer will continue to provide Coverage for an Employee (any Dependents) while an Employee is on a leave of absence for a period not to exceed 12 weeks. The leave of absence may be for a medical leave of absence or it may be a non-medical leave of absence (e.g. temporary layoff). Coverage will be continued during the leave of absence only if there is an anticipation that the Employee will be returning to Actively Working status at the end of the leave of absence. Continued Coverage will be provided only for those Employees and Dependents who were covered on the day preceding the leave of absence and may be contingent on the Employee's payment of any required contribution in connection with such continued Coverage.

The Employer may also require the Employee to use other paid sick leave or other paid leave of absence as may be available under the Plan prior to the FMLA period. In addition, the Employer may require that the Employee substitute accrued paid time under the Employer's sick leave or other paid leave of absence policy for the FMLA period, provided the Employer has notified the Employee in writing that such leave of absence is being counted as FMLA leave of absence.

Contact the Employer for details concerning any applicable company policies concerning time off and FMLA.

TERMINATION OF DEPENDENT COVERAGE
Coverage will terminate for the following Covered Person(s) on the earliest of the following:

1. The date the Plan terminates;
2. The date the Employee's Coverage terminates;
3. The date of the Employee's death;
4. The date a Dependent loses dependency status under the Plan; or
5. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees have not been submitted when due.

The Dependent may be eligible for COBRA Coverage as described in the section entitled "COBRA Coverage."

SPECIAL NOTE ABOUT CANCELLATION OR CESSATION OF COVERAGE IN CONNECTION WITH MID-YEAR CHANGES UNDER SECTION 125 PLAN

There may be additional reasons for cancellation or cessation of coverage for individuals participating in a Section 125 plan. If an employee or dependent is participating in a Section 125 plan offered by the Employer, and the employee/dependent experiences a qualifying event that allows for a mid-year election change resulting in a revocation of a Section 125 election and medical coverage election (e.g. termination of participating under the medical plan), the Employer may allow for a mid-year termination of Coverage on the same date as the revocation of the Section 125 election. This provision only applies if the Employer offers a Section 125 plan and if the Employer's Section 125 plan allows for such revocations in connection with a mid-year election change. The employee/dependent should contact the Employer for details regarding whether (s)he will be permitted to revoke his or her coverage elections under the medical Plan as the result of a Section 125 mid-year election change.

PROHIBITION ON RESCISSION The Plan will not rescind coverage for Covered Persons. This provision does not apply to cases where the Covered Person has engaged in fraud or made an intentional misrepresentation of material fact and advance notice of rescission is made by the Plan.

COBRA COVERAGE

A federal law commonly referred to as COBRA requires that most employers sponsoring group health plans offer Employees and their families the opportunity for a temporary extension of benefits ("COBRA Coverage") at group rates in certain instances where Coverage under the Plan would otherwise end. This notice is intended to inform the Covered Person, in a summary fashion, of the rights and obligations under the COBRA Coverage provisions of the law. If the Covered Person does not choose COBRA Coverage, the Coverage under the Plan will end.

COBRA Coverage applies to the medical benefits under the Plan and also applies to any dental and/or vision coverage if covered under the Plan prior to the Qualifying Event. The Covered Person will only be entitled to receive COBRA Coverage for the coverage(s) (s)he elects to continue during the election process as described herein.

Qualified Beneficiaries
As used herein, a Qualified Beneficiary is a Covered Person who loses Coverage under the Plan as the result of a Qualifying Event.

Qualifying Events
Qualifying Events are any one of the following events, which would normally result in termination of Coverage. These events will qualify a Covered Person to continue coverage as a Qualified Beneficiary beyond the termination date described in the Summary Plan Description. The Qualifying Events are listed below.

1. Death of the Covered Employee;

2. The Covered Employee's termination of employment (other than termination for gross misconduct) or reduction in work hours to less than the minimum required for Coverage under the Plan. This includes a Covered Employee whose employment has been adversely affected by international trade and who is eligible for trade adjustment assistance (TAA) or an individual whose employment has terminated following the last day of leave under the Family Medical Leave Act;

3. Divorce or legal separation from the Covered Employee;

4. The Covered Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan;

5. A Dependent child no longer meets the eligibility requirements of the Plan; and

6. A covered Retiree and their covered Dependents whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.

Notification Requirements

There are a number of notification requirements under COBRA. First, the Third Party Administrator must be alerted to a Qualifying Event in order to offer COBRA Coverage to Qualified Beneficiaries. This notice must be submitted in writing to the Third Party Administrator, either by the Employer, or by the Covered Employee or a Dependent. The nature of the Qualifying Event determines which party must notify the Third Party Administrator. Second, once the Third Party Administrator is notified of a Qualifying Event, the Third Party Administrator will provide notices to the COBRA Beneficiary. The notification requirements established under COBRA are described in this COBRA Coverage section.

Notification by Covered Employee or Dependent

The Covered Employee or Dependent must notify the Third Party Administrator when eligibility for COBRA Coverage results from divorce or legal separate from the Covered Employee or a Dependent Child loss of eligibility under the Plan.

The Covered Employee or Dependent must provide this notice to the Third Party Administrator within 60 days of either the Qualifying Event or date of loss of Coverage, as applicable to the Plan.

For individuals who are requesting an extension of COBRA Coverage due to a disability, the individual person must submit proof of the determination of disability by the Social Security Administration to HealthSCOPE Benefits within the initial 18 month COBRA Coverage period and no later than 60 days after the Social Security Administration's determination. When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within 30 days of such change in status.

These notification requirements also apply to an individual who, while receiving COBRA Coverage, has a second or subsequent Qualifying Event. Refer to the section entitled Period of Continued Coverage for additional information.

The Covered Employee or Dependent, or their representative, must deliver this notice **in writing** to the Third Party Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted. If the requested information is not provided within the time limit set forth above, the Plan Administrator reserves the right to reject the deficient notice, which means that the individual has forfeited their rights to COBRA Coverage.

To protect their rights, it is very important that Covered Employees and Dependents keep the Plan Administrator informed of their current mailing address. Any notices will be sent to individuals at their last known address. It is the responsibility of Covered Employees and Dependents to advise the Plan Administrator of any address changes in a timely manner in order to ensure that notices, such as those regarding their rights under COBRA, are deliverable.

Failure to provide notice to the Third Party Administrator in accordance with the provisions of this notice requirement will result in the person forfeiting their rights to COBRA Coverage under this provision.

Notification by Employer

The Employer is responsible for notifying the Third Party Administrator when eligibility for COBRA Coverage results from any events other than divorce or legal separation, or a Dependent becoming ineligible.

The Employer shall provide this notice to the Third Party Administrator within 30 days of either the Qualifying Event or date of loss of coverage, as applicable to the Plan. The Employer must include information that is sufficient to enable the Third Party Administrator to determine the Plan, the Covered Employee, the Qualifying Event, and the date of the Qualifying Event.

The Employer must deliver this notice **in writing** to the Third Party Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted.

Notification by Plan Administrator

Election Notice: Once the Third Party Administrator receives proper notification that a Qualifying Event has occurred, COBRA Coverage shall be offered to each of the Qualified Beneficiaries by means of a COBRA Election Notice. The time period for providing the COBRA Election Notice shall generally be 14 days following receipt of notice of the Qualifying Event. This time period may be extended to 44 days under certain circumstances where the Employer is also acting as the Plan Administrator.

Notice of Ineligibility: In the event that the Plan Administrator determines that the Covered Employee and/or Dependent(s) are not entitled to COBRA coverage, the Third Party Administrator shall notify the Covered Employee and/or Dependent(s). This notice shall include an explanation of why the individual(s) may not elect COBRA Coverage. A notice of ineligibility shall be sent within the same time frame as described for a COBRA Election Notice.

Notice of Early Termination: The Third Party Administrator shall provide notice to a Qualified Beneficiary of a termination of COBRA Coverage that takes effect on a date earlier than the end of the maximum period of COBRA Coverage that is applicable to the Qualifying Event. The Third Party Administrator shall notify the Qualified Beneficiary as soon as possible after determining that coverage is to be terminated. This notice shall contain the reason coverage is being terminated, the date of termination, and any rights that the individual may have under the Plan, or under applicable law, to elect alternative group or individual coverage.

Election of Coverage

Upon receipt of Election Notice from Third Party Administrator, a Qualified Beneficiary has 60 days from the date the notice is sent to decide whether to elect COBRA Coverage. Each person who was covered under the Plan prior to the Qualifying Event has a separate right to elect COBRA Coverage on an individual basis, regardless of family enrollment. For example, the Employee's spouse may elect COBRA Coverage even if the Employee does not select the coverage. COBRA Coverage may be elected for one, several or all dependent children who are Qualified Beneficiaries and a parent may elect COBRA Coverage on behalf of any dependent child.

In considering whether to elect COBRA Coverage, the Qualified Beneficiary should take into account that a failure to continue coverage may affect future rights under federal law. For example, the Covered Person may lose the right to be provided with a reduction in a pre-existing condition limitation if the gap in coverage is greater than 63 days. The Covered Person also has special enrollment rights under HIPAA that allow him or her to enroll in another group health plan for which (s)he is otherwise eligible when Coverage under this Plan terminates due to a Qualifying Event. The Covered Person also has the same special enrollment rights at the

end of the COBRA Coverage if (s)he receives continued coverage for the maximum period available under COBRA.

If the Qualified Beneficiary chooses to have continued coverage, (s)he must advise the Third Party Administrator in writing of this choice. This is done by submitting a written COBRA Election Notice to the Plan Administrator. The Third Party Administrator must receive this written notice no later than the last day of the 60-day period. If the election is mailed, the election must be postmarked on or before the last day of the 60-day period. This 60-day period begins on the later of the date coverage under the Plan would otherwise end, or the date the notice is sent by the Third Party Administrator notifying the person of his or her rights to COBRA Coverage.

Period of Continued Coverage
The law requires that a Qualified Beneficiary who elects COBRA Coverage be afforded the opportunity to maintain COBRA Coverage for 36 months unless (s)he loses Coverage under the Plan because of a termination of employment or reduction in hours. In that case, the required COBRA Coverage period is 18 months.

