DOCS MARINA GRILL

EMPLOYEE BENEFIT PLAN

FULL PPO NETWORK

PRECIS STANDARD MEC PLAN DOCUMENT

Plan Name: MEC STANDARD PLAN

Effective Date: March 1, 2017

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**Schedule of Benefits Attached Separately*

INTRODUCTION

As a covered employee of the company, we are pleased to provide you with this Plan Document for Docs Marina Grill Minimum Essential Coverage (MEC) Preventive Benefit Plan.

We encourage you to read your Plan Document carefully and become familiar with its content.

The plan benefits described in this booklet have been designed to provide you and your covered dependents with MEC Preventive Service Coverage as required by the Patient Protection and Affordable Care Act (PPACA). **This is not considered a comprehensive major medical benefit plan.**

Your benefit plan has been outlined in the Schedule of Benefits section attached to this Plan Document (see Schedule of Benefits –file attached). This schedule is a helpful, quick reference guide to the benefits available under your Plan. A more detailed description is provided in the pages that follow.

Hawaii Mainland Administrators, LLC is your Claims Administrator appointed by your Employer to answer any questions about your Plan and assist you in any way possible.

Hawaii Mainland Administrators, LLC
P.O. Box 22009
Tempe, Arizona 85285
(866) 826-5317

PURPOSE AND EFFECTIVE DATE

The purpose of the Plan Document and Schedule of Benefits is to set forth the provisions of the benefits plan (the "Plan") which provide for the payment of all or a portion of Covered Benefits the Plan Administrator agrees to pay, subject to all the provisions of the Plan, including amendments, on behalf of the Member entitled to such benefits while covered under this Plan, provided claim is duly made.

The Plan Document and Schedule of Benefits supersede all other documents and previously issued amendments and shall be the sole document used in determining benefits to which Members are eligible. The Plan may be amended from time to time by the Plan Administrator to reflect changes in benefits or eligibility requirements. Any amendments shall be binding on each Member covered and on any other individual or individuals referred to in this Plan Document. This Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation.

The Plan Administrator intends to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan in whole or in part, at any time.

PAYABLE AMOUNTS

This Plan offers a network provider option. The chosen Participating Provider Organization is comprised of a group of physicians and other health care providers from whom Members may obtain some of the covered medical services described within this document.

When you obtain Covered Benefits from a Participating Provider, this Plan offers the following advantages:

- You usually pay less money out of your pocket for health care services;
- You may change your provider at any time, because you are not required to designate a primary care physician;
- The Participating Provider will file claims directly to the Claims Administrator or the network, so you do not have to wait for reimbursement; and

In-network Providers service charges are payable based on a negotiated rate when applicable. Out-of-network Providers care service charges are payable strictly based upon Reasonable and Allowed.

The Plan's maximum payment will be limited to the Plan's Maximum Allowable Amount, as defined within this document.

All benefits payable under this Plan are also subject to the limits on specific benefits referenced within the Schedule of Benefits.

PLAN NOT A CONTRACT OF EMPLOYMENT

This Plan does not constitute a contract of employment or give any Member the right to be retained in the service of the Plan Administrator or to interfere with the right of the Plan Administrator to discharge or otherwise terminate the employment of any Member.

GENERAL INFORMATION

Name of Plan:	Docs Marina Grill Employee Benefit Plan
Plan Number:	501
Name, Address and Phone Number of Employer/Plan Sponsor:	Docs Marina Grill 403 Madison Ave S Bainbridge WA 98110 (206) 842-8339
Employer Identification Number:	54-2101227
Plan Identification:	MEC Standard Health Plan
Type of Plan:	Minimum Essential Coverage (MEC) Preventive Benefit Plan
Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent For Service of Legal Process:	Docs Marina Grill 403 Madison Ave S Bainbridge WA 98110 (206) 842-8339 Docs Marina Grill shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan Documents and make all interpretive and factual determinations as to whether any individuals is entitled to receive any benefit under the terms of this Plan. Any construction of terms of any Plan Documents and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.
Source of Plan Contributions:	Docs Marina Grill and employees covered by the Plan contribute to the cost of the Plan**.** Employee contributions are the employee's share of costs as determined by the employer.
Funding Method:	The employer pays Plan benefits and administration expenses directly from general assets. Contributions received from Members are used to cover Plan costs and are expended immediately. Plan contributions are made by the employer and covered employee. All benefits under the Plan are paid from general assets. Employee required contributions are the employee's share of costs as determined by the employer. From time to time the employer will determine the required employee contributions and will notify employee in writing. Payments of Plan benefits will be based on the provisions of the Plan.
Initial Effective Date:	March 1, 2017
Benefits Year:	March 1 through February 30
Plan Renewal Date:	March 1
Waiting Period:	First day of the month coincident with or following 60 days of continuous full-time employment.

Termination Date of Coverage:	The last day of the month in which employment terminated or for which required premium was paid.
Type of Administration of the Plan:	The self-funded Plan is administered directly by the Plan Administrator. The Plan Administrator has appointed a Claims Administrator to handle the day-to-day operation of the Plan. The Claims Administrator does not serve as an insurer, but only as a Claims Administrator. The Claims Administrator processes claims, then requests and receives funds from the Plan Administrator for the amount of the claims, and processes payment on the claims to hospitals and other providers.
Claims Administrator:	Hawaii Mainland Administrators, LLC (HMA) PO Box 22009 Tempe, AZ 85285-2009 (866) 826-5317
Right to Amend or Terminate the Plan:	The Plan Administrator reserves the right to amend or terminate this Plan at any time. You will be properly notified of any and all changes subject to the Plan's provisions.
Statement of ERISA rights:	The Plan Administrator holds the position that ERISA governs the Plan. The Employer is guided by ERISA provisions as applicable to its Plan. Accordingly, interpretations of the Plan, including words and phrases, shall be guided by ERISA as applicable to the Plan.

REQUIRED NOTICES

HIPAA PRIVACY STATEMENT-USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to a Member to whom health care is provided. These activities include, but are not limited to, the following:

- Quality assessment;
- Determination of eligibility, coverage and Coinsurance amounts (for example, cost of a benefit or Plan maximums as determined for a Member's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related data processing, including auditing payments, investigating and resolving payment disputes and responding to Member inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and
- Reimbursement to the Plan.

"Health Care Operations" include, but are not limited to, the following activities:

- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and creating, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to:
- management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
- Customer service, including the provision of data analysis for policyholders, plan sponsors or other customers;
- Resolution of internal grievances.

THE PLAN WILL USE AND DISCLOSE PHI TO THE PLAN ADMINISTRATOR AND AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE MEMBER

With an authorization, the Plan will disclose PHI to other health benefit plans, health insurance issuers or HMOs for purposes related to the administration of these plans.

The Plan will disclose PHI to the Plan Administrator only upon receipt of a certification from the Plan Administrator that the Plan Documents have been amended to incorporate the following provisions.

WITH RESPECT TO PHI, THE PLAN ADMINISTRATOR AGREES TO CERTAIN CONDITIONS

The Plan Administrator agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by a Member*;*
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Administrator unless authorized by the Member;
5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to a Member in accordance with HIPAA's access requirements*;*
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purpose of determining the Plan's compliance with HIPAA; and
10. If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

SEPARATION BETWEEN PLAN ADMINISTRATOR AND PLAN

The following employees or classes of employees under the control of the Plan Administrator may be given access to PHI by the Plan or a business associate servicing the Plan:

1. Board of Directors
2. Administration
3. Human Resource/Financial Administration Support

The employees who are included in this description will have access to PHI only to perform the administration functions that the Plan Administrator provides to the Plan. Employees who violate this provision will be subject to sanction. The Plan Administrator will promptly report any violation of this provision to the Plan and will cooperate with the Plan to remedy or mitigate the effect of such violation.

GENETIC INFORMATION NONDISCRIMINATION ACT

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information. GINA expands on the provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which protect against discrimination based on genetic information. HIPAA prevents a plan or issuer from imposing a pre-existing condition exclusion based solely on genetic information, and prohibits discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information).

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (Affordable Care Act) adds many protections related to employment-based group health plans for you and your family. These include extending dependent coverage up to

age 26; prohibiting preexisting condition exclusions for children under age 19 and for all individuals beginning in 2014; and requiring easy-to-understand summaries of a health plan's benefits and coverage.

Additional protections that may apply to your plan include the requirement to provide coverage for certain preventive services (such as blood pressure, diabetes and cholesterol tests, regular well-baby and well-child visits, routine vaccinations and many cancer screenings) without cost-sharing, and coverage of emergency services in an emergency department of a hospital outside your plan's network without prior approval from your health plan.

NON-DISCRIMINATION NOTICE

This Plan, including benefits and policies, does not discriminate on the basis of race, color, national origin, sex, age or disability. It complies with applicable federal civil rights laws. Plan participants needing translation assistance should contact HMA at toll free (866) 826-5317. If you feel you were discriminated in any way, you can file a grievance with your Human Resources Department at the employer contact information in the general information section, or you can contact HMA by phone at toll free (866) 826-5317or in writing to Grievance Department, 1600 West Broadway Road, Suite 300, Tempe, Arizona 85282. Or you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by phone at toll free 800-368-1019, TDD users, call toll free 800-537-7697 or by mail at U.S. Department of Health and Human Services, 200 Independence Ave. SW., Room 509F, HHH Building, Washington, DC 20201.

