ANCON CONSTRUCTION CO., INC.

EMPLOYEE MEDICAL BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

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FOR
ANCON CONSTRUCTION CO., INC.
EMPLOYEE MEDICAL BENEFIT PLAN

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INTRODUCTION

This document is a description of ANCON CONSTRUCTION Co., Inc. Employee Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason, including changes to benefit coverage, deductibles, maximums, copays, exclusions, limitations, definitions, eligibility and any other term or condition.

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

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

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

The Plan generally allows the designation of a primary care provider. A Covered Person has the right to designate any primary care provider who participates in the network and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider who participates in the network and who is available to accept the child as a patient. A Covered Person does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who participates in the network. However, the health care professional may be required to comply with certain Plan procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating providers, please contact the network or the PHP TPA Services website using the contact information contained on the ID card.

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

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

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

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

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.
This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Plan Exclusions. Shows what charges are not covered.

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

Claim Procedures. Explain the rules for filing claims and the claim appeal process.

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

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

Continuation of Coverage Options. Explain when a person's coverage under the Plan ceases and the continuation options which are available.

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

ANCON CONSTRUCTION Co., Inc. believes this Plan is a **"grandfathered health plan"** under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the Human Resources Department of ANCON CONSTRUCTION Co., Inc.by calling 574-533-9561. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees. All Full-Time Active Employees of the Employer.

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

(1) Is a Full-Time, Active, Employee of the Employer. An Employee is considered to be Full-Time if he or she is expected at the time of hire to regularly work at least 30 Hours of Service per week and is on the regular payroll of the Employer for that work. Employees under this provision shall be subject to monthly eligibility for their first year of employment and then transition to the 12-month look back period for ongoing employees. If a Full-Time Employee, during their first year of employment, reduces hours to Part-Time, therefore becoming ineligible for coverage, may immediately re-enroll in the Plan, with the same level of coverage (or less) on the day Full-Time status resumes.

(2) Coverage for all Salaried personnel will be on the first day of Full-Time employment. Coverage for all other Full-Time employees begins upon completion of ninety (90) days of Full-Time service with the Company. Completion of an enrollment form is also a Plan requirement.

(3) Is a Part-Time, Active Employee of the Employer. An Employee is considered to be Part-Time if he or she is expected at the time of hire by the Employer to average less than 30 Hours of Service per week and is on the regular payroll of the Employer for that work. If this Employee ultimately averages 30 Hours of Service per week over the measurement period described below, and is on the regular payroll for that work, he or she is eligible as of the immediately following Stability Period. The Waiting period is accounted for during the measurement period.

(4) Is in a class eligible for coverage.

Measurement / Administrative / Stability Periods:

- Ongoing Employees
  - Measurement Period / Look back Period (12 months): 1/1 – 12/31
  - Administrative Period (2 months): 11/1 – 12/31
  - Stability Period (12 months): 1/1 – 12/31

- Newly Hired Employees
  - Measurement Period: 12 months
  - Administrative Period: 1 month
  - Stability Period: 12 months

  If a Part-Time, variable hour or seasonal Employee averages at least 30 hours per week during the measurement period, then the Employee may enroll for the following stability period regardless of hours. If a Part-Time Employee changes job classifications to Full- Time status, he or she will be eligible for coverage immediately upon satisfaction of the Waiting Period or the end of the administrative period, whichever occurs first.

Coverage for such Employees will be effective on the first day of the Ongoing Employees stability period and the Employee will remain eligible throughout the stability period if employed by the Employer.

(3) **Waiting Period.** Generally, an Employee must satisfy a Waiting Period prior to receiving coverage under the Plan. A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan. Medical coverage is effective as follows:

- Class I Salaried Employees – Coverage shall be effective on the hire date.
- Class II All Others: Coverage shall be effective on the 1st calendar day following ninety (90) days of employment.

Regardless, during the stability period, the Employee is still subject to the Plan's timely enrollment requirements, which means the Employee may not be able to enroll if the Employee waives coverage when he or she first becomes eligible to enroll or if he or she fails to timely enroll in the Plan, until the next annual offer of coverage.