This 18-month period may be extended if a subsequent or second Qualifying Event (for example, divorce, legal separation, an Employee becoming entitled to Medicare or death) occurs during that 18-month period. A second event may be a valid Qualifying Event only if it would have been a valid first Qualifying Event. That is, a second Qualifying Event shall qualify only if it would have caused a Covered Person to lose Coverage under the Plan if the first Qualifying Event had not occurred. A second or subsequent Qualifying Event is therefore limited to the following Qualifying Events:

1. Death of a Covered Employee;

2. Divorce or legal separation between the spouse and the Covered Employee; and

3. Dependent Child's loss of Dependent status under the Plan.

The Covered Employee's Medicare entitlement may also be considered a subsequent or second Qualifying Event for any Dependents who are Qualified Beneficiaries following the first Qualifying Event, but only if the Medicare entitlement would have resulted in loss of Coverage under the Plan had the first Qualifying Event not occurred.

Under no circumstances, however, will Coverage last beyond 36 months from the date of the event that originally made the Covered Person eligible to elect Coverage. Only a person covered prior to the original Qualifying Event or a child born to or Placed for Adoption with a Covered Employee during a period of COBRA Coverage is eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event. Any other Dependent acquired during COBRA Coverage is not eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event.

Period of Continued Coverage for Disabled Person
A person who is totally disabled may extend COBRA Coverage from 18 months to 29 months. Non-disabled family members may also elect to extend COBRA Coverage even if the disabled individual does not elect to extend his coverage.

The disabled person must be disabled for Social Security purposes at the time of the Qualifying Event or within 60 days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the Third Party Administrator within the initial 18-month COBRA Coverage period and no later than 60 days after the latest of the following:

1. The date of the Social Security Administration's determination;

2. The date of the Qualifying Event;

3. The date the Qualified Beneficiary would lose Coverage under the plan; or

4. The date the Qualified Beneficiary is informed of the obligation to provide the disability notice, either through this Summary Plan Description or the initial COBRA Notice provided by the Employer.

Refer to the guidelines set forth in the subsection Notification Requirements.

When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Third Party Administrator within 30 days of such change in status.

Cost of Coverage and Payments
The Employer requires that Qualified Beneficiaries pay the entire costs of their COBRA Coverage, plus a two percent administrative fee. This must be remitted to the Employer or the Employer's designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

The premium for an extended COBRA Coverage period due to a total disability may also be higher than the premium due for the first 18 months. If the disabled person elects to extend coverage the Employer may charge 150% of the contribution during the additional 11 months of COBRA Coverage. If only the non-disabled family members elect to extend coverage the Employer may charge 102% of the contribution.

For purposes of determining monthly costs for continued coverage, a person originally covered as an Employee or as a spouse will pay the rate applicable to a Covered Employee if Coverage is continued for himself alone. Each child continuing Coverage independent of the family unit will pay the rate applicable to a Covered Employee.

Timely payments must be made for the COBRA Coverage. The initial payment must be made within 45 days after the date the person notifies the Employer that he has chosen to continue Coverage. The initial payment must be the amounts needed to provide Coverage from the date continued benefits begin, through the date of election.

Thereafter, payments for COBRA Coverage are to be made monthly. These monthly payments are due on the first day of each month. If the premium is not received by the first day of the month, the Employer will consider that Coverage has been allowed to terminate until the monthly payment has been received. However, a 30-day grace period is allowed for receipt of this monthly payment before the termination becomes final. Claims will be denied until the monthly premium payment is received. There shall be no grace period for making payments, other than the grace period described in this paragraph.

If the initial payment, or any subsequent monthly payment received, is short by an insignificant amount (the lesser of $50 or 10% of the premium), the Covered Person will be sent a notice at the Covered Person’s last known address stating that the remaining amount due must be sent within 30 days to continue Coverage under COBRA if the Plan Administrator requires the payment to be made in full. The Plan Administrator may also choose to accept the payment, which was short by an insignificant amount, as payment in full. Should you have any questions in regards to how payments short by an insignificant amount will be handled under this Plan, please contact the Plan Administrator.

Special Note About Tax Credit for TAA-Eligible Individuals: In accordance with the Trade Act of 2002, individuals who become eligible for TAA assistance may take a tax credit of 65% of premiums paid for

qualified health coverage, which includes COBRA Coverage. The Trade Act of 2002 provides for advance payment of the tax credit to the health plan.

When Continuation Coverage Begins
When COBRA Coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the Qualifying Event or loss of coverage, as applicable to the Plan, so that no break in Coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

Dependents Acquired During Continuation
A spouse or Dependent child newly acquired during COBRA Coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during COBRA Coverage. A Dependent acquired and enrolled after the original Qualifying Event, other than a child born to or Placed for Adoption with a Covered Employee during a period of COBRA Coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of Coverage.

End of COBRA Coverage
COBRA Coverage will end on the earliest of the following dates:

1. 18 months from the date continuation began because of a reduction of hours or termination of employment of the Covered Employee;

2. 36 months from the date continuation began for Dependents whose coverage ended because of the death of the Covered Employee, divorce or legal separation from the Covered Employee, the child's loss of Dependent status, or Medicare entitlement;

3. The end of the period for which contributions are paid if the Covered Person fails to make a payment on the date specified by the Employer or by the end of the grace period;

4. The date coverage under this Plan ends and the Employer offers no other group health benefit plan;

5. The date the Covered Person first becomes entitled to Medicare after the COBRA election;

6. The date the Covered Person first becomes covered under any other group health plan without regard to a pre-existing condition after the COBRA election. If the replacing group health plan has a pre-existing condition limitation, the Covered Person may remain covered under the Plan until he or she has satisfied the pre-existing condition limitation under the new group health plan, or until he or she is no longer eligible under the COBRA Coverage, as set forth herein;

7. The date the Covered Person is terminated from the Plan for cause, provided an active Covered Employee would be terminated under the Plan for the same cause; or

8. 36 months from the date continuation began for the surviving spouse and Dependent children of a Retiree who dies, when the Retiree’s Qualifying Event was the Employer’s bankruptcy filing;

The Plan Administrator shall provide notice of any early termination. Refer to subsection Notification Requirements, Plan Administrator.

The COBRA law also requires that an individual who has elected COBRA Coverage be permitted to enroll in any individual conversion health plan that is provided under the Plan. Contact the Plan Administrator about the availability of a conversion policy.

The Third Party Administrator and Contact Information
Notice of COBRA qualifying events as required herein must be provided and postmarked by the deadlines stated to the Third Party Administrator at:

HealthSCOPE Benefits
P.O. Box 2459
Little Rock, AR 72203

The Plan Administrator and Contact Information
An Employee may obtain additional information about his or her COBRA Coverage rights from the Plan Administrator. If the Employee has any questions concerning his or her COBRA Coverage rights, or if (s)he wants a copy of the Summary Plan Description, (s)he should contact the Plan Administrator.

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

The name, address and telephone number of the Plan Administrator is:

Metromont Corporation
20 Two Notch Road
Greenville, SC 29605
864-605-5006

Your Employer may have contracted certain COBRA services to a COBRA administrator. Contact the Employer for details concerning your COBRA rights.

CLAIMS INFORMATION

CLAIM FORMS

When the Covered Person is submitting the claim for benefits on his or her own behalf, (s)he may obtain a claim form from the Employer. If forms are not available, send a written request for claim forms to HealthSCOPE Benefits. Written notice of services rendered may also be submitted to HealthSCOPE Benefits without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

1. Name of patient;
2. Patient's relationship to the Covered Employee;
3. Identification number;
4. Date, type and place of service;
5. Name of Provider; and
6. The Covered Person's signature and the Provider's signature.

NOTE ABOUT PRESCRIPTION DRUG CLAIMS:

Refer to the section entitled "Prescription Drug Benefits" for information on how to submit a claim.

TIME FRAME FOR SUBMITTING CLAIM

The claim form must be submitted within 365 days of receiving Covered Services and must have the data needed to determine benefits. An expense is considered incurred on the date the service or supply is given. The claim form should be submitted to the address shown on the Covered Person's identification card.

It is important to note that if the Provider is a Network Provider, the Provider will likely submit the claim on behalf of the Covered Person. It is in the Covered Person's best interest to ask the Provider if the claim will be filed on his or her behalf by the Provider.

In the event of termination of the agreement between the Claims Administrator and the Plan Sponsor, all notices of claims for Covered Services received after the termination of such agreement should be provided to the Plan Sponsor.

NOTE ABOUT PRESCRIPTION DRUG CLAIMS:

Refer to the section entitled "Prescription Drug Benefits" for information on how to submit a claim.

CLAIM REVIEW PROCEDURE

This section describes the claim review procedures under the Plan. A claim is defined as any request for a benefit made by a Covered Person or by a Provider on behalf of the Covered Person that complies with the Plan's reasonable procedure for making a claim for benefits. The times shown in this section are maximum times only. A period of time begins at the time the claim is filed. The days shown in this section are counted as calendar days.

Under the Plan, the Covered Person can check on the status of a claim at any time by contacting the Customer Service number appearing on the Covered Person's identification card.

There are different time frames for reviewing a claim and providing notification concerning the claim. The time frames are based on the category of the claim. For the purpose of this provision, there are three categories of claims: Pre-Service Claims, Urgent Care Claims and Post-Service Claims.

Pre-Service Claims - Pre-Service Claims are those claims for which the Plan requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification, pre-authorization or pre-determination. For Pre-Service Claims (other than Urgent Care Claims), the following time frames apply concerning review and notification of the benefit determination:

1. **Notification Concerning Failure to Follow Procedure -** In the event the Covered Person, or Provider on behalf of the Covered Person, fails to follow the proper procedure for providing notification of a Pre-Service Claim, the Covered Person or Provider will be notified within 5 days.

2. **Benefit Determination Period** – The Covered Person will be notified of the benefit determination within 15 days following receipt of notification concerning the Pre-Service Claim.

3. **Extension of Benefit Determination Period** - If a benefit determination cannot be made within the standard 15-day benefit determination period due to matters beyond the Plan Administrator's control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 15-day benefit determination period. Only one extension is permitted for each Pre-Service Claim.

   If a benefit determination cannot be made within the standard 15-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 15-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

Urgent Care Claims - Urgent Care Claims are those **Pre-Service Claims** in which the time periods for making claim determinations for Pre- or Post-Service Claims could seriously jeopardize the Covered Person's life, health or ability to regain maximum function or when a Physician with knowledge of the Covered Person's medical condition determines that the Covered Person would be subject to severe pain that cannot be adequately managed or controlled without the treatment that is the subject of the claim. For Urgent Care Claims, the following time frame applies concerning review and notification concerning the benefit determination:

1. **Notification Concerning Incomplete Claim -** In the event the Covered Person, or Provider on behalf of the Covered Person, fails to submit complete information in connection with an Urgent Care Claim, the Covered Person or Provider will be notified of the specific information needed to complete the claim within 24 hours.