ERISA RIGHTS STATEMENT

As a Member in Docs Marina Grill Employee Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Members shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Securities Administration. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Plan Document and Summary of Benefits. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report.

The Plan Administrator is required by law to furnish each main subscriber with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Schedule of Benefits and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan Members, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Members and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all

within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

For all covered and approved services, Members have the choice of using either a Participating Provider or a Non-Participating Provider. The Schedule of Benefits indicates covered services and what the benefit differential is between the use of Participating and Non-Participating Providers.

PARTICIPATING PROVIDERS

A Participating Provider is a provider which has an agreement in effect with the Participating Provider Organization (PPO) to accept a reduced rate for services rendered to Members. This is known as the negotiated rate. The Participating Provider cannot bill the Member for any amount in excess of the negotiated rate. Members may go to any provider of service. The Plan will determine if the provider is a Participating Provider and pay benefits at the negotiated rate. The Member is responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the negotiated rate for Participating Providers.

Advantages of using a Participating Provider:

1. The Member is not billed for charges that exceed the negotiated rate.
2. The Member saves money on health care costs because (a) of the reduced rate (negotiated rate) and (b) the Plan is able to provide greater benefits for the services of Participating Provider

How to use the Participating Provider

1. When the Member needs to see a physician or other health care provider, refer to the customer service and website information located on the back of the Members identification card. The Member should contact the provider to verify the provider is still a member of the Participating Provider Organization. If the provider is still a member, the appointment can be scheduled.
2. Upon arrival for the scheduled appointment, the Member should show the Participating Provider the identification card. The Participating Provider's billing office will submit the claim on behalf of the Member to the Claims Administrator.
3. If additional services from other providers are required, such as diagnostic x-ray and laboratory, the Member should ask the Participating Provider to ensure other such provider is also a Participating Provider.

NON-PARTICIPATING PROVIDERS

A Non-Participating Provider does not have an agreement in effect with the Participating Provider Organization.

This Plan will allow only the Reasonable and Allowed amount as a Covered Benefit. The Plan will reimburse the Reasonable and Allowed amount based on Maximum Payable Amount for the Non-Participating Provider services, supplies and treatment. The Member is responsible for the remaining balance. This results in greater Out-of-Pocket expenses to the Member. For Non-Participating Providers, the Member is responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the billed amount.

Non-Participating Providers are reimbursed based on a "Reasonable and Allowed" reimbursement model for the services they render. "Reasonable and Allowed" reimbursement amount is based on Medicare and other published costs and pricing data applying either an additional amount on top of the Medicare amount or an additional amount on top of the facility costs (Medicare-plus or Cost-plus). "Reasonable and Allowed" establishes the prevailing prices for medical services using objective and normative data such as Medicare Rates, cost data, average reimbursements/payments, Medicare Provider Reimbursement Manual et al, and other public and private data sources. The reference price takes into account prevailing area charges and other objective data to evaluate the reasonableness of the charges and validates the Medicare Allowable Prices specific to the services rendered.

Except as specifically stated otherwise, no benefits will be payable for Excess Charges (charges in excess of the Reasonable and Allowed charges for services or supplies provided). It is the Plan's position that the Provider should not balance-bill the Plan Participant for amounts in excess of the Reasonable and Allowable Amount. It is the Plan's position that these Excess Charges are clearly excessive and exorbitant. However, balance-billing for such amounts can occur and the Plan has no control over the actions of the Providers or their desire to you for such amounts.

MEDICAL EXPENSE BENEFITS

This section describes the Covered Benefits of the Plan. All Covered Benefits are subject to applicable Plan provisions including, but not limited to, any applicable Deductible, Copayment or Coinsurance, as outlined within the Schedule of Benefits. All expenses incurred by the Member for services, supplies or treatment provided will not be considered Covered Benefits by this Plan if they are greater than the Maximum Payable Amount, as applicable. The Covered Benefits for services, supplies or treatment provided must be recommended by a physician or professional provider and be medically necessary care and treatment for the illness or injury suffered by the Member. Specified preventive care expenses will be covered by this Plan.

COPAYMENT

The Copayment is the amount payable by the Member for certain services, supplies or treatment. The service and applicable Copayment are shown on the Schedule of Benefits. The Member selects a provider and pays the provider the Copayment. The Plan pays the remaining Covered Benefits at the negotiated rate or Reasonable and Allowed amount. The Copayment must be paid each time a treatment or service is rendered. The Copayment will be applied toward the maximum Out-of-Pocket expense.

COINSURANCE

The Plan pays a specified percentage of Covered Benefits at the Reasonable and Allowed amount for Non-Participating Providers, or the percentage of the negotiated rate for Participating Providers. The percentage specified in the Schedule of Benefits is the percentage the Member is responsible for of the Reasonable and Allowed amount.

BENEFIT YEAR DEDUCTIBLE

Individual Benefit Year Deductible

The Deductible applies to all specific eligible charges during a benefit year for each Member, as indicated in the Schedule of Benefits.

Family Benefit Year Deductible

Once the family has satisfied the maximum family Deductible, no further Deductible applies to any member of the family during the remaining benefit year. However, even if the employee and dependents are covered under the family coverage rules, no one individual is required to pay more than the individual benefit year Deductible.

BENEFIT YEAR OUT-OF-POCKET EXPENSE LIMIT

Individual Benefit Year Out-of-Pocket Expense Limit

After the Member has incurred an amount equal to the Out-of-Pocket expense limit listed on the Schedule of Benefits for Covered Benefits (after satisfaction of any applicable Deductibles), the Plan will begin to pay one hundred percent (100%) for Covered Benefits for the remainder of the benefit year.

Family Benefit Year Out-of-Pocket Expense Limit

After all family members have incurred a combined amount equal to the family Out-of-Pocket expense limit listed on the Schedule of Benefits; the Plan will pay one hundred percent (100%) of Covered Benefits for all covered family members for the remainder of the benefit year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the benefit year Out-of-Pocket expense limit:

1. Expenses for services, supplies and treatments not covered by this Plan.
2. Charges in excess of the Maximum Payable Amount.
3. Penalties assessed for non-compliance with the precertification process.

COVERED MEDICAL EXPENSES

Some covered services require pre-certification as referenced in Utilization Review. Refer to the Schedule of Benefits for the services that require pre-certification.

PREVENTIVE CARE SERVICES

The Plan shall provide coverage for evidence-based items or services, such as:

1. 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);
2. Immunizations currently recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention;
3. Infants, children, and adolescents: Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
4. Women: Additional preventive care and screenings not described above in number one (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
5. Current recommendations of the United States Preventive Service Task Force (USPSTF) regarding breast cancer screening, mammography, and prevention.

For the most current list of U.S. Preventative Services Task Force A & B recommendations that are relevant to the Affordable Care Act, please see: https://www.uspreventiveservicestaskforce.org **or** https://www.healthcare.gov/coverage/preventivecare-benefits/ for more details.

Covered Preventative Service for:	
Adults	▪ **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked ▪ **Alcohol Misuse** screening and counseling ▪ **Aspirin** use for men and women of certain ages (covered under prescription drug plan) ▪ **Blood Pressure** screening for all adults ▪ **Cholesterol** screening for adults of certain ages or at higher risk ▪ **Colorectal Cancer** screening for adults over 50 ▪ **Depression** screening for adults ▪ **Type 2 Diabetes** screening for adults with high blood pressure ▪ **Diet** counseling for adults at higher risk for chronic disease ▪ **HIV** screening for all adults at higher risk ▪ **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary: • Hepatitis A • Hepatitis B • Herpes Zoster • Human Papillomavirus • Influenza (Flu Shot) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Tetanus, Diphtheria, Pertussis • Varicella ▪ **Obesity** screening and counseling for all adults ▪ **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk ▪ **Tobacco Use** screening for all adults and cessation interventions for tobacco users ▪ **Syphilis** screening for all adults at higher risk
Women, Including Pregnant Women	• **Anemia** screening on a routine basis for pregnant women • **Bacteriuria** urinary tract or other infection screening for pregnant women • **BRCA** counseling about genetic testing for women at higher risk • **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40

Covered Preventative Service for:	
	• **Breast Cancer Chemoprevention** counseling for women at higher risk • **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women • **Cervical Cancer** screening for sexually active women • **Chlamydia Infection** screening for younger women and other women at higher risk • **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs • **Domestic and interpersonal violence** screening and counseling for all women • **Folic Acid** supplements for women who may become pregnant (covered under prescription drug plan) • **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes • **Gonorrhea** screening for all women at higher risk • **Hepatitis B** screening for pregnant women at their first prenatal visit • **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women • **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older • **Osteoporosis** screening for women over age 60 depending on risk factors • **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk • **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users • **Sexually Transmitted Infections (STI)** counseling for sexually active women • **Syphilis** screening for all pregnant women or other women at increased risk • **Well-woman visits** to obtain recommended preventive services for women under 65
Children	▪ **Alcohol and Drug Use** assessments for adolescents ▪ **Autism** screening for children at 18 and 24 months ▪ **Behavioral** assessments for children of all ages ▪ **Blood Pressure** screening for children ▪ **Cervical Dysplasia** screening for sexually active females ▪ **Congenital Hypothyroidism** screening for newborns ▪ **Depression** screening for adolescents ▪ **Developmental** screening for children under age 3, and surveillance throughout childhood ▪ **Dyslipidemia** screening for children at higher risk of lipid disorders ▪ **Fluoride Chemoprevention** supplements for children without fluoride in their water source (covered under prescription drug plan) ▪ **Gonorrhea** preventive medication for the eyes of all newborns ▪ **Hearing** screening for all newborns ▪ **Height, Weight and Body Mass Index** measurements for children ▪ **Hematocrit or Hemoglobin** screening for children ▪ **Hemoglobinopathies** or sickle cell screening for newborns ▪ **HIV** screening for adolescents at higher risk ▪ **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary: • Diphtheria, Tetanus, Pertussis