Hour of Service

An "hour of service" is an hour for which the Employee is a common law Employee of the Employer or a related employer and the Employee is:

(1) For Hourly Employees, each hour:

(a) paid or entitled to pay for performance of duties for the Employer or a related employer, or

(b) paid or entitled to pay for any period during which the Employee does not perform any duties due to vacation, holiday, illness, incapacity (including short-term disability), layoff, jury duty, military duty or a company-approved leave of absence.

(2) For Non-Hourly Employees:

(a) receiving credit for 8 hours of service for each day on which he or she performs duties for the Employer or a related employer, or

(b) paid or entitled to pay for any period during which the Employee does not perform any duties due to vacation, holiday, illness, incapacity (including short-term disability), layoff, jury duty, military duty or a company-approved leave of absence.

No service will be credited for an hour of service during any period in which:

(a) the Employee is not a common law Employee of the Employer or a related employer; or

(b) the Employee is an independent contractor or leased Employee.

Leave. For eligibility purposes, while an Employee is on a paid or unpaid company-approved leave of absence for USERRA, FMLA and jury duty, his or her average hours worked when he or she was not on leave will be credited for each full week of the leave (or prorated for each partial week of leave) for the purpose of determining whether he or she is an eligible part-time Employee under the Plan.

Breaks in service exceeding 13 weeks. If the Employee terminates employment with the Employer or a related employer, does not perform any services for at least 13 consecutive weeks and then resumes employment with the Employer or a related employer, the Employee will be considered a new Employee. In that case, the Employer will determine whether the Employee is an eligible Employee based on the circumstances at the time of rehire If the Employer determines that the Employee is not an eligible Full-Time Employee when employment resumes, a new initial measurement period will apply and the Employee will become an eligible Part-Time Employee only if he or she works an average of 30 hours per week during the new initial measurement period or any standard measurement period that begins after employment recommences.

Breaks in service of less than 13 weeks. If an Employee resumes employment with the Employer or a related

employer within 13 weeks after the date the Employee was last credited with an hour of service, and he or she was an eligible Employee prior to termination of employment, the Employee will remain eligible and may re-enroll in the Plan with the same level of coverage (or less) on the date employment resumes. If the Employee had not completed the initial measurement period prior to terminating employment, the initial measurement period will resume. Employee shall be credited with zero hours for the period of separation.

Corrective Action. If, at any time, the Plan Administrator determines that an Employee became an eligible Employee during a previous period, but was not offered an opportunity to enroll, it may, but need not, deem the Employee and Dependent children to have elected coverage as of the date coverage should have started. Once it determines the Employee was an eligible Employee and decides to offer retroactive coverage, it will notify the Employee of eligibility and offer an opportunity to enroll themselves and any Dependents as of the date the Employee first became eligible. In that case, the Employee will have an opportunity to submit any covered medical expenses for reimbursement subject to the terms of the Plan, and the Plan will waive any premiums for the period of coverage prior to the date the Employee is notified of eligibility to enroll.

Excluded Classifications. The following are not eligible to participate in the Plan:

- A temporary or a Part-Time Employee working fewer than 30 hours per week;
- An Employee who is a student or intern (regardless of the number of hours worked);
- A leased Employee who is not a common law Employee of the Employer or a related employer; or
- An independent contractor.

Retiree Coverage. A Retired Employee may continue coverage under this plan if he or she satisfies all of the following criteria:

a. Was an Officer of the Company participating in the plan, for himself, and any covered dependents, prior to the date of retirement;

b. Who reached a minimum age of 55;

c. Has a minimum of 20 years of service with the Company.

Retired Employees as defined above will be eligible for benefits up to age 65 at which time coverage will terminate

The Dependent Spouse of an Eligible Retired Employee will be eligible for benefits up to age 65. Covered Dependent Children will be covered according to the current provisions of the Plan relating to coverage for Dependent Children.

A Dependent Spouse of a deceased Eligible Retired Employee will be eligible for benefits up to age 65 provided the Retired Employee and Dependent Spouse were covered prior to the Employees death. Dependent Children will be covered to the Maximum age limit as currently stated in the plan.

Interpretation / Administration. The foregoing provisions shall be interpreted and administered in accordance with the Affordable Care Act. The Plan Administrator may adopt procedures to further administer eligibility provisions.