2. **Benefit Determination Period** – The Covered Person will be notified of the benefit determination concerning an Urgent Care Claim within 72 hours following receipt of notification concerning the Urgent Care Claim.

3. **Extension of Benefit Determination Period** - In the event additional information is needed in order to make a benefit determination, the Covered Person must be notified within 24 hours following receipt of notification concerning the Urgent Care Claim. Notification of the extension will include a detailed explanation of the information needed to make the benefit determination. Upon receipt of the notification of the required extension, the Covered Person has 48 hours to provide the requested information. The determination will be made within 48 hours following receipt of the requested information from the Covered Person. If the Covered Person fails to provide the requested information, the benefit determination will be made within 48 hours following the end of the period allowed for providing said information.

4. **Benefit Determination Period For Request of Continuation of Treatment** - Any request to continue the course of treatment that is an Urgent Care Claim shall be decided as soon as possible. The Covered Person will be notified of the benefit determination within 24 hours of the receipt of the claim, provided that such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-Service Claims - Post-Service Claims are those claims for services, other than Pre-Service and Urgent Care Claims, which have been rendered by a Provider. For Post-Service Claims, the following time frames apply concerning review and notification of the benefit determination:

1. **Benefit Determination Period** - The Covered Person will be notified of the benefit determination within 30 days following receipt of notification concerning the Post-Service Claim.

2. **Extension of Benefit Determination Period** - If a benefit determination cannot be made within the standard 30-day benefit determination period due to matters beyond its control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 30-day benefit determination period. Only one extension is permitted for each Post-Service Claim.

   If a benefit determination cannot be made within the standard 30-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 30-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

PATIENT ADVOCACY CENTER: Group C Only
It is the Plan's position that the Provider should not balance bill the Covered Person for amounts in excess of the Reasonable and Allowable Charge. It is the Plan's position that these Excess Charges are clearly excessive and exorbitant. However, balance billing for such amounts can occur for out of network claims and the Plan has no control over the actions of the Providers or their desire to pursue you for such amounts.

In the event you receive a balance-bill for an amount in excess of the Reasonable and Allowable Charge payable, please immediately email pac@hstechnology.com or call the Patient Advocacy Center toll free at (888) 837-2237.

Please Note: The Patient Advocacy Center provides assistance to Covered Persons with the understanding that (i) the Patient Advocacy Center is not acting in a fiduciary capacity under this Plan, (ii) that the Covered Person must make their own independent decision with respect to any course of action in connection with any balance-bill, including whether such course of action is appropriate or proper based on the Participant's specific circumstances and objectives, and (iii) the Patient Advocacy Center does not provide legal or tax advice.

CLAIM APPEAL PROCESS
Requirements for Appeal: Groups A and C (All Locations Except Winchester, VA)
The Covered Person must file the first appeal, in writing (although oral appeals are permitted for pre-service urgent care claims), within 180 days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Covered Person chooses to orally appeal, the Covered Person may telephone:

Named Fiduciary c/o HealthSCOPE Benefits, Inc.
501-218-7865

To file an appeal in writing, the Covered Person's appeal must be addressed as follows and mailed or faxed as follows:

Named Fiduciary c/o HealthSCOPE Benefits, Inc.
P.O. Box 2860
Little Rock, Arkansas 72203

Requirements for Appeal: Group B (Winchester, VA Location)
To file an appeal of a pre-service urgent claim orally via telephone, the Participant must call the number listed below. To file an appeal of a pre-service in writing, the Participant's appeal must be mailed and addressed to the following address:

UHC APPEALS - UMR
P.O. Box 400046
San Antonio, TX 78229
866-494-4502

To file an appeal of a post-service claim, the Participant must mail the appeal to the following address:

HealthSCOPE Benefits
P.O. Box 2860
Little Rock, AR 72203

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

- The name of the employee/Covered Person;

- The employee/Covered Person's social security number;

- The group name or identification number;

- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal**;

- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

- Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.

- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

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

Manner and Content of Notification of Adverse Benefit Determination on First Appeal
The Plan Administrator shall provide a Covered Person with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- Information sufficient to allow the Covered Person to identify the claim involved (including date of service, the healthcare 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);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

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

- A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- 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 Covered Person's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Covered Person 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 Covered Person's claim for benefits;

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

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

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Covered Person, free of charge, upon request; and

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is**

brought.

SECOND APPEAL LEVEL

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Covered Person has 60 days to file a second appeal of the denial of benefits. The Covered Person again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Covered Person has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Covered Person's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The Plan shall notify the Covered Person of the Plan's Benefit Determination on review within a reasonable period of time, but not later than 30 days after receipt of the second appeal. The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan's response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Covered Person to perfect the Claim and an explanation of why such information is needed; and (b) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

Decision on Second Appeal to be Final
If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law. **All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 3 years after the Plan's Claim review procedures have been exhausted. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within 3 years after the date of service.**

Appointment of Authorized Representative
A Covered Person is permitted to appoint an Authorized Representative to act on his behalf with respect to a benefit Claim or appeal of an Adverse Benefit Determination. An assignment of benefits by a Covered Person to a Provider or Facility will not constitute appointment of that Provider or Facility as an Authorized Representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator. In the event a Covered Person designates an Authorized Representative, all future communications from the Plan will be with the Authorized Representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

External Review Process

A. Scope

1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Covered Person or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The Federal external review process applies only to:
   (a) An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
   (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard External Review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within 5 business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
   (d) The claimant has provided all the information and forms required to process an external review.

   Within 1 business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting

organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least 3 IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

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

C. Expedited external review

Urgent or Emergency Care
This Plan does not require a Covered Person to obtain prior approval for pre-service urgent care Claims or emergency care services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these Claims. In an emergency or urgent care situation, the Covered Person should follow instructions from his/her health care provider, and file the Claim as a post-service Claim. If the post-service Claim results in an Adverse Benefit Determination, the Covered Person may file an appeal in accordance with the Plan's provisions for "Appeal Process", which are explained above.

Appeals of Claims involving concurrent care will be subject to the Plan's provisions for expedited external review, as explained below.

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

   (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   (b) A first internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the first internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a Facility.
   (c) A second internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the second internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a Facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph B.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph B.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph B.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review 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 notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

COORDINATION OF BENEFITS, SUBROGATION AND THIRD PARTY RECOVERY

COORDINATION OF BENEFITS PROVISION

All benefits provided as described in this Summary Plan Description are subject to Coordination of Benefits ("COB"). COB determines when a benefit plan is primary or secondary when a Covered Person is covered by more than one benefit plan.

This COB provision applies when the Covered Person is also covered by this Plan and another benefit plan ("Other Benefit Plan"). When more than one coverage exists, one plan will pay its benefits in full according to the terms of that plan and the other plan(s) will pay a reduced benefit to prevent duplication of benefits. The plan that pays its benefits in full is considered to be the "primary plan." The plan that pays reduced benefits to prevent duplication is considered to be the "secondary plan." A common set of rules is used to determine the order of benefits determination.

When the Plan is primary, the Plan will pay benefits without regard to any Other Benefit Plan. Additionally, when this Plan is secondary, the benefits payable under this Plan will be reduced so that the sum of benefits paid by all Other Benefit Plans and this Plan do not exceed 100% of the total Allowable Expenses. As secondary plan, this Plan would base its payment on the difference between the total amount of the Allowable Expenses and the amount that has been paid by the Other Benefit Plan(s) as the primary plan(s). If the amount paid by the primary plan equals or exceeds the amount that would have been payable by this Plan if were the primary plan, then no further benefit payments will be made by the Plan in connection with that claim. Any applicable Deductible, Copayment or Coinsurance requirement under the Other Benefit Plan and this Plan will not be considered an Allowable Expense. This provision is considered "non-duplication of benefits."

Definitions: As used in this section, the following terms are defined as:

"Other Benefit Plan" means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

"Allowable Expenses" means any Eligible Expenses incurred while the Covered Person is covered under this Plan, except that any eligible expenses incurred that apply toward the Covered Person's copayment, deductible, or coinsurance requirement under this Plan or any Other Benefit Plan will not be included as an Allowable Expense.

Automobile Limitations: When medical payments coverage is available under the vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles or other out-of-pocket requirements under the vehicle plan. This Plan shall always be considered secondary regardless of the Covered Person's election under Personal Injury Protection (PIP) or any no-fault coverage with the automobile carrier.

Motor-Vehicle Related Injury: The Plan will not cover the cost of health care expenses resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent that such services or expenses are payable under any Personal Injury Protection, no-fault, medical payments provision, or any other category (including such benefits mandated by law) of any automobile or vehicle insurance plan.

ORDER OF BENEFITS DETERMINATION (OTHER THAN MEDICARE)
Which plan provides primary or secondary Coverages will be determined by using the first of the following rules that applies:

1. **No COB**. If the Other Benefit Plan contains no COB provision, it will always be primary.

2. **Employee or Member**. The benefit plan covering the Covered Person as an employee, member or subscriber (other than a Dependent) is primary.

3. **Medicare Eligible**. If a Covered Person is eligible for Medicare, benefits will be coordinated with Medicare as set forth in the section entitled "Order of Benefits Determination for Medicare."

4. **Dependent Child of Parents (Not Divorced or Legally Separated)**. When a Dependent is covered by more than one plan of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary. If both parents have the same birthday, the plan that covered the parent longer will be primary. If a Dependent is covered by two benefit plans and the Other Benefit Plan does not have coordinate benefits based on the birthday of the parent (e.g., benefits are coordinated based on the gender of the parents), the rule of the Other Benefit Plan will determine the primary and secondary contract.

5. **Dependent Child of Parents Divorced or Legally Separated**. When a Dependent is covered by more than one plan of different parents who are separated or divorced, the following rules apply:

    a. If the parent with custody has not remarried, his or her coverage is primary;

    b. If the parent with custody has remarried, his or her coverage is primary, the stepparent's is secondary and the coverage of the parent without custody pays last; or

    c. If a court decree specifies the parent who is financially responsible for the Child's health care expenses, the coverage of that parent is primary.

6. **Active Employees vs. Laid Off or Retired Employees**. When a plan covers the Covered Person as an active employee or a Dependent of such employee and the Other Benefit Plan covers the Covered Person as a laid-off or retired employee or as a Dependent of such person, the plan that covers the Covered Person as an active employee or Dependent of such employee is primary.

7. **Above Rules Do Not Apply**. When the rules above do not apply, the plan that has covered the Covered Person longer is primary.

8. **Special Note about Continued Coverage**. If the Covered Person is covered under an Other Benefit Plan that is primary but also has continued Coverage under this Plan (e.g., COBRA) due to the Other Benefit Plan's pre-existing condition exclusion, then this Plan will be primary for expenses incurred in connection with such pre-existing condition only.