Covered Preventative Service for:	
	• Haemophilus influenzae type b • Hepatitis A • Hepatitis B • Human Papillomavirus • Inactivated Poliovirus • Influenza (Flu Shot) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Rotavirus • Varicella ▪ **Iron** supplements for children ages 6 to 12 months at risk for anemia (covered under prescription drug plan) ▪ **Lead** screening for children at risk of exposure ▪ **Medical History** for all children throughout development ▪ **Obesity** screening and counseling ▪ **Oral Health** risk assessment for young children ▪ **Phenylketonuria (PKU)** screening for this genetic disorder in newborns ▪ **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk ▪ **Tuberculin** testing for children at higher risk of tuberculosis ▪ **Vision** screening for all children

PLAN EXCLUSIONS

The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a physician or professional provider.

With respect to any services which are otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury or Illness if the Injury or Illness is the result of a documented medical condition or from the Member's being the victim of an act of domestic violence.

1. Charges for services, supplies or treatment from any hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
2. Charges for an injury sustained or illness contracted while on active duty in military service, unless payment is legally required.
3. Charges for services, supplies or treatment for treatment of illness or injury which is caused by or attributed to by war or any act of war (whether declared or undeclared, civil or international, or any substantial armed conflict between organized forces of a military nature), participation in a riot, civil disobedience or insurrection.
4. Charges in connection with any illness or injury arising out of or in the course of any employment intended for wage or profit, including self-employment.
5. Charges made for a service, supply and treatment which is not Medically Necessary for the treatment of illness or injury, or which are not recommended and approved by the attending physician, except as specifically stated herein.
6. Charges in connection with any illness or injury sustained while taking part or attempting to take part in an illegal act, including but not limited to misdemeanors and felonies; or for any Injury or Illness that arises from or is caused during the commission of any illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result for the Plan Administrator to determine that an act constitutes an illegal act. Proof beyond a reasonable doubt is not required to be deemed an illegal act. The Plan Administrator has the sole discretion to determine whether a particular act constitutes an Illegal Act.
7. Charges in connection with any activity made illegal due to the use of alcohol, controlled substances or chemicals, or charges in connection with any Injury or Illness sustained during, or as a result of, the use of alcohol. Expenses will be covered for Members other than the person partaking in the activity or a state of intoxication, and expenses may be covered for substance abuse treatment as specified elsewhere in this Plan, if applicable, and subject to all Plan limitations.
8. Any charge in connection with any Illness or Injury that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Plan Member's customary occupation or if it involves leisure time activities considered by the Plan Administrator, taking all circumstances into account, as involving unusual or exceptional risks, characterized by a threat of danger or risk of bodily harm. Hazardous pursuits, hobbies, or activities include, but are not limited to, reckless operation of machinery, travel to countries with advisory warnings, and use of weapons and explosives.
9. To the extent that payment under this Plan is prohibited by any law of the jurisdiction in which the Member resides at the time the expense is incurred.
10. Charges for services rendered and/or supplies received prior to the effective date or after the termination date of a Member's coverage.
11. Any services, supplies or treatment for which the Member is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
12. Charges for services, supplies or treatment that is considered Experimental/Investigational. The Plan Administrator has the sole discretion to make this determination.
13. Charges incurred outside the United States if the Member traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

14. Charges for services, supplies or treatment rendered by any individual who is a close relative, as determined by the Plan Administrator, of the Member or who resides in the same household as the Member.

15. Charges for services, supplies or treatment rendered by facilities, physicians or professional providers beyond the scope of their license; for any treatment, confinement or service which is not recommended by or performed by an appropriate professional provider.

16. Charges for illnesses or injuries sustained by a Member due to the action or inaction of any party if the Member fails to provide any information as specified in Subrogation section or as requested by the Plan in connection with any third-party recovery.

17. Claims not submitted within the Plan's filing limit deadlines as specified in Claim Filing Procedures.

18. Charges for e-mail or telephone consultations, completion of claim forms, charges associated with missed appointments.

19. Benefits which are payable under any one section of this Plan shall not be payable as a benefit under any other section of this Plan. For example, if a benefit is eligible under both the Medical Expense Benefits section and the Prescription Drug Program section, and is paid under the Medical Expense Benefit, the remaining balance will not be paid under the Prescription Drug Program Benefit.

20. Charges for treatment of any intentionally self-inflicted illness or injury, including suicide or attempted suicide.

21. Excess Charges - Except as specifically stated otherwise, no benefits will be payable for charges in excess of the Reasonable and Allowed charges for services or supplies provided.

22. Charges incurred for which the Plan has no legal obligation to pay.

23. Court ordered treatment or services - charges for services, treatment or care of any kind that are provided due to a court order, or are required by a court of law and/or are imposed as an alternative to, or in addition to, fine or imprisonment. This exclusion shall not apply to expenses for the illness or injury that would be covered under the Plan in the absence of a court order, and for which the Member is legally obligated to pay.

24. Private duty or shift care services of a health care provider

25. Examinations - charges for examinations, testing, vaccinations or other services related to employment, licensing, insurance, adoption, marriage license, sports, or camp applications, or travel outside the United States.

26. Taxes, Excise and Sales - You are not covered for tax of any kind imposed on medical services or Prescription Drug(s).

27. Administrative or Adjunctive Charges - charges for administrative fees; completion, filing or copying of claim forms, itemized bills or medical reports; reports or appearances in legal proceedings, mailing, postage, or shipping and handling; missed appointments; late fees; sales tax; interest or penalties; travel time or expenses; or telephone consultations.

28. Charges for the release and review of medical records.

29. Duplicate Item - You are not covered for duplicate durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that is intended to be used as a backup device, for multiple residences, or for traveling, e.g., a second wheeled mobility device specifically for work or school use or a backup manual wheelchair when a power wheelchair is the primary means of mobility. Note: ventilators at home are not included in this exemption).

30. A dependent child of a covered dependent child shall not be covered by this plan.

31. Charges not included as eligible charges in the Schedule of Benefits or explicitly outlined in the Covered Medical Expenses section.

32. Charges based on billing mistakes, improprieties, or illegitimate billing entries, including but not limited to up-coding, duplicate charges, charges for care, supplies, treatment and/or services not actually rendered or performed or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard; it is in the Plan Administrator’s sole discretion to determine what constitutes an Error under the terms of this Plan.

33. Charges (a) that are found to be based on Errors (as defined in this Plan Document); unbundling, misidentification, or unclear description; (b) charges for fees or services determined not to be Medically Necessary or Reasonable; (c) charges found by the Plan Administrator to be in excess of the Maximum Allowable Charge or the Reasonable and Allowed Amount; or (d) charges that are otherwise determined by the Plan Administrator to be invalid or impermissible based on any applicable law, regulation rule for professional standard.

34. Charges for an item billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT (Current Procedural Terminology), the Healthcare Common Procedure Coding System (HCPCS) code used by CMS, or any industry standard guidelines in effect at the time services were rendered.

PRESCRIPTION DRUG PROGRAM

PREVENTATIVE PRECRIPTION SERVICES

Mandatory Generic Only - Preventive Prescription Services as defined by PPACA.

Generic equivalent drugs have been put through a rigorous, multi-step approval process from quality and performance to manufacturing and labeling by the FDA.

Per the PPACA, certain medications and prescription drugs that prevent illness and disease are covered at no-cost. In order for these medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs.

Dispense As Written (DAW) Penalty

If you or your doctor requests a brand-name medicine when a generic alternative is available, your prescription cost will be higher. The Dispense As Written (DAW) Penalty is the amount you pay for a brand name drug when a generic drug is available. In these instances, you will pay the difference between the brand name drug and the generic drug.

ELIGIBILITY

This section identifies the Plan's requirements for a person to be eligible to enroll. Refer to Enrollment and Effective Date of Coverage for more information.

EMPLOYEE ELIGIBILITY

All employees regularly scheduled to work at least 30 hours per work week shall be eligible to enroll for coverage under this Plan. This does not include temporary or seasonal employees.

DEPENDENT ELIGIBILITY

The following describes dependent eligibility requirements. The employer will require proof of dependent status.

1. Spouse:

The term "spouse" means the spouse of the employee under a legally valid existing marriage, unless court ordered separation exists; or

2. Domestic Partner:

The term "Domestic Partner" means a person of the same sex with whom the employee has established a Domestic Partnership.