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

(1) A covered Employee's Spouse who is legally recognized as the marital partner of the covered Employee. Such Spouse must have met all requirements for a valid legal marriage. The Plan Administrator may require

documentation proving a legal marital relationship.

(2) A covered Employee's children from birth to the end of the month they reach the limiting age of twenty-six (26).

The term "children" shall include natural children, foster children, adopted children or children placed with a covered Employee in anticipation of adoption, or stepchildren. If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, and who has not attained the age of twenty-six (26) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such covered Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption, and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan. A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

(3) A covered Dependent child who reaches the limiting age of twenty-six (26) and is Totally Disabled (provided the disability began prior to attainment of the specified limiting age), incapable of self-sustaining employment by reason of intellectual or physical disability, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two (2) years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the covered Employee; or any person who is separately covered under the Plan as an Employee.

If a Covered Person has a status change while covered under this Plan (i.e. from Employee to Dependent, Dependent to Employee, or COBRA to Active) and no interruption in coverage has occurred, the Plan will provide continuance of coverage with respect to deductible(s), coinsurance and maximum benefits. If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage. At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

Prohibition of Rescissions of Coverage

The Plan Administrator shall not rescind coverage under this benefit Plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the Plan, unless:

(a) The individual or person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud; or

(b) The individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan coverage.

The Plan Administrator shall provide at least thirty (30) days advanced written notice to the individual affected before the rescission is effective.

Notwithstanding anything to the contrary in the Plan, in the event an enrollee's coverage should have been terminated retroactively because the enrollee became ineligible, the enrollee shall automatically be responsible for the full cost of premiums attributable to such coverage from the date of ineligibility. The premium value shall equal the COBRA premium, and shall be due on the 1st of each month, commencing with the month following the date of ineligibility. If the enrollee was required to provide notice to the Plan Administrator, within 60 days of the event under COBRA, the enrollee's coverage shall be retroactively terminated for failure to pay premiums. If required by COBRA, an enrollee shall be provided with a COBRA election notice which allows the person to elect to continue coverage retroactive to the date of ineligibility, provided, however, that coverage will retroactively terminate if the individual does not timely pay COBRA premiums.

FUNDING

Cost of the Plan. This is a self-funded benefit plan funded from the general assets of Ancon Construction Co., Inc. who shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application. The Plan may choose an online alternative as directed through the enrollment process.

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

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization within 31 days of your date of eligibility. If you fail to enroll within 31 days, you and your eligible Dependents must wait until open enrollment to enroll. No changes can be made to your Plan until the next annual open enrollment period except as described under the Special Enrollment section.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee is not automatically enrolled in this Plan. Enrollment must be received by the Plan Administrator no later than 31 days from birth to be eligible. Charges for covered nursery care and covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs. If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

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

If two (2) Employees (spouses to each other) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) Late Enrollment - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.
If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of

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

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

SPECIAL ENROLLMENT PERIODS

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, or meets a change in status under the Plan's Section 125 of the Internal Revenue Code as applicable. The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage, thus, the time between the dates a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals Losing other Coverage**. An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual;

(b) If required by the Plan Administrator, the Employee stated in writing at the time that enrollment for coverage was offered and that the other health coverage was the reason for declining enrollment;

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated; and

(d) The Employee or Dependent requests enrollment in this Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

(2) **Loss of Eligibility.** As used herein, "loss of eligibility" includes but is not limited to the following types of losses:

(a) Loss of eligibility under the other coverage due to divorce, dissolution, or legal separation. In this instance, the eligible Employee and any Dependent children would be eligible to enroll;

(b) Loss of eligibility under the other coverage due to cessation of Dependent status. In this instance, the eligible Employee, Spouse, and any Dependent children would be eligible to enroll;

(c) Loss of eligibility under the other coverage due to death of the Employee. In this instance, the eligible Employee (whose Spouse has died) and any Dependent children would be eligible to enroll;

(d) Loss of eligibility under the other coverage due to termination of employment or reduction of hours. In this instance, the eligible Employee, Spouse, and any Dependent children would be eligible to enroll;

(e) Loss of eligibility under the other coverage because the individual no longer resides in the service area. In this instance, the eligible Employee, Spouse, and any Dependent children would be eligible to enroll;

(f) Loss of eligibility under the other coverage because the other employer ceases to provide health care benefits to similarly situated individuals. In this instance, the eligible Employee, Spouse, and any Dependent children would be eligible to enroll.