ORDER OF BENEFITS DETERMINATION FOR MEDICARE

Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which are payable by such secondary coverage when said coverage is primary, except to the extent that such costs are payable in any event by the Plan.

Applicable to Active Employees and Their Spouses Ages 65 and Over

A Covered Person that is an active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or decline coverage under this Plan at open enrollment or some other specified special enrollment period. 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 declined by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare. The Plan will at all times, when applicable, adhere to the requirements set forth in the Medicare Secondary Payer regulations.

Applicable to All Other Covered Persons Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay Covered Services at the Reasonable and Allowable/Customary and Reasonable Charge before Medicare makes any secondary payment for 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 (as described under the Article entitled "Coordination of Benefits"). The Covered Person will be assumed to have full Medicare coverage (that is, both Parts A & B) whether or not the Covered Person has enrolled for the full coverage. If the Provider accepts assignment with Medicare, Covered Services will not exceed the Medicare allowable amount.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Covered Persons Who Are Covered Under This Plan

If any Covered Person 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.

SUBROGATION AND THIRD PARTY RECOVERY

What is Subrogation?

Subrogation applies to situations where the Covered Person is injured and another party is responsible for payment of health care expenses (s)he incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injury on another's property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Covered Person's injuries under the Plan may be recovered from the other party. Any payments made to the Covered Person for such injury may be recovered from the Covered Person from any judgment or settlement

of his or her claims against the other party or parties.

By accepting Coverage under the Plan, the Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. Therefore, the Plan Administrator may act as the Covered Person's substitute in the event any payment made by this Plan for health care benefits is or becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim.

The Covered Person must cooperate fully and provide all information needed under the Plan to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure such rights to the Plan. The other party may be sued in order to recover the payments made for the Covered Person under the Plan.

Right of Reimbursement and Recovery
Specifically, by accepting Coverage under the Plan the Covered Person agrees that if the Covered Person receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a tortfeasor, (2) a liability insurer for a tortfeasor, or (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers' compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage ("Recovery"), the Covered Person must repay the Plan in full for any medical, dental, vision, or disability benefits which have been paid or which will in the future be payable under the Plan for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.

Pursuant to *Sereboff v. Mid Atlantic Med. Servs.*, 126 S.Ct. 1869 (2006), the Plan has an equitable lien against the Recovery rights of the Covered Person and has the right to be paid from any such Recovery any and all monies or properties: (1) paid; (2) payable to; or (3) for the benefit of, a Covered Person to the extent of benefits paid by the Plan ("Subrogated Amount"), whether or not the Covered Person has been "made whole" for the injuries received. This right applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the Covered Person constitute a full or partial recovery, and applies to funds paid for non-health care charges or attorney fees, or other costs and expenses. This right for first priority in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Covered Person or any person or entity responsible for paying any Recovery attempts to designate or characterize the Recovery, regardless of whether the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically linked to certain kinds of damages or payments. Payment of the Subrogated Amount to the Plan shall be without reduction, set-off or abatement for attorney's fees or costs incurred by the Covered Person in the collection of damages. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or propertieAt the discretion of the Plan Administrator, the Plan may reduce any future Eligible Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Subrogated Amount that is subject to the equitable lien. All rights of recovery will be limited to the amount of payments made under this Plan.

The equitable lien shall also attach to the first right of Recovery to any money or property that is obtained by anybody, including but not limited to the Covered Person, the Covered Person's attorney, and/or a trust for the direct or indirect benefit of the Insured or for his/her "special needs," as a result of an exercise of the Covered Person's rights of Recovery.

The Plan may, in its sole discretion, require the Covered Person, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist the Plan to secure the Plan's right to payment of the Subrogation Amount from the third party. In the event that the Plan does not receive payment

of the Subrogated Amount, the Plan may, in its sole discretion, bring legal action against the Covered Person or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Covered Person. If the Plan takes legal action to enforce its subrogation rights, the Plan shall be entitled to recover its attorneys' fees and costs from the Covered Person.

The following provisions apply to the Plan's right of subrogation, reimbursement, and creation of an equitable lien:

1. **"Pursue and Pay."** The Plan Administrator has elected a "pursue and pay" in connection with the subrogation, reimbursement and equitable lien rights. At its sole discretion, the Plan Administrator may elect to "pursue and pay" in connection with the subrogation, reimbursement and equitable lien rights for all claims involving Eligible Expenses of $1,000 or more. Pursuant to the election of "pursue and pay", the Plan Administrator has the right to apply the subrogation, reimbursement and equitable lien rights prior to making any benefit payments under the Plan, and such payment shall be reduced by any amounts that were paid by any other party as described in this section.

2. **Scope of Subrogation, Reimbursement and Equitable Lien Rights.** The subrogation, reimbursement and equitable lien rights apply to any benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:

    a. Any no-fault insurance;
    b. Medical benefits coverage under any automobile liability plan. This includes the Covered Person's Plan or any third party's policy under which the Covered Person is entitled to benefits;
    c. Under-insured and uninsured motorist coverage;
    d. Any automobile medical payments and personal injury protection benefits;
    e. Any third party's liability insurance
    f. Any premises/guest medical payments coverage;
    g. Any medical malpractice recovery;
    h. Workers' compensation benefits. The right of subrogation, reimbursement and equitable lien attach to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services arose out of and in the course of employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made.
    i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).

3. **Excess Payments.** If the Plan erroneously makes total payments that exceed the maximum amount to which the Covered Person is entitled at any time under the Plan, the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.

4. **Reduction of Future Benefits.** The Plan provides that recovery of excess amounts may include a reduction of future benefit payments available to the Covered Person under the Plan of any amount up to the aggregate amount of Reimbursable Payments that have not been reimbursed by the Plan.

5. **"Make Whole" and "Common Fund" Rules Do Not Apply.** The provisions of the Plan concerning subrogation, reimbursement, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines and/or state laws commonly referred to as the "make whole" rule and the "common fund" rule.

6. **No Deductions for Costs or Attorneys' Fees.** The reimbursement required under the Plan shall not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator at the exercise of its sole discretion.

GENERAL PROVISIONS

ALTERATION OF APPLICATION
An enrollment application may not be altered by anyone other than the applicant unless the applicant has given his or her written consent allowing alterations.

AMENDMENT OF THE PLAN
Amendment: The Employer reserves the right to amend this Plan at any time by an instrument duly executed by an authorized officer. Such amendment shall be binding upon the Employer and all Covered Persons. The Employer shall furnish to each Covered Employee a summary, written in a manner calculated to be understood by the average Covered Employee, of any modification to the Plan or change in the information required to be included in the Summary Plan Description.

Retroactive Amendments: An amendment to this Plan may be made retroactively effective so long as it does not adversely affect the rights of Covered Persons to benefits under this Plan for covered health care expenses which are incurred after the effective date of the amendment but before the amendment is adopted.

Material Reduction: Amendments that are a material reduction in Covered Services or benefits must be disclosed not later than 60 days after the date of adoption of the modification or change. A "material reduction in covered services or benefits" means any modification to the plan or change in the information required to be included in the Summary Plan Description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average Covered Employee to be an important reduction in Covered Services or benefits under the Plan. A "reduction in covered services or benefits" generally would include any Plan modification or change that: eliminates benefits payable under the Plan; reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, Deductibles, Coinsurance, Copayments, or other amounts to be paid by a Covered Employee.

APPLICABLE LAW
This Plan shall be construed in accordance with the laws of the State of South Carolina and of the United States of America. Any provision of this Plan that is in conflict with applicable law is amended to conform with the minimum requirements of that law.

ASSIGNMENT OF BENEFITS
Benefits for Covered Expenses under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered. As described in Section 10.03, this means that the Plan will reimburse the Provider directly. However, if the Plan pays benefits directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will only consider valid an Assignment of Benefits as defined under this Plan. Payment of benefits through a valid Assignment of Benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the claim or proof of loss is submitted.
Conditions and Limitations of an Assignment of Benefits:

1. The validity of an Assignment of Benefits by a Covered Person to a Provider or Facility is limited by the terms of this Summary Plan Description. An Assignment of Benefits is considered valid on the condition that Provider or Facility accepts the payment received from the Plan as consideration, in full, for Covered Services 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 or Facility may bill the Covered Person directly for these amounts.

2. An Assignment of Benefits cannot be inferred, implied or transferred. An Assignment of Benefits must be made by the Covered Person to the Provider or Facility directly through a valid written instrument

that is signed and dated by the Covered Person.

3. Unless specifically prohibited by a Participant, a Provider or Facility with a valid Assignment of Benefits may exhaust, on behalf of the Covered Person, any administrative remedies available under the terms of the Summary Plan Description, including initiating an internal or external appeal of an adverse benefit determination in accordance with the terms of the Summary Plan Description. Notwithstanding the foregoing, the Covered Person does not, under any circumstances, have the right to assign to any Provider or Facility (or their representative) through an Assignment of Benefits any right to initiate any cause of action against the Plan that the Covered Person 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 Covered Persons under ERISA section 502(a). The assignment of any right to initiate suit against the Plan to a Provider or Facility is strictly prohibited.

4. An Assignment of Benefits does not grant the Provider or Facility 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 Covered Person as the sole recipient of the benefits available under the terms of the Plan.

6. An Assignment of Benefits by a Participant to a Provider or Facility will not constitute the appointment of an Authorized Representative.

By submitting a claim to the Plan and accepting payment by the Plan, the Provider or Facility is expressly agreeing to the foregoing conditions and limitations of an Assignment of Benefits in addition to the terms of the Summary Plan Description. The Provider or Facility 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 or Facility 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 or Facility 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 or Facility may bill the Covered Person directly for these amounts.

If a Provider or Facility 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 Summary Plan Description will be payable directly to the Covered Person, and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Expense.

BENEFITS NOT TRANSFERABLE
Except as otherwise stated herein, no person other than an eligible Covered Person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

BONDING
Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

COUNTERPARTS
This Plan may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together constitute one instrument, which may be sufficiently evidenced by any counterpart.

EFFECTIVE DATE
Except where specifically stated otherwise in this Summary Plan Description, the provisions of this amended and restated Summary Plan Description are effective January 1, 2020 and this Summary Plan Description shall supersede and replace all prior versions of the Summary Plan Description as of that date.