Domestic Partnership is a relationship between an Employee and one other person of the opposite or same sex. All of the following requirements apply to both persons:

a. They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
b. They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
c. They must share the same permanent residence and the common necessities of life.
d. They must be at least 18 years of age.
e. They must be mentally competent to consent to contract.
f. They must be financially interdependent and they have furnished documents to support at least two of the following conditions of such financial interdependence:
    i. They have a single dedicated relationship of at least 6 months duration.
    ii. They have joint ownership of a residence.
    iii. They have at least two of the following:
        a) A joint ownership of an automobile.
        b) A joint checking, bank or investment account.
        c) A joint credit account.
        d) A lease for a residence identifying both partners as tenants.
        e) A will and/or life insurance policies which designates the other as primary beneficiary.

The Employee and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

3. **Child/Children:**

The term "Child/Children" means the employee's natural child, stepchild, legally adopted child, foster child, and a child for whom the employee or covered spouse has been appointed legal guardian, provided the child has not reached the end of the month of his or her twenty-sixth (26^{th}) year of age.

4. **Qualified Medical Child Support Order (QMCSO):**

An eligible child shall also include any other child of an employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan, even if the child is not residing in the employee's household. Such child shall be referred to as an alternate recipient. Alternate recipients are eligible for coverage regardless of whether the employee elects coverage for himself. An application for enrollment must be submitted to the employer for coverage under this Plan. The employer/plan administrator shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the Plan pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the employer/plan administrator shall determine whether such order is a Qualified Medical

Child Support Order or a National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

The employer/plan administrator reserves the right, at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

5. Adopted Children:

Adopted children, who are less than 18 years of age at the time of adoption, shall be considered eligible from the date the child is placed for adoption. "Placed for adoption" means the date the employee assumes legal obligation for the total or partial financial support of the child during the adoption process.

6. **Developmentally or Physically Disabled Child:**

A child who is unmarried, incapable of self-sustaining employment, and dependent upon the employee for support due to a mental and/or physical disability, and who was covered under the Plan prior to reaching the maximum age limit or other loss of dependent's eligibility, will remain eligible for coverage under this Plan beyond the date coverage would otherwise be lost.

Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the employer or Claims Administrator, but not more than once every two (2) years.

Eligibility may not be continued beyond the earliest of the following:

a. Cessation of the mental and/or physical disability;
b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination;
c. Eligible dependents do not include:
    i. A spouse who is legally separated or divorced from the employee. Such spouse must have met all requirements of a valid separation or divorce decree.
    ii. Children of a dependent son or daughter.
    iii. Children who are, or become, a full-time member of the armed forces of any country.
    iv. Any person who is covered as a dependent of another employee under this Plan.
    v. Any person who is eligible as an employee under the Plan.
    vi. The spouse of a dependent child.

ENROLLMENT

The benefits of this Plan are based on a benefit year. If an employee or dependent enrolls for coverage at any time during the benefit year, the benefits shall be calculated on a benefit year

APPLICATION FOR ENROLLMENT

An employee must file a written application with the employer for coverage hereunder for himself and his eligible dependents within thirty-one (31) days of becoming eligible for coverage; and within thirty-one (31) days of marriage or the acquiring of children or birth of a child. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder. Once a properly completed application for enrollment has been submitted to the employer and coverage has become effective, as defined in the section titled, Effective Date of Coverage, the employee's enrollment options shall remain in effect. The only opportunity to change the enrollment option shall be at the annual open enrollment period, or upon a Special Enrollment option as defined below.

The employer must be notified of any change in eligibility of dependents within thirty-one (31) days of the change, including the birth of a child that is to be covered and adding or deleting any other dependents. Forms are available from the employer for reporting changes in dependents' eligibility as required.

Failure to complete the application for enrollment within thirty-one (31) days shall result in the Late Enrollment provision applying to the individual. An alternate recipient can be enrolled in the Plan at any time and shall not be subject to the Late Enrollment provision.

Employee/Spouse Enrollment

Every eligible employee may enroll eligible dependents. However, if both the husband and wife or domestic partner are employees, each individual will be covered as an employee. An employee cannot be covered as an employee and a dependent. Eligible children may be enrolled as dependents of one spouse, but not both.

Transfer of Coverage

If a husband and wife are both employees and are covered as employees under this Plan and one of them terminates, the terminating spouse and any of the eligible enrolled children will be permitted to immediately enroll under the remaining employee's coverage. Such new enrollment will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the employee or the dependent of the terminated employee.

SPECIAL ENROLLMENT PERIOD: LOSS OF ELIGIBILITY FOR OTHER COVERAGE

An employee or dependent who did not enroll for coverage under this Plan because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this Plan, may request a special enrollment period if he is no longer eligible for the other coverage. The employer may require proof of the Special Enrollment event noted below. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits)
2. Cessation of employer contributions toward the other coverage
3. Legal separation or divorce
4. Termination of other employment or reduction in number of hours of other employment
5. Death of spouse who had the coverage under the other plan.

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

The employee or dependent must request the special enrollment and enroll no later than thirty-one (31) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the employer's receipt of the completed enrollment form.

SPECIAL ENROLLMENT PERIOD: DEPENDENT ACQUISITION

An employee who is not covered under the Plan, but who acquires a new dependent may request a special enrollment period. For the purposes of this provision, the acquisition of a new dependent includes:

1. Marriage
2. Birth of a dependent child
3. Adoption or placement for adoption of a dependent child

The employee must request the special enrollment within thirty-one (31) days of the acquisition of the dependent.

The effective date of coverage as the result of a special enrollment shall be:

1. In the case of marriage, the first day of the first calendar month following the employer's receipt of the completed enrollment form;
2. In the case of a dependent's birth, the date of such birth;
3. In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

SPECIAL ENROLLMENT PERIOD: MEDICAID AND CHIP ELIGIBILITY

An eligible employee, or an employee's eligible dependent, who is not enrolled under the Plan, shall be permitted to enroll for coverage hereunder if either of the following conditions is met:

1. Termination of Medicaid or CHIP Coverage: If the employee or dependent is covered under a State Medicaid plan under Title XIX of the Social Security Act, or under a State Child Health Plan under Title XXI of the Social Security Act, and coverage of the employee or dependent under such coverage is terminated as a result of loss of eligibility for such coverage.
2. Eligibility for Premium Assistance Under Medicaid or CHIP: If the employee or dependent becomes eligibility for premium assistance, with respect to coverage under the Plan, under a Medicaid plan or State Child Health Plan.

The employee or dependent must submit a complete application for enrollment to the employer within sixty (60) days of either: (1) termination of coverage under such other coverage, or (2) the date the employee or dependent is determined to be eligible for premium assistance. Failure to submit the completed application for enrollment within the designated time shall result in the employee's or dependent's forfeiture of this enrollment right and shall be subject to enrolling upon the next open enrollment period sponsored by the employer.

OPEN ENROLLMENT

Open enrollment is the period designated by the employer during which the employee may elect coverage for himself and any eligible dependents if he is not covered under the Plan and does not qualify for a Special Enrollment as described herein. Enrolled employees may add or drop coverage for dependents during this open enrollment period.

An open enrollment will be permitted once in each benefit year during a period selected by employer. Coverage changes shall be effective on the first day of the month following the open enrollment period provided a properly completed application for enrollment is submitted to the employer during the designated open enrollment period and must be received by the employer by the last day of the open enrollment period.

LATE ENROLLMENT

With the exception of the provisions identified in Special Enrollment above, applications for employee or dependent coverage which are not filed with the employer within thirty-one (31) days of meeting the eligibility requirements of the Plan shall be subject to this late enrollment provision.

Late enrollment applicants shall be eligible to enroll for coverage during the Plan's annual open enrollment period. Coverage shall be effective the first of the month following the open enrollment period provided a properly completed application for enrollment has been received by the employer. This late enrollment provision shall not apply to an alternate recipient.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

Eligible employees, as described in Eligibility, are covered under the Plan the first of the month coincident with or following 60 days of continuous full-time employment; provided a properly completed enrollment form was submitted to the employer.

In the event a part-time employee changes employment status to full-time, coverage will be effective on the date the employee meets the Plan's eligibility requirements, provided the employee worked in a part-time capacity for the employer for at least the period of time equal to the Plan's waiting period.

If the employee does not enroll for coverage within thirty-one (31) days of meeting the Plan's eligibility requirements, the effective date of coverage will be delayed. Refer to Enrollment.

DEPENDENT EFFECTIVE DATE

Eligible dependents, as described in Eligibility, will become covered under the Plan on the later of the dates listed below, provided the employee has enrolled them in the Plan within thirty-one (31) days of meeting the Plan's eligibility requirements. If the employee does not enroll eligible dependents within thirty-one (31) days of meeting the Plan's eligibility requirements, the dependents' effective date of coverage will be delayed. Refer to Enrollment.

1. The date the employee's coverage becomes effective.
2. The date the dependent is acquired, provided any required contributions are made and the employee has applied for dependent coverage within thirty-one (31) days of the date acquired.
3. Newborn children shall be covered as follows:
   A. If the employee is enrolled for family coverage and paying the required contributions, a newborn shall be covered from birth. An application for enrollment must be submitted to the employer for administrative purposes.
   B. If the employee is enrolled for single coverage, an application for enrollment must be submitted to the employer within thirty-one (31) days of birth for coverage to be effective as of the date of birth. If the application for enrollment is received more than thirty-one (31) days following birth, the newborn will be subject to the Plan's Late Enrollment provision.
4. Coverage for a newly adopted child shall be effective on the date the child is placed for adoption.