ELIGIBILITY DETERMINATIONS UNDER HIPAA
Federal Law, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), prohibits the Plan Sponsor from denying Coverage under the Plan based on any of the following health-related factors:

1. Health status;
2. Medical condition (including both physical and mental Illnesses);
3. Receipt of healthcare;
4. Medical history;
5. Genetic information;
6. Evidence of insurability (including conditions arising out of acts of domestic violence); and
7. Disability.

EMPLOYMENT RIGHTS
The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between the Covered Employee and the Employer to the effect that (s)he will be employed for any specific period of time or retained in the service of the Employer and does not affect in any way the Employee's employment rights.

ERRONEOUS INFORMATION
If any information pertaining to any Covered Person is found to have been reported erroneously to the Plan Sponsor or to HealthSCOPE Benefits, as the claims administrator, and such error affects his or her Coverage, the facts will determine to what extent, if any, the Covered Person was or is covered under the Plan.

EXEMPTION FROM ATTACHMENT
To the full extent permitted by law, all rights and benefits under the Plan are exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Covered Employee or other Covered Person.

FREE CHOICE OF HOSPITAL AND PHYSICIAN
Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to make a free choice to select a Facility or Hospital, Provider or other Provider of health care services. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have higher out-of-pocket expenses if the Covered Person uses the services of a Non-Network Provider.

INABILITY TO HANDLE AFFAIRS
If a benefit is owed when the Covered Person is not able to handle his or her affairs, the benefit may be paid to a relative by blood or marriage. This would happen if the Covered Employee had died or become mentally incompetent. The Plan will make payment to a relative whom it judged to be entitled in fairness to the money. Any such payment would discharge any obligation to the extent of such payment.

INCONTESTABILITY
All statements made by the Employer or by the Covered Employee shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the Employer or by the Covered Person, as the case may be. A statement made shall not be used in any legal contest unless such statement is made in writing and signed by such person and a copy of the instrument containing the statement is or has been furnished to the other party to

such a contest.

INTERPRETATION OF PLAN PROVISIONS
All provisions of this Plan shall be interpreted and administered in accordance with the provisions of applicable law in a non-discriminatory manner and in a manner that will assure compliance of the Plan's operation therewith. All persons in similar circumstances shall receive uniform, consistent, and non-discriminatory treatment hereunder.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator has the discretionary authority to decide whether a charge is Customary and Reasonable/Reasonable and Allowable. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

LEGAL ACTIONS: Groups A and B (SC Locations & Winchester, VA Location)
No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of 60 days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of 1 year from the date the expense was incurred.

LIABILITY AND LIMITATION OF ACTION
This Plan will not give the Covered Person any claim, right, action or cause of action against any person or entity other than the Provider rendering Covered Services to the Covered Person for acts or omissions of such Provider. Contributions being made to and held by the Plan are made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms. Except with respect to the right of a Covered Person to receive benefits under this Plan, no Covered Person shall have any right or interest in or to the assets of the Plan or in or to any contributions to the Plan.

The Plan Sponsor and HealthSCOPE Benefits do not actually furnish health care services as described in this Summary Plan Description. Rather, Coverage will be provided for the health care services covered under the Plan when rendered by a Provider
to the Covered Person.

STATUTE OF LIMITATIONS/FORUM: Group C Only (All Locations Except SC Locations & Winchester, VA Location)
Before filing a lawsuit, the Plan Participant must exhaust all available levels of administrative review as described in this Plan, 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 Adverse Benefit 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, exclusively in South Carolina. The 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, 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.

PHYSICAL EXAMINATION AND AUTOPSY
By accepting Coverage, as described in this Summary Plan Description, the Covered Person agrees that (s)he

may be required to have one or more physical examinations. Performance of an autopsy may also be required in the case of death where it is not forbidden by law. These examinations and/or autopsy will help to determine what benefits will be payable, particularly when there are questions concerning services on a claim.

PLAN RIGHT TO RECOVERY

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, according to the terms of the Plan, the Plan will have the right to recover these excess payments. Whenever payments have been made from the Plan that, according to the terms of the Plan, should not have been made, the Plan will have the right to recover these incorrect payments. The Plan has the right to recover any such overpayment or incorrect payment from the person or entity to whom payment was made, or from any other appropriate party, whether or not such payment was made due to the Plan Administrator's own error.

RIGHTS OF PLAN

To the full extent permitted by law, all rights and benefits under the Plan are exempt from attachment or garnishment or other legal process for the debts or liabilities of any Covered Person.

RIGHT TO ENFORCE PLAN PROVISIONS

Failure by the Plan Sponsor or HealthSCOPE Benefits to enforce any provision of the Plan provision shall not affect the Plan Sponsor's or HealthSCOPE Benefits' right thereafter to enforce such provision or any other provisions of the Plan.

SECONDARY COVERAGE: Groups A and B (SC Locations & Winchester, VA Locations)

Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

A Provider or Facility that accepts the payment from the Plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Covered Person and (ii) it shall not "balance bill" a Covered Person for any amount billed but not paid by the Plan.

SECONDARY COVERAGE: Group C (All Metromont Locations Except SC Locations & Winchester, VA Location)

Plan Participants who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Plan Participant incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which are payable by such secondary coverage when said coverage is primary, except to the extent that such costs are payable in any event by the Plan.

TERMINATION OF THE PLAN

Right to Terminate: It is the intention of the Employer to continue this Plan indefinitely. However, the Plan Sponsor reserves the right to terminate this Plan at any time by an instrument duly executed by it.

Effect of Termination: Unless otherwise provided, upon the effective date of Plan termination, the Coverage of all Covered Persons shall cease and no person shall become entitled to any benefits hereunder for any expenses incurred after the effective date of Plan termination. The Plan shall remain liable to pay benefits for expenses incurred prior to the effective date of Plan termination, but only to the extent of the assets set aside for that purpose.

TITLES ARE FOR REFERENCE ONLY

The titles used in the Plan are for reference only. In the event of a conflict between a title and the content of a Section, the content of the Section shall control.

WORKERS' COMPENSATION COVERAGE
The Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

WORD USAGE
Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine, or neuter form.

WRITTEN DIRECTIONS
Whenever a person must or may act upon the written direction of another, he shall not be required to inquire into the propriety of such direction, and he shall follow the direction unless it is clear on its face that the actions to be taken under that direction are prohibited by law or the terms of this Plan. Moreover, such person shall not be responsible for failure to act without such written direction.

GENERAL PLAN, ERISA AND PLAN ADMINISTRATION INFORMATION

The Plan has been established and operates under the guidelines of ERISA (Employment Retirement Income Security Act of 1974). As an ERISA Plan, there is a requirement that certain disclosures must be made to Covered Persons. This page and the following pages provide this information.

1. **GENERAL PLAN INFORMATION**

a. **Name Of The Plan**

Metromont Corporation Health Benefit Plan

b. **Name, Business Address And Telephone Number Of The Plan Sponsor**

Metromont Corporation
20 Two Notch Road
Greenville, SC 29605
864-605-5006

c. **Plan Sponsor Identification Number**

58-2322112

d. **Plan Number**

501

e. **Name, Business Address And Telephone Number Of The Plan Administrator**

Metromont Corporation
20 Two Notch Road
Greenville, SC 29605
864-605-5006

f. **Name And Address Of The Person Designated As Agent For The Service Of Legal Process**

Metromont Corporation
20 Two Notch Road
Greenville, SC 29611

g. **Plan Year (For Fiscal Record Keeping)**

January 1 to December 31

h. **Claims Administrator**

HealthSCOPE Benefits, Inc.
27 Corporate Hill Drive
Little Rock, Arkansas 72205
501-225-1551

Send Non-PPO Claims to:
HealthSCOPE Benefits
P.O. Box 99005
Lubbock, TX 79490-9005

Send PPO Claims to the PPO Network appearing on the Identification Card.

Send Prescription Drug Claims to the Prescription Drug Vendor appearing on the Identification Card.

i. **Address And Telephone Number Of The Office Of The Department Of Labor**

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Room N-5644
Washington, D.C. 20210
(202) 565-7500

j. **Effective Date Of The Plan**

January 1, 2020

k. **Type Of Plan**

Group health benefits, which include medical and prescription drug.

l. **Type of Administration:**

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Administrator to provide claims payment and ministerial administration.

m. **Sources of Contributions and Funding:**

Benefits under the Plan will be paid as needed directly from the general assets of the Employer that sponsors the Plan. In addition, if the Employer has purchased insurance contract(s) in connection with the Plan, benefits will also be paid from said insurance contract(s).

Contributions for Plan expenses are obtained from the Employer and from the participating Employees. The Employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the Employer and the amount to be contributed by the participating Employees.

Note about COBRA: COBRA premiums will be the Qualified Beneficiaries' full responsibility and are generally 102% of the costs for non-COBRA individuals, except in special circumstances where a greater amount is permitted under COBRA. Refer to the section that addresses COBRA Coverage for additional details.

2. **STATEMENT OF ERISA RIGHTS**

Right to Receive Information About the Plan: As a participant in this Plan, the Employee is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to: (a) examine, without charge, at the Plan Sponsor's office and at other specified locations, such as work sites, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions; (b) obtain copies of all Plan documents and other Plan information upon written request of the Plan Sponsor. The administrator may make a reasonable charge for the copies; and (c) receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Coverage: The participant may be eligible to continue group health Coverage for himself and his Dependents if there is a loss of Coverage due to a COBRA qualifying event. In this event, Coverage will continue for the period(s) of time set forth in this Summary Plan Description and subject to the conditions and limitations set forth herein. The participant's COBRA rights are explained in this Summary Plan Description.

The Covered Person should be provided with a certificate of Creditable Coverage, free of charge, from his group health plan or health insurance issuer when coverage is lost, or when COBRA Coverage ceases, if one is requested before losing Coverage or if one is requested up to 24 months after Coverage has been lost.

Actions by the Fiduciary: In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Employee and other Covered Persons and beneficiaries. No one, including the Employer, or any other person, may fire the Employee or otherwise discriminate against the Employee in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforcement of Participant Rights: If the participant's claim for a welfare benefit is denied in whole or in part, the Employee must receive a written explanation of the reason for denial. The participant has the right to have the Plan review and reconsider his or her claim.
Under ERISA, there are steps the participant can take to enforce the above rights. For instance, if the participant requests materials from the Plan and does not receive them within 30 days, the participant may file suit in a federal court. The Plan's claim procedures must be exhausted by the claimant before the

claimant files a benefits suit. Refer to the section entitled "Claims Information" for additional details regarding claim procedures. In such a case, the court may require the Plan Sponsor to provide the materials and pay the Employee up to $110 a day until (s)he receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the participant has a claim for benefits that is denied or ignored, in whole or in part, and if s(he) has exhausted the claims procedures available under the Plan, (s)he may file suit in a state or federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if the participant is discriminated against for asserting his or her rights, (s)he may seek assistance from the U.S. Department of Labor, or (s)he may file suit in federal court. The court will decide who should pay the court costs and legal fees. If the participant is successful, the court may order the person (s)he has sued to pay these costs and fees. If the participant loses, the court may order the participant to pay these costs and fees (e.g. if the court finds the participant's claim is frivolous).