TERMINATION OF COVERAGE

Except as provided in the Plan's Continuation of Coverage (COBRA) provision, coverage under this plan will terminate on the earliest of the following dates:

EMPLOYEE TERMINATION DATE

1. The date the employer terminates the Plan whether or not the employer offers a different plan.
2. The last day of the month in which the employee ceases to meet the eligibility requirements of the Plan.
3. The last day of the month in which employment terminates.
4. The date the employee becomes a full-time, active member of the armed forces of any country.
5. Midnight on the first day after the date any required contribution is due but not paid, unless the Member has received confirmation in writing from a representative of the Plan that coverage will not be terminated.
6. The date the employee fails to return from an approved leave of absence.
7. At any time, coverage may be rescinded, or retroactively terminated, effective the date the employee commits or has committed an intentional act of fraud or material misrepresentation with respect to the Plan, with 30 days written notice from the Plan.

DEPENDENT TERMINATION DATE

1. The date the employer terminates the Plan and offers no other group health plan.
2. The date the employee's coverage terminates. However, if the employee remains eligible for the Plan, but elects to discontinue coverage, coverage may be extended for alternate recipients.
3. The date such person ceases to meet the eligibility requirements of the Plan.
4. Midnight on the first day after the date any required contribution is due but not paid, unless the Member has received confirmation in writing from a representative of the Plan that coverage will not be terminated.
5. The date the dependent becomes a full-time, active member of the armed forces of any country.
6. The date the Plan discontinues dependent coverage for any and all dependents.

7. The last day of the month in which the dependent becomes eligible as an employee.
8. At any time, coverage may be rescinded, or retroactively terminated, effective the date the employee commits or has committed an intentional act of fraud or material misrepresentation with respect to the Plan, with 30 days written notice from the Plan.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, when the employee is on an authorized leave of absence from the employer. In no event will coverage continue for more than ninety (90) days after the employee's active service ends. If the employee fails to return to work after an approved leave of absence, any time applied toward the approved leave of absence shall apply concurrently toward the continuation of coverage provision under COBRA.

ADMINISTRATIVE LEAVE

Coverage will continue for any employee and/or dependents, where the employee is placed on Administrative Leave by the employer. The employer shall continue to pay the applicable contributions for coverage for the employee and/or dependent's coverage. Such coverage under the Plan shall continue until the investigation of the employee is brought to a close. Should the result of the investigation prove improper action on the part of the employee and the decisions is to suspend the employee for a duration of time less than thirty (30) days; the Plan will continue to provide coverage during the Administrative suspension.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period.

Contributions

During this leave, the employer will continue to pay the same portion of the employee's contribution for the Plan. The employee shall be responsible to continue payment for eligible dependent's coverage and any remaining employee contributions. If the covered employee fails to make the required contribution during a FMLA leave within thirty-one (31) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the Plan was terminated during an approved FMLA leave, and the employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the employee returns to active work as if coverage had not terminated, provided the employee makes any necessary contributions and enrolls for coverage within thirty-one (31) days of his return to active work.

Repayment Requirement

The employer may require employees who fail to return from a leave under FMLA to repay any contributions paid by the employer on the employee's behalf during an unpaid leave. This repayment will be required only if the employee's failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the employee's control.

EMPLOYEE REINSTATEMENT

Employees and eligible dependents that lost coverage due to an approved leave of absence, layoff, or termination of employment with the employer are eligible for reinstatement of coverage as follows:

1. Reinstatement of coverage is available to employees and dependents that were previously covered under the Plan.
2. Rehire or return to work must occur within ninety (90) days of separation of employment.
3. The employee must submit the completed application for enrollment to the employer within thirty-one (31) days of rehire or return to work.
4. Coverage shall be effective from the date of rehire. Prior benefits and limitations, such as Deductible and Maximum Benefit Amount shall be applied with no break in coverage.

If the provisions of (1) through (3) above are not met, the Plan's provisions for eligibility and application for enrollment shall apply. An employee who returns to work after ninety (90) days of an approved leave of absence, layoff, or

separation of employment will be considered a new employee for purposes of eligibility and will be subject to all eligibility requirements.

CONTINUATION OF COVERAGE

This section pertains to employers that are eligible and have elected COBRA coverage. If you have any questions, please contact your Human Resources Department.

In order to comply with federal regulations, this Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug, and vision benefits as provided under the Plan.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a Member to lose coverage under this Plan, even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

1. Death of the employee.
2. The 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.
3. Divorce or legal separation from the employee.
4. The 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.
6. The last day of leave under the Family Medical Leave Act of 1993.
7. The call-up of an employee reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee, or a child's loss of dependent status, the employee or dependent must notify the employer of that event within sixty (60) days of the event. The employee or dependent must advise the date and nature of the qualifying event and the name, address and Social Security number of the affected individual. Failure to provide such notice to the employer will result in the person forfeiting their rights to continuation of coverage under this provision.
2. The employer has thirty (30) days to notify the Claims Administrator of the qualifying event. Within fourteen (14) days of receiving notice of the qualifying event, the COBRA administrator will notify the employee or dependent of his right to continuation of coverage, and what process is required to elect continuation of coverage.
3. After receiving notice, the employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the Plan prior to the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. The COBRA Administrator must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:
    a. The date coverage under the Plan would otherwise end; or
    b. The date the person receives the notice from the employer of his or her rights to continuation of coverage.
4. Within forty-five (45) days after the date the person notifies the COBRA Administrator that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.
5. The employee or dependent must make payments for the continued coverage.

COST OF COVERAGE

1. The employer requires that Members pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the COBRA Administrator, 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.
2. 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 an employee if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an employee.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, 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.

Since a reduction in employment hours is a qualifying event under this provision, any continuation of coverage granted by the employer (leave of absence, layoff, Family Medical Leave Act) shall run simultaneously with the continuation of coverage provided under this provision (COBRA).

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or dependent child newly acquired during continuation coverage is eligible to be enrolled as a dependent. The standard enrollment provision of the Plan applies to enrollees during continuation 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 continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an employee,
2. Divorce or legal separation from an employee,
3. Employee's entitlement to Medicare, or
4. The child's loss of dependent status.

If one of these subsequent qualifying events occurs, a dependent may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

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 continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other dependent acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the employee.
2. Thirty-six (36) months from the date continuation began for dependents whose coverage ended because of the death of the employee, divorce or legal separation from the employee, or the child's loss of dependent status.
3. The end of the period for which contributions are paid if the Member fails to make a payment on the date specified by the employer.
4. The date coverage under this Plan ends and the employer offers no other group health benefit plan.
5. The date the Member first becomes entitled to Medicare after the date of election of COBRA continuation coverage.
6. The date the Member first becomes covered under any other group health plan after the date of election of COBRA continuation coverage.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is totally disabled may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the COBRA Administrator within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The disabled person and the family members who were covered prior to the qualifying event are eligible for up to twenty-nine (29) months of continuation of coverage. The employer may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage. Extended coverage will end on the month that begins thirty (30) days after the person is no longer considered disabled.

MILITARY MOBILIZATION

If an employee or an employee's dependent is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the employee or the employee's dependent may continue their health coverage, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the employee or employee's dependent may not be required to pay more than the employee's share, if any, applicable to that coverage. If the leave is thirty-one (31) days or more than, then the employer may require the employee or employee's dependent to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the employee fails to return to employment within the time allowed.

Whether or not the individual elects continuation of coverage under USERRA, upon return from uniformed services, the employee or the employee’s dependent coverage will be reinstated the date of return to work, provided the uniformed service member was released under honorable conditions, and returns to work within the following timelines:

1. Following completion of the military service for a leave of less than thirty-one (31) days, upon the first full regularly scheduled work period after the expiration of eight (8) hours after a period allowing for the save transportation of the person from the place of service to the person’s residence;
2. Within fourteen (14) days of completing military services for a leave of thirty-one (31) days to one hundred eighty (180) days;
3. Within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days.

The employee or the employee's dependent coverage will be reinstated without exclusions or a waiting period.

CLAIM FILING PROCEDURE

FILING A CLEAN CLAIM

Whenever you incur an expense for treatment covered under the Plan, an itemized bill for services should be submitted to the claim address printed on your identification card. Appropriate forms for filing claims can be obtained from your employer. Your provider may file claims for you by submitting the following:

- Current version of CMS–1500 and UB-04

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

The Member may ask the provider to file a claim form. However, it is ultimately the member's responsibility to make sure the claim has been filed for benefits.

FOREIGN CLAIMS

In the event a Member incurs a Covered Benefit in a foreign country, the Member shall be responsible for providing the following to the Claims Administrator before payment of any benefits due are payable:

1. The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into dollars.
3. A current conversion chart validating the conversion from the foreign country's currency into dollars.

TIME LIMIT FOR FILING ALL CLAIMS

A claim for benefits should be submitted to the Claims Administrator within ninety (90) days after the occurrence or commencement of any services covered by the Plan, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce any claim if the Member submits proof to the Plan Administrator that: (1) it was not reasonably possible to file a claim within that time; (2) and that such claim was furnished as soon as possible, but no later than twelve (12) months after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a Member or his beneficiary, if any, to the Plan Administrator or to any authorized agent of the Plan with information sufficient to identify the Member, shall be deemed notice of claim.

TYPES OF CLAIMS

There are four types of Claims:

Pre-Service Claim

A Pre-Service Claim is a reduction in benefits for certain Covered Services because the Member did not obtain the required Plan approval before receiving the care or treatment. This Plan does require prior approval for certain Covered Services or treatments as a condition to receiving benefits under the Plan. The review program is known as pre-certification. See the Schedule of Benefits and the Utilization Review Section for more information.

Urgent Care Claim

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

Concurrent Care Determination

A Concurrent Care Determination is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments.

Post-Service Claim

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

PAYMENT OF BENEFITS

After a claim has been submitted to the Claims Administrator, if additional information is needed to adjudicate the claim, the Claims Administrator will request the information. Submission of additional information must be received by the Claims Administrator no later than the timeframes set forth below. **The failure to do so may result in claims being denied or reduced.**

The Claims Administrator shall notify the Member, in accordance with the provision set forth below, of its decision regarding payment of the claim, including any Adverse Benefit Determination within the following timeframes:

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

c. Request by Member Involving Non-urgent Care. If the Claims Administrator receives a request from the Member for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).
d. Request by Member Involving Rescission. With respect to rescissions, the following timetable applies:

i.	Notification to Member	30 days
ii.	Notification of Adverse Benefit Determination on appeal	30 days

4. Post-service Claims:
   a. If the Member has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
   b. If such an extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
   c. If the Member has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Member will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Member will be notified of the determination by a date agreed to by the Claims Administrator and the Member.

5. Extensions:
   a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
   b. Pre-service Non-urgent Care Claims. This period may be extended for up to 15 days, provided that the Plan Administrator, or its designee both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Member, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   c. Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator, or its designee both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Member, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

NOTIFICATION OF ADVERSE BENEFIT DETERMINATION

The Claims Administrator shall provide a Member with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. Information sufficient to allow the Member to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
3. 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.
4. A description of any additional information necessary for the Member to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.

6. A statement that the Member 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 Member's claim for benefits.
7. Upon request, 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).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Member, free of charge, upon request).
9. 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 Member's medical circumstances, or a statement that such explanation will be provided to the Member, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

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

An Adverse Benefit Determination means a denial in benefits, a reduction in benefits, a rescission of coverage even if the rescission does not impact a current claim for benefits, termination of benefits, a. failure to provide or make a payment (in whole or in part), or a failure to cover a certain item or service because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Covered Person's failure to timely pay required premiums.

EXPLANATION OF PAYMENT

Benefits available to Providers are limited such that if a Provider advances or submits claims which exceed

amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

If the charge billed by a Provider for any Covered Charge is higher than the Maximum Allowable Amount determined by the Plan, the Member is responsible for the excess unless the Provider accepts an Assignment of Benefits as consideration in full for services rendered. When Participating Providers have agreed to accept a negotiated discounted fee as full payment for their services, The Member is not responsible for any billed amount that exceeds that fee.

Providers accepting an Assignment of Benefits shall do so as consideration in full for services rendered, and send the Member's claims directly to the Third Party Administrator. The Plan will pay the scheduled benefit amount, less any required deductibles and copayments, and subject to any limits or exclusions, directly to the Provider.

When available, benefits will be limited by the terms of the Plan, including provisions which limit benefits to the Reasonable and Allowed amounts. The Plan will not pay any expense that is not a Covered Charge.

ASSIGNMENTS

Benefits for medical expenses covered under this Plan may be assigned by a Member to the Provider as consideration in full for services rendered. An Assignment of Benefits occurs when a Member assigns their right to submit a request for benefits to the Plan to a services Provider. Assignment of Benefits should be provided to a Provider, and accepted by a Provider, as payment in and of itself, for services rendered. As such, Assignment of Benefits is itself consideration from the Member to the Provider, and must be deemed payment in full in order to be achieved.

If benefits are paid directly to the Member, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned 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 proof of loss is submitted.

Note: By submitting a claim to the Third Party Administrator and accepting payment by the Plan, the Provider is expressly agreeing to the Assignment of Benefits provision as well as the terms of the Plan Document. The Provider further agrees that the payments received constitute an **"**accord and satisfaction**"** and consideration in full for the services, supplies and/or treatment rendered and will take precedence over any previous terms and the patient will not be balance billed for any amount beyond the patient responsibility (deductible/copayment/coinsurance) that may be applicable.

If a Provider refuses to accept an Assignment of Benefits as consideration in full for the services rendered, the Reasonable and Allowable Amount payable under the terms of the Plan Document will be payable directly to the Plan Participant and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Expense. In that event, the Plan Participant will be responsible for all amounts that fall under the patient responsibility (deductible/co-pay/co-insurance) as well as any amount that exceeds the Reasonable and Allowable Amount payable by the Plan.

The Assignment of Benefits does not grant the Provider the right to sue that is afforded to the Plan Participants as set forth in ERISA section 502(a). The Assignment of Benefits accepted by a Provider only allows them to receive payment and to appeal an adverse benefit determination.

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

The Plan pays the percentage listed Schedule of Benefits at the Reasonable reimbursement level. The Member is responsible for the difference between the percentage the Plan paid and 100% for the negotiated rate for Providers. For Providers, the Member is responsible for the difference between the percentage of the Reasonable Charge reimbursement level and 100% of the billed amount. The Member's portion of the coinsurance represents the out-of - pocket expenses.

The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Member and the assignee, has been received before the proof of loss is submitted.

No Member shall, at any time, either during the time in which he or she is a Member in the Plan, or following his or her termination as a Member, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

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

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

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

PROVIDER RECONSIDERATION REQUEST

When a Provider receives a copy of an Adverse Benefit Determination related to a Claim, the Provider may request a reconsideration of the decision. The request must be in writing and must be sent to the Claims Administrator within 180 days after the date of the Adverse Benefit Determination. The request must include the claim number, the reason for the request (i.e., an explanation of why the provider thinks the claim was processed incorrectly), and supporting documentation that was not included with the initial claim submission. Provider reconsideration requests sent later than 180 days after the date of the determination will not be considered. A Provider does not have the

same rights as a Member and Providers are not Authorized Representatives of Members unless specifically appointed in writing. However, Providers will be allowed to exhaust the internal claims procedures under the terms of this Plan on behalf of a Member without the appointment as the Member's Authorized Representative. The Provider shall not under any circumstances have the right to sue the Plan.

APPEALING A CLAIM

In cases where a Claim is denied, in whole or in part, and the Member believes the claim has been denied wrongly, the Member may appeal the denial and review pertinent documents. The Claim Filing Procedure of this Plan provide a Member with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180-day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180-day timeframe.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. A review that takes into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Member if presented by the Member in support of the claim.
9. That a Member will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Member's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Member's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances.
10. That a Member will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Member to respond to such new evidence or rationale.

Two Levels of Appeal

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

Once a Member receives an Adverse Benefit Determination in response to an initial claim for benefits, the Member may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Member receives an Adverse Benefit Determination in response to that initial appeal, the Member may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Member receives an Adverse Benefit Determination in response to the Member's second appeal, such Adverse Benefit Determination will constitute

the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

Requirements for First Level Appeal

The Member must file the 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 Claim, oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Member's appeal must be addressed as follows:

Hawaii Mainland Administrators, LLC (HMA)
P.O. Box 22009
Tempe, AZ 85285-2009
(866) 206-7920

It shall be the responsibility of the Member or Authorized Representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Member.
2. The Employee/Member's social security number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Member has which indicates that the Member is entitled to benefits under the Plan.

Timing of Notification of Benefit Determination on Review

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

1. 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.
2. 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.
3. 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.
4. Post-service Claims: Within a reasonable period of time, but not later than 30 days per internal appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time 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 Review

The Claims Administrator shall provide a Member 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:

1. Information sufficient to allow the Member to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.

3. A reference to the specific portion(s) of the summary plan description on which the denial is based.
4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A statement that the Member 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 Member's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Member, free of charge, upon request.
7. A description of any additional information necessary for the Member to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
10. 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 Member's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Member, free of charge, upon request.
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Requirements for Second Level Appeal

If the Member does not agree with the Claims Administrator's determination from the first Level of Internal Review, the Member must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination, along with any additional supporting information to:

Hawaii Mainland Administrators, LLC (HMA)
P.O. Box 22009
Tempe, AZ 85285-2009
(866) 206-7920

The Second Level of Internal Review will be conducted by the Plan Administrator, or its designee. The Plan Administrator, or its designee, will review the information initially received and any additional information provided by the Member, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator or its designee will send a written or electronic Notice of Determination for the second level of review to the Member within 30 days of receipt of the appeal.

The decision by the Plan Administrator, or its designee, on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. If the Member is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Member may be eligible for an External Review as defined in the ***External Review Process*** section of the Plan Document. All internal and external claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

<u>Exception to the Deemed Exhaustion Rule</u>

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

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

External Review Process

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

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves medical judgment (including, but not limited to, those based on the Plan'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.
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

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

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

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

    a. The Member 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 Internal Adverse Benefit Determination does not relate to the Member's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).
    c. The Member has exhausted the Plan's internal appeal process unless the Member is not required to exhaust the internal appeals process under the final regulations.

d. The Member has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Member. 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 Member to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

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 Third Party Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

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.