Additionally, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the status of a Qualified Medical Child Support Order (QMCSO), the participant may file suit in a Federal court.

Questions: If the participant has any questions about the Plan, (s)he should contact the Plan Sponsor. If the participant has any questions about this statement or about his or her rights under ERISA, the participant should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor. Participants may also request certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration, U.S. Department of Labor.

3. OPERATION AND ADMINISTRATION OF THE PLAN

Plan Sponsor and Plan Administrator: The Plan is administered through Metromont Corporation which has been established and shall be maintained for the exclusive benefit of the Employees. Metromont Corporation is the Employer and Plan Sponsor and also functions as the Plan Administrator, unless another individual or entity is appointed by the Employer. The Plan Administrator shall have full charge of the operation and management of the Plan.

Plan Fiduciary: Metromont Corporation shall also function as the Plan Fiduciary under ERISA unless the Employer appoints another individual or entity to act in this capacity. The Plan Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the Plan, to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary, including, but not limited to, the denial of certification of the Medical Necessity of Hospital or medical services, supplies and treatment, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Fiduciary will be final and binding on all interested parties. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

Claims Administrator: Under the Plan, HealthSCOPE Benefits, Inc. ("HealthSCOPE Benefits"), has agreed to provide certain administrative services on behalf of the Plan Sponsor according to the terms and limitations of the Plan. The responsibilities of HealthSCOPE Benefits are spelled out in an agreement between the Plan Sponsor and HealthSCOPE Benefits and include but are not limited to the administration of claims on behalf of the Plan Sponsor. Claims for benefits under the Plan shall be filed, processed, reviewed, and, if denied, appealed in accordance with the procedures set forth in this Summary Plan Description.

Except as otherwise provided by law, the appeal procedures set forth in this Summary Plan Description shall be the sole and exclusive remedy.

HealthSCOPE Benefits does not furnish health care services and is not liable for the quality of health care services received by a Covered Person. HealthSCOPE Benefits does not provide insurance coverage or benefits nor does HealthSCOPE Benefits underwrite the liability of this Plan. HealthSCOPE Benefits will not act nor assume the responsibility to act as the Plan Administrator, Plan Fiduciary or Named Fiduciary in connection with this Plan. HealthSCOPE Benefits is merely providing assistance with the administration of this Plan by adjudicating claims in accordance with the terms of the Plan.

Administrative Committee: The Employer, at its option, shall appoint a committee to oversee the administration of the Plan on behalf of the Employer. The members of the Administrative Committee shall serve at the pleasure of the Employer that appointed them.

Delegation of Responsibilities: The Employer may delegate its responsibilities hereunder to other persons or entities. Such delegation shall be effective only if the proposed delegate executes an instrument acknowledging acceptance of the delegated responsibilities.

Administrative Duties: The following responsibilities shall be performed in the administration of the Plan. These duties may be performed by the Employer or by a committee of individuals appointed by the Employer to assist in the administration of the Plan:

a. Maintaining all Plan records;

b. Filing tax returns and reports required under federal and state law and complying with all other governmental reporting and disclosure requirements;

c. Authorizing payments and resolving questions concerning the Plan and interpreting, in its discretion, the Plan's provisions related to benefits and eligibility;

d. Hiring outside professionals to assist with Plan Administration and render advice concerning the responsibility they have under the Plan, including but not limited to hiring a claims administrator, actuaries, attorneys, accountants, brokers, consultants and other specialists to render advice concerning any responsibility they have under the Plan;

e. Establishing policies, interpretations, practices and procedures of the Plan;

f. Receiving all disclosures required of fiduciaries and other service providers under any federal or state law;

g. Acting as the Plan's agent for service of legal process;

h. Administering the Plan, including but not limited to the Plan's claims procedures as set forth in the Summary Plan Description;

i. Paying benefits under the Plan, by drawing checks, or instructing others to draw checks, against the Plan established for this purpose. With respect to claims that are administered by the claims administrator, this responsibility includes instructing the claims administrator to withdraw monies from the funding account for the purpose of administering claims incurred under the Plan; and

j. Performing all other responsibilities allocated to the Plan Administrator.

Final Authority of the Plan Document: The terms and provisions contained in this Plan Document and Summary Plan Description shall be final and binding upon all Participants. Contradictory benefit information received from any other source will not effect the terms of the Plan as set forth herein. Participants are advised

to conclusively rely upon the benefit information provided in this Plan Document and Summary Plan Description only.

Statute of Limitations: before filing a lawsuit, a Covered Person must exhaust all available levels of review as described in the Claim Review 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, the Covered Person, 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, Covered Persons, 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.

DEFINITIONS

Actively Working/Actively At Work - Means the Employee is performing his or her regular duties on behalf of, and in the regular business of the Plan Sponsor for the hours as set forth in this Summary Plan Description and is reasonably being compensated by the Plan Sponsor on a regular basis for such duties. An Employee will retain eligibility for Coverage under the Plan if absent on an approved leave of absence, with the expectation of returning to work following the approved leave of absence as determined by the Employer. The Employer's classification of an individual is conclusive and binding for purposes of determining eligibility under the Plan.

Adverse Benefit Determination - means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

Alcoholism Treatment Facility - Means a Facility that is primarily engaged in the treatment of alcoholism. The Facility must have in effect plans for utilization and peer review and programs for rehabilitation or rehabilitation and detoxification of alcoholism. The Facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Health.

Ambulatory Surgical Facility - Means a Facility, with an organized staff of Physicians, which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
2. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the Facility;
3. Does not provide Inpatient accommodations; and
4. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other Professional.

The Facility must be accredited by the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Association.

Approved Clinical Trial - means a phase I, II, III or IV trial if it is:

1. Conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, and;
2. Is one of the following:
    a. Approved and funded by one or more of the following:
        i. National Institutes of Health (NIH);
        ii. Centers for Disease Control and Prevention (CDC);
        iii. Agency for Health Care Research and Quality (AHRQ);
        iv. Centers for Medicare and Medicaid Services (CMS);
        v. A non-governmental research entity identified in the NIH guidelines for center support grants;
        vi. Department of Defense, Department of Veterans' Affairs or Department of Energy (if the trial has undergone unbiased, scientific peer review by experts without conflict and the Department of Health and Human Services Secretary deems the review to be comparable to the NIH peer review system);
        vii. Cooperative group or center for any of the above agencies, other than Department of Energy; or

b. Is either:
    i. Conducted under an investigational new drug application (IND) reviewed by the Food and Drug Administration; or
    ii. A drug trial that is exempt from the IND application requirements.

Benefit Period - Means the period beginning on January 1st and ending on December 31st of each year.

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

Clean Claim - A claim for a Covered Service that (a) is timely received by the Administrator; (b) (i) when submitted via paper has all the elements of the UB 04 or CMS 1500 (or successor standard) forms; or (ii) when submitted via an electronic transaction, uses only permitted transaction code sets (e.g. CPT4, ICD9, ICD10, HCPCS) and has all the elements of the standard electronic formats required by applicable Federal authority; (c) is a claim for which the Plan is the primary payor or the Plan's responsibility as a secondary payor has been established; and (d) contains no defect, error or other shortcoming resulting in the need for additional information to adjudicate the claim; and (d) that does not lack necessary substantiating documentation to completely adjudicate the claim.

A Clean Claim does not include a claim that is being reviewed for the Reasonable and Allowable Charge payable under the terms of the Plan. Additionally, any claim over $50,000 must be accompanied by a valid itemization, and submitted to the Third Party Administrator before it will be deemed a Clean Claim.

Coinsurance - Means a percentage of the Reasonable and Allowable/Customary and Reasonable Charge that a Covered Person pays for Covered Services.

Community Mental Health Facility - Means a Facility that is primarily engaged in the treatment of mental Illness, including substance abuse. The Facility must have in effect utilization and peer review plans. The Facility must also be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by the Department of Health.

Confinement - Means an Inpatient stay in a Hospital or other Facility. Two successive Confinements will be considered one Confinement if readmission is for the same or related condition for which the Covered Person was previously confined and the readmission occurs within 90 days.

Copayment - Means the dollar amount payable by the Covered Person for a service, treatment or procedure rendered. The Copayment is applicable on a per occurrence basis.

Coverage - Means the payment for Covered Services as specified and limited by this Summary Plan Description.

Covered Dependent Child(ren) – Means the Dependent Child(ren) who is (are) covered under this Plan.

Covered Employee - Means the Employee of the Employer (also referred to as the participant) who has satisfied the eligibility requirements under the Plan and has enrolled for Coverage under the Plan.

"Covered Expense"
Those Medically Necessary services, supplies and/or treatment that are covered under this Plan. Covered Expense does not necessarily mean the actual charge made nor the specific service or supply furnished to a

Plan Participant by a Provider or Facility. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider or Facility's medical error are not considered Covered Expenses. A finding of Provider or Facility negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered an Excess Charge or not a Covered Expense.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

Covered Person - Means the Covered Employee, the Covered Spouse and/or Covered Dependent Child(ren).

Covered Services - those Medically Necessary services, supplies and/or treatment that are covered under this Plan. Covered Services do not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a Provider. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider's medical error are not considered Covered Services. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not reasonable and allowed or not a Covered Service.

Covered Spouse – Means the Spouse who is covered under this Plan.

Creditable Coverage - Means coverage under any of the following:

1. Group health plan;
2. Health insurance coverage, group or individual;
3. Medicare;
4. Medicaid;
5. Medical and dental coverage for member and certain former members of Uniformed Services, and their dependents (Title 10 U.S.C. Chapter 55);
6. Medical care program of the Indian Health Services or a tribal organization;
7. State health benefits risk pool;
8. Public health plan;
9. Federal Employees Health Benefits Program;
10. Health benefit plan under Peace Corps Act; and
11. State Children's Health Insurance Program.