Expedited external review

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

   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Member for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function and the Member has filed a request for an expedited internal appeal.
   b. A Final Internal Adverse Benefit Determination, if the Member has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Member 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 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Member 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 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 Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Member'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 Member and the Plan.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when the Member is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "Reasonable and Allowed fees". Only the amount paid by this Plan will be charged against the Maximum Benefit Amount.

The Coordination of Benefits provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this Plan, part or all of which would be covered under this Plan. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this Plan.

When this Plan is secondary, "Allowable Expense" will include any Deductible or Coinsurance amounts not paid by the Other Plan(s).

When this Plan is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Member for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for Members in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;
2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a government program and any coverage required or provided by any statute;
6. Group automobile insurance;
7. Individual automobile insurance coverage;
8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;
9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
10. Labor/management trustee, union welfare, employer organization, or employee benefit organization plans.

"This Plan" shall mean that portion of the employer's Plan which provides benefits that are subject to this provision.

"Claim Determination Period" means a benefit year or that portion of a benefit year during which the Member for whom a claim is made has been covered under this Plan.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a Member for each claim determination period for the Allowable Expenses. If this Plan is secondary, the benefits paid under this Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

If the rules set forth below would require this Plan to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this Plan.

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent
   The plan which covers the claimant as a Member (or named insured) pays as though no Other Plan existed. Remaining Covered Benefits are paid under a plan which covers the claimant as a dependent.

3. Dependent Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

   A. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent pays fourth.
   B. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody pays fourth.

5. Active/Inactive
   The plan covering a person as an active (not laid off or retired) employee, or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.

6. Limited Continuation of Coverage
   If a person is covered under another group health plan, but is also covered under this Plan for continuation of coverage due to the Other Plan's limitation for pre-existing conditions or exclusions, the Other Plan shall be primary for all Covered Benefits which are not related to the pre-existing condition or exclusions. This Plan shall be primary for the pre-existing condition only.

7. Longer/Shorter Length of Coverage
   If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

COORDINATION WITH MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.

1. When an employee becomes entitled to Medicare coverage and is still actively at work, the employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.

2. When a dependent becomes entitled to Medicare coverage and the employee is still actively at work, the dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.

3. If the employee and/or dependent is also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.

4. If the employee and/or dependent elect to discontinue health coverage under this Plan and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payer.

5. A Member that is an active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan 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 rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

6. To the extent required by Federal regulations, this Plan will pay Covered Expenses at the Reasonable and Allowed Amount before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payer (as described under the Article entitled "Coordination of Benefits"). The Member will be assumed to have full Medicare coverage (that is, both Parts A & B) whether or not the Member has enrolled for the full coverage. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

7. If any Member 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.

This section is subject to the standard terms of the Medicare Secondary Payer laws and regulations, including but not limited to, determination of first and second payer for a person with End Stage Renal Disease, or a person eligible for Medicare due to disability. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

In no event shall the Member recover under this Plan and all Other Plan(s) combined more than the total Allowable Expenses offered by this Plan and the Other Plan(s). Nothing contained in this section shall entitle the Member to benefits in excess of the total Maximum Allowable Payment of this Plan during the claim determination period. The Member shall refund to the employer any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this Coordination of Benefits provision, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information with respect to any Member. Any person claiming benefits under this Plan shall furnish to the employer such information as may be necessary to implement the Coordination of Benefits provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plan, the employer shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the employer shall be fully discharged from liability.

MINOR STATUS

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

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

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

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

GENERAL PROVISIONS

PLAN ADMINISTRATOR AND FIDUCIARY

Docs Marina Grill shall be the Plan Administrator and named Fiduciary of this Plan and as such, has the authority to control and manage the operation and administration of the Plan. The Plan Administrator intends to continue the Plan indefinitely, but reserves the right to terminate or amend the Plan in any way. No consent of any Member or any other person referred to in the Plan will be required to terminate, modify, amend or change the Plan. The Plan Administrator may amend any provision, condition, limitation or exclusion of the Plan. Notice will be given to all covered employees within 60 days after the date of adoption of the modification or change. No agent is authorized to modify the Plan.

ASSIGNMENT

The Plan will pay benefits under this Plan to the employee unless payment has been assigned to a hospital, physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the Claims Administrator is notified in writing of such assignment prior to payment hereunder. This Plan will pay benefits to the responsible party of an alternate recipient as designated in a qualified medical child support order.

Participating Providers normally bill the Plan directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The Member's portion of the negotiated rate, after the Plan's payment, will then be billed to the Member by the Participating Provider.

BENEFITS NOT TRANSFERABLE

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

CLERICAL ERROR

No clerical error on the part of the employer or Claims Administrator shall operate to defeat any of the rights, privileges, services, or benefits of any employee or any dependent(s) hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the Plan which is in conflict with statutes which are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The Effective Date of the Plan is March 1, 2017.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restricts or interferes with the right of any person entitled to benefits hereunder to select a hospital or to make a free choice of the attending physician or professional provider. However, benefits will be paid in accordance with the provisions of this Plan, and the Member will have higher Out-of-Pocket expenses if the Member uses the services of a Non-Participating Provider.

INCAPACITY

If, in the opinion of the employer, a Member for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for his estate, the employer may on behalf of the Plan, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the employer or by the employee covered under this Plan 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 Member, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of sixty (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 two (2) years from the date the expense was incurred, or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the employer shall not be liable for any obligation of the Member incurred in excess thereof. The employer shall not be liable for the negligence, wrongful act, or omission of any physician, professional provider, hospital, or other institution, or their employees, or any other person. The liability of the Plan shall be limited to the reasonable cost of Covered Benefits and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the Plan Administrator is unable to locate the Member to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the Member for the forfeited benefits within the time prescribed in Claim Filing Procedure.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a Member or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same services, supplies or treatment, payment under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the Plan.

MISREPRESENTATION

If the Member or anyone acting on behalf of a Member makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the Member, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the Member in making application for coverage, or any application for reclassification thereof, or for service there under shall render the coverage under this Plan null and void.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the employer and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the employer or to interfere with the right of the employer to terminate the employment of any employee at any time.

PLAN MODIFICATION AND AMENDMENT

The employer may modify or amend the Plan from time to time at its sole discretion, and such amendments or modifications which affect Members will be communicated to the Members. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the effective date of the modifications, and shall be signed by the employer's designee.

An amendment to the Plan may be retroactively effective, but shall not adversely affect the rights of Members under this Plan for Covered Benefits provided after the effective date of the amendment but before the amendment is adopted. Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the employer, or a written copy thereof shall be deposited with such master copy of the Plan.

PLAN TERMINATION

The employer reserves the right to terminate the Plan at any time. Upon termination, the rights of the Members to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to the Members. Upon termination of this Plan, all claims incurred prior to termination, but not submitted to either the employer or Claims Administrator within three (3) months of the effective date of termination of this Plan, will be excluded from any benefit consideration.

PRONOUNS

All personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, the Plan will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the Plan, should not have been made, the Plan may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

SECONDARY COVERAGE

Members 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 Member 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.

STATUS CHANGE

If an employee or dependent has a status change while covered under this Plan (i.e. dependent to employee, COBRA to Active) and no interruption in coverage has occurred, the Plan will provide continuance of coverage with respect to any pre-existing condition limitation, Deductible(s), Coinsurance and Maximum Benefit Amount.

STATUTE OF LIMITATIONS

Before filing a lawsuit, a Claimant must exhaust all available levels of review as described in document, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of Plan's determination on the final level of internal or external review, whichever is applicable.

TIME EFFECTIVE

The effective time with respect to any dates used in the Plan shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the Plan Administrator.

WORKERS' COMPENSATION NOT AFFECTED

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

DEFINITIONS

Adverse Benefit Determination

"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
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 Member's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Alternate Recipient

Any child of an employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan.

Ambulatory Surgical Facility

A facility provider with an organized staff of physicians which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc. or by the Plan, which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an outpatient basis;
2. Provides treatment by or under the supervision of physicians and nursing services whenever the Member is in the ambulatory surgical facility;
3. Does not provide inpatient accommodations; and
4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician.

Assignment of Benefits

An arrangement whereby the Member assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to any Provider. If the Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Member, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an Assignment of Benefits as consideration in full for services, supplies, and/or treatment rendered.

Benefit Year

The twelve-month period beginning March 1 through February 30 for which all Plan benefits shall be calculated. Any applicable Deductible, Out-of-Pocket maximum expense limit, or Maximum Benefit Amount shall accrue on a benefit year basis.

Claims Administrator

The company contracted by the employer which is responsible for the processing of claims for benefits under the terms of the Plan and other administrative services deemed necessary for the operation of the Plan as delegated by the employer.

Clean Claim

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

and Allowed or any other matter that may prevent the charge(s) from being Covered Benefits in accordance with the terms of this document.

Close Relative
The employee's spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the employee's spouse.

Coinsurance
The benefit percentage of Covered Benefits payable by the Plan for benefits that are provided under the Plan. The Coinsurance is applied to Covered Benefits after the Deductible(s) have been met, if applicable.

Copayment
A cost sharing arrangement whereby a Member pays a set amount to a provider for a specific service at the time the service is provided.

Covered Benefits
Medically necessary services, supplies or treatments, and payments for the same, that are recommended or provided by an approved licensed professional provider for the treatment of an illness or injury and:

1. that are sought and provided in accordance with the terms of this document;
2. the charged amount for such services, supplies, or treatments does not exceed the Maximum Payable Amount;
3. that are not specifically excluded from coverage herein.