Customary and Reasonable Charge – Means the maximum amount of charges for Covered Services (other than Outpatient Dialysis Covered Services) rendered by a Non-Preferred Provider. The Customary and Reasonable Charge that applies to a given service, treatment or supply which shall not exceed the general level of charges assessed by Providers rendering the same type of service, treatment or supplies. The Customary and Reasonable Charge is established using historical data collected for charges by Providers within specific geographic areas for the same or similar services, treatment or supplies. The data may be supplemented with information provided by independent research firms who specialize in the collection of Provider charge data. Unusual circumstances that reasonably require additional time, skill or experience for a Provider's service, are taken into consideration by the Plan and may result in reimbursement of an amount above the Customary and Reasonable maximum but not exceeding the actual charge. The Customary and Reasonable charge does not apply to Preferred Providers or Outpatient Dialysis Covered Services.

Deductible - Means the amount of Eligible Expenses a Covered Person must incur before the Plan will pay any benefits during a Benefit Period. The Individual Deductible is the Deductible that applies to each Covered Person. The Family Deductible is the Deductible that applies to all family members combined. This Deductible may be satisfied by any one individual in its entirety or by a combination of all covered family members.

Dependent - Means the Spouse and/or the Dependent Child(ren).

Dependent Child - Means a dependent child who satisfies the eligibility criteria set forth in the Summary Plan Description. Refer to the section entitled "Eligibility Provisions."

Dependent Limiting Age - Means the date on which the Dependent Child attains the age of 26.

Effective Date - Means the date on which Coverage begins.

Eligible Employee - Means an Employee of the Employer who satisfies the eligibility criteria set forth in this Summary Plan Description. Refer to the section entitled "Eligibility Provisions."

Eligible Expenses - Means expenses for Covered Services that are incurred by a Covered Person. Eligible Expenses do not include expenses in excess of the Reasonable and Allowable/Customary and Reasonable Charge.

Emergency Services - means, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee – Means an employee of Metromont, Inc.

Enrollment Date - Means the first day of Coverage, or if there is a waiting period, the first day of the waiting period. As used in this definition, the waiting period means the period that must pass before Coverage for an Employee or Dependent who is otherwise eligible to enroll under the Plan can become effective.

Essential Health Benefits - means, under section 1302(b) of the Patient Protection and 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 - the part of an expense for services, supplies and/or treatment of an Injury or Illness that is in excess of the Reasonable and Allowable Amount/Customary and Reasonable Charge.

Experimental or Investigative – Means a drug, device or medical treatment or procedure is Experimental or Investigative:

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

2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials or under study to determine its:

    a. Maximum tolerated dose, or

b. Toxicity, or
c. Safety, or
d. Efficacy, or
e. Efficacy as compared with the standard means of treatment or diagnosis, or

3. If reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:

   a. Maximum tolerated dose, or
   b. Toxicity, or
   c. Safety, or
   d. Efficacy, or
   e. Efficacy as compared with the standard ·means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative peer reviewed medical and scientific literature, or
2. The written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same drug, device or medical treatment or procedure, or
3. The written informed consent used by the treating Facility or by another Facility studying substantially the same drug, device or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the FDA but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug; provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
4. In the treatment of cancer, the National Comprehensive Cancer Network's Drugs and Biologics Compendium or Thomson Micromedex DRUGDEX.

Facility - Means a Facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, Rehabilitation Hospital, community mental health center, dialysis center, residential treatment Facility, psychiatric treatment Facility, Substance Abuse Treatment Center, Birthing Center, Home Health Care Center, or any other such Facility that the Plan approves.

Family Coverage - Means Coverage for the Covered Employee and one or more Dependents.

Family or Medical Leave of Absence - Means an unpaid leave of absence to care for a newborn, newly adopted Dependent Child, a sick Dependent Child, spouse or parent, or an unpaid leave of absence due to a serious health condition pursuant to the Family and Medical Leave Act.

Genetic Testing – means medical tests used to identify changes in chromosomes, genes or proteins.

GINA - means 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.

The term "genetic information" means, with respect to any individual, information about:

- Such individual's genetic tests;
- The genetic tests of family members of such individual; and
- The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Therefore, this Plan will not discriminate in any manner with its participants on the basis of such genetic information.

Health Breach Notice Rule – Means 16 CFR Part 318.

Home Health Care - Means the continual care and treatment of an individual if:

- The institutionalization of the individual would otherwise have been required if home health care was not provided;
- The treatment plan covering the home health care service is established and approved in writing by the attending Physician; and
- The home health care is the result of an Illness or Injury.

Home Health Care Agency - Means an agency or organization which provides a program of Home Health Care and which:

- Is approved as a Home Health Agency under Medicare;
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
- Meets all of the following requirements:
    - 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;
    - It has a full time administrator;
    - It maintains written records of services provided to the patient;
    - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
    - Its employees are bonded and it provides malpractice insurance.

Hospice Provider - Means a Facility that provides medical, social, psychological and spiritual care as palliative treatment for terminally ill patients in the home and/or as an Inpatient using an interdisciplinary team of professionals. A Hospice Provider must be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by Medicare.

Hospital – Means a Facility that meets all of the following requirements:

- It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
- It is under the supervision of a staff of Physicians;
- It provides 24 hour a day nursing service by registered nurses;
- It is duly licensed as a hospital, except that this requirement will not apply in the case of a State tax-supported Facility;
- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or

training-type Facility, or a Facility which is supported in whole or in part by a Federal government fund; and

- It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Facility is accredited as such a Facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center."
Facility

Hours of Service - means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

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

Illness - Means any physical disease or mental illness. Pregnancy, premature birth, congenital anomalies and birth anomalies are considered to be Illnesses.

Initial Measurement Period - For "Initial Measurement Period" please refer to the Plan's Eligibility Appendix.

Individual Coverage - Means Coverage for the Covered Employee only.

Injury - Means an accidental bodily injury caused by external and violent means. Injury to the teeth as a result of biting and chewing is not considered an accidental bodily Injury.

Inpatient - Means a Covered Person who is admitted to a Hospital or Other Medical Facility as a registered Inpatient and who remains in the Hospital or Other Medical Facility for 24 or more hours.

Laboratory - Means a Facility which is maintained to perform diagnostic tests and which is approved for Medicare reimbursement.

Loss of Eligibility – As it relates to the HIPAA Special Enrollment Period described herein, Loss of Eligibility includes, but is not limited to the following types of losses:

1. Loss of Eligibility under the other coverage due to divorce, dissolution, legal separation. In this instance, the Eligible Employee and any Dependent Children would be eligible to enroll;
2. Loss of Eligibility under the other coverage due to cessation of dependency status. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll;
3. Loss of Eligibility under the other coverage due to death of the Employee. In this instance, the Eligible Employee (whose Spouse has died) and any Dependent Children would be eligible to enroll;
4. Loss of Eligibility under the other coverage due to termination of employment or reduction of hours. In

this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll;
5. Loss of Eligibility under the other coverage because the individual no longer resides in the service area. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll;
6. Loss of Eligibility under the other coverage because the overall Maximum Benefit has been reached. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll; and
7. Loss of Eligibility under the other coverage because the other employer ceases to provide health care benefits to similarly situated individuals. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll.

Maximum Benefit – Means the maximum amount the Plan will pay for a given benefit. The Maximum Benefit can be stated as a dollar amount or the maximum number of days or visits for a specific benefit. In addition, Coverage is subject to a lifetime Maximum Benefit for all Covered Services combined. This is referred to as the Lifetime Maximum Benefit. The Lifetime Maximum Benefits applies to the Medical Benefits only. Refer to the Schedule of Benefits for Maximum Benefit amounts.

Medical Benefits Means the medical Covered Services described in the section entitled "Medical Benefits" and the payment made by the Plan for such services as set forth in this Summary Plan Description.

Medically Necessary (or Medical Necessity): Groups A & C
Means the criteria used to determine the Medical Necessity of Covered Services under this Summary Plan Description. To be Medically Necessary, Covered Services must:

1. Be rendered in connection with an Injury or Illness or condition;
2. Be consistent with the diagnosis and treatment of the Covered Person's condition;
3. Be in accordance with the standards of good medical practice;
4. Not be considered Experimental or Investigative; and
5. Not be for the Covered Person's convenience or the convenience of the Covered Person's Physician.

To be Medically Necessary, Covered Services must also be provided at the most appropriate level of care or in the most appropriate type of health care Facility. Only the Covered Person's medical condition (not the financial status or family situation, the distance from a Facility or any other non-medical factor) is considered in determining which level of care or type of health care Facility is appropriate.

In order for Covered Services to be paid, the services must be Medically Necessary. Any service failing to meet the Medical Necessity criteria may be the Covered Employee's liability.

Medically Necessary / Medical Necessity: Group B (Winchester, VA Location)
"Medically Necessary" or "Medical Necessity" means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by the Plan or its designee, within its sole discretion:

- In accordance with Generally Accepted Standards of Medical Practice; and
- Clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the Participant's Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for the Participant's convenience or that of his or her doctor or other health care Provider; and
- Is the most appropriate, most cost-efficient level of service(s), supply, or Drug that can be safely provided to the Participant and that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Participant's Illness, Injury, disease, or symptoms.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Plan reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within the Plan's sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Participants by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare - Means the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Negotiated Rate – Means the rate established by the contract in effect between the PPO Network and the Preferred Provider. Under this contract, the Preferred Provider has agreed to accept a reduced rate ("Negotiated Rate") as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate.

Network - Refers to Covered Services rendered by a Preferred Provider.

New Employee Stability Period - Means the 12 Calendar Month period that begins on the first day of the Calendar Month following the Calendar Month that begins on or after the Employee's anniversary date.

Non-Network - Refers to Covered Services rendered by a Non-Preferred Provider.

Non-Preferred Provider - Means a Provider who is not participating in the PPO Network that appears on the Covered Person's identification card.

Ongoing Employee - Shall have the same meaning as Ongoing Employee set forth in the Summary Plan Description.

Ongoing Employee Stability Period - Means the 12 Calendar Month period that begins on the first day of each Plan Year following the end of the Plan's Standard Measurement Period.

Ophthalmologist - Means a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.) legally qualified to practice medicine, including diagnosis, treatment and prescribing of medications and lenses related to conditions of the eye.

Other Benefit Plan - Refers to COB and means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or Employee benefit organization plans; or any tax supported or governmental program.

Out-of-Pocket Limit - Means the limit on the Covered Person's out-of-pocket requirement in a Benefit Period and acts as a cap or limit on the Medical Deductible and Coinsurance under the Medical Benefits. Once the Covered Person reaches the Out-of-Pocket Limit, 100% of Eligible Expenses will be paid for the remainder of the Benefit Period or until (s)he reaches the Maximum Benefits as described in this Summary Plan Description, whichever occurs first. Only the Medical Deductible and Coinsurance expense is used to meet the Out-of-Pocket Limit.

An Individual Out-of-Pocket Limit is the maximum amount each Covered Person is required to pay in Medical Deductible and Coinsurance expense in a Benefit Period. A Family Out-of-Pocket Limit is the limit that applies to all family members combined.

Outpatient - Means a Covered Person who receives medical care or treatment when he or she is not an Inpatient.

Partial Hospitalization - Means a psychiatric and/or substance abuse program that is accredited by the Joint Commission of Accreditation of Health Care Organizations or in compliance with equivalent standards for patients who require skilled level of care in a Hospital or Other Medical Facility but who do not need treatment for an acute or life threatening condition. A Partial Hospitalization is provided in a treatment setting that is less than a 24-hour residential setting.

Pharmacy - Means a Facility that is a licensed establishment where prescription drugs are dispensed by a pharmacist under applicable state laws.

Physician - Means one of these professionals licensed under the applicable state laws:

1. Doctor of Medicine (M.D.)
2. Doctor of Osteopathy (D.O.)
3. Podiatrist (D.P.M.) or Surgical Chiropodist (D.S.C.)
4. Dental Surgeon or Dentist (D.D.S.)
5. Chiropractor (D.C.)
6. Doctor of Optometry (O.D.)
7. Psychiatrist
8. Psychologist
9. Ophthalmologist

Plan Document - Means the governing document for the Health Plan, as required under ERISA, that has been adopted and sponsored by the Plan Sponsor. The Summary Plan Description is considered the Plan Document.

PPO Network – Means the network of Preferred Providers to which the Covered Persons will have access under this Plan.

Preferred Provider - Means a Provider who is a member of the PPO Network that appears on the Covered Person's identification card.

Prescription Drug Benefits - Means the Covered Services for prescription drugs obtained from a Pharmacy and/or Mail Order Drug Company as described in the section entitled "Prescription Drug Benefits" and the payment made by the Plan for such services as set forth in this Summary Plan Description.

Primary Care Physician ("PCP") – Means a Physician in Family Medicine, General Medicine, Internal Medicine, Pediatrics, and Gynecology.

Protected Health Information - Means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Personal health information includes information of persons living or deceased.

The following components of a member's information also are considered personal health information:

a. Names;
b. Street address, city, county, precinct, zip code;
c. Dates directly related to a member, including birth date, health Facility admission and discharge date, and date of death;
d. Telephone numbers, fax numbers, and electronic mail addresses;
e. Social Security numbers;
f. Medical record numbers;
g. Health plan beneficiary numbers;
h. Account numbers;
i. Certificate/license numbers;
j. Vehicle identifiers and serial numbers, including license plate numbers;
k. Device identifiers and serial numbers;
l. Web Universal Resource Locators (URLs);
m. Biometric identifiers, including finger and voice prints;
n. Full face photographic images and any comparable images; and
o. Any other unique identifying number, characteristic, or code.

Protected Health Information includes Electronic Protected Health Information as defined at 45 C.F.R. §160.103 that is received from, or created or received on behalf of the Plan.

Provider - Means a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or approved by the Plan Administrator.

Qualified Medical Dependent Child Support Order (QMCSO) – Means a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan. An Eligible Employee may obtain a copy of such procedures from the Plan Sponsor.

Qualifying Part-time Employee - Shall have the same meaning as Qualifying Part-time Employee set forth in the Summary Plan Description.

Reasonable and Allowable Charge: Group C Only (Locations other than SC Locations and Winchester, VA Location)

"Reasonable and Allowable Charge" means the maximum amount payable by the Plan for a service, supply and/or treatment that is considered a Covered Service. The Reasonable and Allowable Charge is the lesser of: 1) the charge made by the Provider that furnished the care, service, or supply; 2) the negotiated amount established by a discounting or negotiated arrangement; 3) the reasonable and customary charge for the same treatment, service, or supply furnished in the same geographic area by a Provider of like service of similar training and experienced as further described below; or 4) an amount equivalent to the following:

1. For Inpatient or Outpatient Facility claims, an amount equivalent to 140% of the Medicare

equivalent allowable amount;
2. For specialty drugs, the lesser of the average wholesale price (AWP) minus 18% or the amount set by the Plan's prescription drug service vendor.

The term 'reasonable and customary charge' shall mean an amount equivalent to the lesser of a commercially available database or such other cost or quality-based reimbursement methodologies as may be available and utilized by the Plan from time to time.

If there is insufficient information submitted for a given procedure, the Plan will determine the Provider's Reasonable and Allowed Charge based upon charges made for similar services. Determination of the reasonable and customary charge will take into consideration the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that Provider.

The term 'geographic area' shall be defined as a metropolitan area, county, zip code, state or such greater area as is necessary to obtain a representative cross-section of Providers, persons, or organizations rendering such treatment, service or supply for which a specific charge is made. For Covered Services rendered by a Physician, Hospital or Ancillary Provider in a geographic area where applicable law may dictate the maximum amount that can be billed by the rendering Provider, the Reasonable and Allowed Charge shall mean the lesser of amount established by applicable law for that Covered Service or the amount determined as set forth above.

The Plan Administrator or its designee has the *ultimate discretionary authority* to determine the Reasonable and Allowable Charge, including establishing the negotiated terms of a Provider arrangement as the Reasonable and Allowable Charge even if such negotiated terms do not satisfy the lesser of test described above.

Regular Full-time Employee - Means a common law employee who is regularly scheduled to work thirty (30) Hours of Service or more per week.

Rehabilitation Facility – Means a Facility that is primarily engaged in the Inpatient treatment and rehabilitation of the Covered Person as the result of an acute Illness or Injury, not including the rehabilitation of a condition resulting from substance abuse. The Facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Health.

Routine Patient Costs – means all items and services that the Plan would otherwise cover if the Participant were not enrolled in a clinical trial.

Schedule of Benefits - Means a separate schedule showing vital information with respect to the Coverage under this Plan.

Seasonal Employee - Means an Employee hired by the Employer into a position that is typically no longer in duration than six (6) months and begins at the same time of the year each year.

Significant Break - Means a period of 63 consecutive days during each of which the individual does not have Creditable Coverage**.**

Skilled Nursing Facility - Means a Facility that mainly provides Inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal custodial care, ambulatory or part time care or that provides treatment for mental illness, alcoholism, drug abuse or tuberculosis. The Skilled Nursing Facility must be certified by the Medicare program.

Special Enrollment Period – Means a period following the Eligible Employee's initial eligibility under the

Plan during which the Employee and Eligible Dependents may enroll for Coverage following the loss of other coverage, marriage, birth or adoption of a child as set forth herein.

Specialized Hospital - Means a Facility that is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must also be provided under the supervision of a registered nurse.

"Specialty Injectable"
"Specialty Injectable" means a prescription drug used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Spouse – Means an individual of the opposite or same sex who is legally married to the Eligible Employee in accordance with the laws of the state in which the marriage was performed. For purposes of this Plan, "married" shall not include common law marriage.

Standard Measurement Period - For "Standard Measurement Period" please refer to the Plan's Eligibility Appendix.

Summary Health Information - Means information, that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

Summary Plan Description – Means the document that is provided by the Plan Administrator and that describes, in understandable terms, the Covered Person's rights, benefits and responsibilities under the Health Plan. This document serves as the Summary Plan Description for the Health Plan administered by the Plan Administer and sponsored by the Plan Sponsor.

HIPAA PRIVACY AND SECURITY STATEMENT AND OTHER IMPORTANT NOTICES

HIPAA PRIVACY STATEMENT

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Covered Person' s privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

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. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. 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;

7. 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;

8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

9. 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);

10. 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);

11. 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);

12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

14. 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

15. 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:

        (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

    (b) In the event any of the individuals described in 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. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. 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.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

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 un-enrolled 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 may hereby authorize and direct the Plan, through the Plan Administrator or the third party 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.

Other Disclosures and Uses of PHI:

Permissible Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.

3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Other Permissible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

(a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse, neglect or domestic violence;
(b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
(c) locate and notify persons of recalls of products they may be using; and
(d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Personthat such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Personof the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The Plan may also disclose, as authorized by law, PHI to organizations that handle organ, eye, or tissue donation and transplantation.

8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. Inmates: The Plan may disclose PHI when to the correctional institution or law enforcement official for: the institution to provide health care to the Covered Person; the Covered Person's health and safety and the health and safety of others; or the safety and security of the correctional institution.

12. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

13. Emergency Situations: The Plan may disclose PHI in an emergency situation, or if the Covered Personis incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. The Plan will use professional judgment and experience to determine if the disclosure is in the Covered Person's best interest. If the disclosure is in the Covered Person's best interest, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the Covered Person's care.

14. Fundraising Activities: The Plan may disclose PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does not contact the Covered Person for fundraising activities, the Plan will give the Covered Person the opportunity to opt-out, or stop, receiving such communications in the future.

15. Group Health Plan Disclosures: The Plan may disclose PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Covered Person. The Plan can disclose PHI to that entity if that entity has contracted with the Plan to administer the Covered Person's health care program on its behalf.

16. Underwriting Purposes: The Plan may disclose PHI for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does not disclose the Covered Person's PHI for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI that is genetic information.

Uses and Disclosures of PHI that Require Authorization

1. Sale of PHI: The Plan will request written authorization before it makes any disclosure that is deemed a sale of PHI, meaning the Plan is receiving compensation for disclosing the PHI in that manner.

2. Marketing: The Plan will request written authorization to use or disclose PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Covered Person or when the Plan provides promotional gifts of nominal value.

3. Psychotherapy Notes: The Plan will request written authorization to use or disclose any of the Covered Person's psychotherapy notes that may be on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described above will be made only with written authorization. If the Covered Person provides the Plan with such authorization, it may be revoked in writing and the revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that the Plan already used or disclosed, relying on the authorization.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Covered Person.

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

3. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.

4. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Rights to Individuals

The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.

3. Copy of this Notice: The Covered Person is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.

6. Amendment: The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Metromont Corporation
20 Two Notch Road
Greenville, SC 29605
864-605-5006

NOTICE CONCERNING WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 ("WHCRA")

Group health plans and issuers are required to provide Coverage for the following services in connection with a mastectomy that has been performed and that is covered under the Plan:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan is required to notify the Covered Person of his or her WHCRA rights each year.

NOTICE CONCERNING RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and issuers generally may not 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 delivery by cesarean section. However, the group health plan or issuer may pay for a shorter stay if the attending Provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or issuer may not, under federal law, require a Physician or other health care Provider to obtain authorization for prescribing a length of stay of up to 48 or 96-hours.