Covered Benefits applies to service type as well as charged amount.

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 Member 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 Expenses. 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.

Deductible
A deductible is the dollar amount you pay for health care services before your plan begins to pay.

Dependents
For a complete definition of dependent, refer to Eligibility, Dependent Eligibility.

Effective Date
The date of this Plan or the date on which the Member's coverage commences, whichever occurs later.

Emergency
The sudden onset of an illness or injury where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the Member's life in jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.

Employee
A person directly involved in the regular business of and compensated for services by the employer, who is regularly scheduled to work not less than 30 hours per work week.

Employer
The employer is Docs Marina Grill.

Enrollment Date
A Member's enrollment date is the first day of any applicable service waiting period or the date of hire.

Errors
Errors shall mean charges based on billing mistakes, improprieties or illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible, or improper based on any applicable law, regulation, rule or professional standard. It is in the Plan Administrator's sole discretion to determine what constitutes an Error under the terms of the Plan.

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

Full-Time
Employee's regularly scheduled to work not less than 30 hours per work week.

Generic Drug
A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or physician and must be clearly designated by the pharmacist or physician as generic.

Illness
A bodily disorder, disease, physical sickness, or pregnancy of a Member.

Incurred or Incurred Date
With respect to a Covered Benefit, the date the services, supplies or treatment are provided.

Injury
A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include illness or infection of a cut or wound.

Invalid Charges
Invalid Charge(s) shall mean charges (a) that are found to be based on Errors (as defined in this Document), unbundling, misidentification or unclear description; (b) charges for fees or services determined not to have been Medically Necessary or reasonable; (c) charges found by the Plan Administrator to be in excess of the Maximum Allowable Charge or the "Reasonable and Allowed", or (d) charges that are otherwise determined by the Plan Administrator to be invalid or impermissible based on any applicable law, regulation, rule or professional standard.

Late Enrollee
A Member who did not enroll in the Plan when first eligible or as the result of a Special Enrollment Period.

Layoff
A period of time during which the employee, at the employer's request, does not work for the employer, but which is of a stated or limited duration and after which time the employee is expected to return to full-time, active work. Layoffs will otherwise be in accordance with the employer's standard personnel practices and policies.

Leave of Absence
A period of time during which the employee does not work, but which is of stated duration after which time the employee is expected to return to active work.

Maximum Benefit Amount

Any one of the following, or any combination of the following:

1. The maximum amount paid by this Plan for any one Member during the entire time he is covered by this Plan.
2. The maximum amount paid by this Plan for any one Member for a particular Covered Benefit. The maximum amount can be for:
    a. The entire time the Member is covered under this Plan, or
    b. A specified period of time, such as a calendar year.
3. The maximum number the Plan acknowledges as a Covered Benefit. The maximum number relates to the number of:
    a. Treatments during a specified period of time, or
    b. Days of confinement, or
    c. Visits by a home health care agency.

Maximum Payable Amount, Maximum Amount, or Maximum Allowable Charge

Shall mean the benefit payable for a specific coverage item or benefit under the Plan.
The maximum allowable amount shall be calculated by the Plan Administrator taking into account and after having analyzed:

1. For Participating Provider covered services, the amount established in the agreement with the Preferred Provider Organization being made available to provide covered services
2. For Non-Participating Provider covered services
    a. The Reasonable and Allowed amount as defined by the plan, or
    b. The amount calculated based on the Plan's Reference-Based Price provisions; or
    c. The charge otherwise specified under the terms of the Plan; or
    d. Plan negotiated rates with provider(s); or
    e. An amount taking into consideration the findings or assessments of any, some, or all of the following:
        i. The National Medical Associations, Societies, and organizations; and
        ii. The Food and Drug Administration; as well as
        iii. Using objective and normative data such as, but not limited to,
            a) Medicare Rates,
            b) Cost information,
            c) Medicare Provider Reimbursement Manual et al, Manufacturer's wholesale pricing (MWP) and/or average wholesale price (AWP) for supplies, devices and/or prescriptions.

The Plan will reimburse the actual charge(s) if they are less than the Reasonable and Allowed amount(s). The Plan has the discretionary authority to decide if a charge is Reasonable and Allowed, as well as Medically Necessary.
In no event will the Maximum Payable Amount exceed benefits for the Maximum Benefit Amount.

Certain services in the Schedule of Benefits are subject to specific limitations, and certain general limitations apply to benefits payable for all services. The Plan will take these limitations into account in calculating its Maximum Allowable Amount. The Maximum Payable will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; and Part C, Miscellaneous provisions regarding both programs; and including any subsequent changes or additions to those programs.

Member

An Employee or Dependent who is enrolled and covered under this Plan at the time services are rendered.

Negotiated Rate

The rate the Participating Providers have contracted to accept as payment in full for Covered Benefits of the Plan.

Non-Participating Pharmacy

Any pharmacy, including a hospital pharmacy, physician or other organization, licensed to dispense prescription drugs which do not fall within the definition of a participating pharmacy.

Non-Participating Provider
A physician, hospital, or other health care provider which does not have an agreement in effect with the Participating Provider Organization at the time services are rendered.

Nurse
A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Participating Pharmacy
Any pharmacy licensed to dispense prescription drugs and is contracted within the Pharmacy Organization.

Physician
A person duly licensed to practice medicine, to prescribe and administer drugs, or to perform surgery. This definition includes a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), Dentists, Podiatrists, Chiropractors, Psychologists, Psychiatrists provided that each, who is practicing within the scope of his license is permitted to perform services covered under this Plan and that this Plan does not exclude the services provided by such physician.

Placed For Adoption
The date the employee assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan
"Plan" refers to the benefits and provisions for payment of same as described herein.

Plan Administrator
The Plan Administrator is responsible for the day-to-day functions and management of the Plan. The Plan Administrator is the employer.

Plan Sponsor
The Plan Sponsor is the employer.

PPACA
The Patient Protection and Affordable Care Act of 2010.

Participating Provider
A physician or ancillary provider who has an agreement in effect with the Participating Provider Organization at the time services are rendered. Participating Providers agree to accept the negotiated rate as payment in full.

Participating Provider Organization
An organization who selects and contracts with certain hospitals, physicians, and other health care providers to provide Members services, supplies and treatment at a negotiated rate.

Pregnancy
The physical state which results in childbirth or miscarriage.

Preventive Care
Preventive care services as recommended by the U.S. Preventive Task Force to include, but not limited to preventive screenings, immunizations, and pediatric care. For a complete listing, go to:
https://www.healthcare.gov/coverage/preventive-care-benefits/ or https://www.uspreventiveservicestaskforce.org/

Professional Provider
A person or other entity licensed where required and performing services within the scope of such license. The covered professional providers are:
1. Audiologist

2. Certified Addictions Counselor
3. Certified Registered Nurse Anesthetist
4. Certified Registered Nurse Practitioner
5. Chiropractor
6. Clinical Laboratory
7. Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
8. Dental Hygienist
9. Dentist
10. Dietician
11. Dispensing optician
12. Midwife
13. Nurse (R.N., L.P.N., L.V.N.)
14. Occupational Therapist
15. Optician
16. Optometrist
17. Physical Therapist
18. Physician
19. Physician's Assistant
20. Podiatrist
21. Psychologist
22. Respiratory Therapist
23. Speech Therapist

Reasonable and Allowed

"Reasonable and Allowed Amount" or "Reasonable and Allowable Amount" means the maximum amount payable by the Plan for a service, supply and/or treatment that is considered a Covered Expense. The Reasonable and Allowable Amount and 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 as determined by the Plan and is based on the Medicare equivalent allowable amount;
2. For physician, professional and ancillary (such as laboratory and radiology), an amount as determined by the Plan and is based on the current National Medicare fee schedule and the Clinical Laboratory fee schedule amount;
3. For specialty drugs, the lesser of the average wholesale price (AWP) minus 10% or the amount set by the Plan's prescription drug service vendor.

The 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 adopted by the Plan from time to time. If there is insufficient information submitted for a given procedure, the Plan will determine the Reasonable and Allowed Amount based upon charges made for similar services. Determination of the reasonable and customary charge will consider 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 Expenses rendered by a Physician, Hospital or Ancillary Provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering Provider, the Reasonable and Allowed Amount shall mean the amount established by applicable law for that Covered Expense.

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

"Reasonable and Allowed" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Member 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 Expenses or Reasonable and Allowed. The Plan Administrator will determine whether a specific procedure, service or supply is Reasonable and Allowed. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Appropriate.

Security Incidents

The term "Security Incidents" has the meaning set forth in 45 C.F.R.§ 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with systems operations in an information system. For the purpose of the Plan Sponsor's requirement to report any Security Incidents, only successful unauthorized access, use, disclosure, modification or destruction of information or interference with systems operations in an information system shall be included.

Total Disability or Totally Disabled

The employee is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a dependent is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

ADOPTION STATEMENT

Docs Marina Grill has caused this Employee Benefit Plan (Plan) to take effect as of March 1, 2017 in Bainbridge WA 98110.

I have read the document herein and certify the document reflects the terms and conditions of the employee benefit plan as established by Docs Marina Grill.

Sign: Tom Applotte

Print: Tom Applotte

Date: 8/11/2020