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

(3) Dependent Beneficiaries. If:

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

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, designation of legal guardianship, or placement as foster child,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. In the case of marriage, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage and any Dependent child(ren) who is/are acquired as the result of the marriage, are permitted to enroll during this Special Enrollment Period. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption, placement for adoption, designation of legal guardianship or placement of a foster child. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31 day period.

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

(a) In the case of marriage, the date of marriage;

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

(c) In the case of a Dependent's adoption, placement for adoption, designation of legal guardianship, or placement of a foster child, the date of the adoption, placement for adoption, designation of legal guardianship or placement of a foster child, respectively.

(4) Individuals losing coverage under state sponsored Medicaid or Children's Health Insurance Program (CHIPRA). An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if either of the following conditions is met:

(a) The Employee or Dependent loses eligibility to participate in the state sponsored insurance program.

(b) The Employee or Dependent qualifies for a premium assistance subsidy offered by a state sponsored insurance program.

The Special Enrollment period is a period of 60 days and begins on the date of the qualifying event listed in items (a) and (b) above.

QUALIFIED MEDICAL CHILD SUPPORT ORDER OR QMCSO

The term "Qualified Medical Child Support Order" or "QMCSO" means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state administrative agency that:

(1) Creates, recognizes or assigns to a child of a covered Employee the right to receive Plan benefits either:

(a) Is made according to state domestic relations law (including a community property law) to provide child support or health benefit coverage to a child of covered Employee;

(b) Or enforces a law relating to medical child support described in section 1908 of the Federal Social Security Act with respect to the Plan

(2) Specifies the name and last known mailing address of the covered Employee and each child of that Employee covered by the judgment, decree, order, or agreement

(3) Specifies a reasonable description the type of coverage and benefits to be provided by the Plan to each child, or the manner in which the type of coverage and benefits are to be determined

(4) Specifies the time period to which the judgment, decree, order or agreement applies

(5) Specifies the Plan as the group health plan to which the judgment, decree, order or agreement applies

(6) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided in the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act.

If the Plan Administrator receives a court order or an order issued through a state administrative process requiring the Plan to provide medical coverage to your child, the Plan Administrator will follow the order only if it determines that the order is a Qualified Medical Child Support Order (QMCSO). The Plan Administrator will determine whether a medical child support order is a QMCSO. When the Plan receives a medical child support order from a court, the Plan Administrator will promptly notify the Employee and each child named in the order, in writing, of its receipt, and will deliver to each, at the address(es) listed in the order, a copy of the Plan's procedures for determining the qualified status of the order. The Plan Administrator will also notify each child named in the order of his or her right to designate a representative to receive copies of all notices he or she receives regarding the order. Within a reasonable period of time after the Plan Administrator will determine whether the order is a QMCSO and notify the Employee and each child named in the order, in writing, of the determination. The Plan Administrator will suspend payment of any benefit claims until the order is determined to be a QMCSO. If the order is determined to be a QMCSO, the specified children will become covered Dependents as of the first date to which the QMCSO applies as if the Employee had enrolled them in the Plan as of that date. This provision also applies to National Medical Support Notices (NMSN).

EFFECTIVE DATE

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

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

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

to take effect.

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

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants may request a certificate that will show the period of coverage under this Plan. If you would like a copy of Creditable Coverage from PHP TPA Services, simply call the phone number listed on your ID card, or write to PHP TPA Services at the address listed at the end of this document.

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

(1) Last day during which the Employee ceases to be a full-time Employee. This includes death or termination of Active Employment of the covered Employee. (See Continuation of Coverage)

(2) Date the Employee ceases to be in an Eligible Class.

(3) Date the Employee fails to make any required contribution of coverage when due.

(4) Date the Plan is terminated or, with respect to any benefit of the Plan, the date of termination of such benefit.

(5) Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan, by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Continuation During Periods of Employer-Certified Disability / Leave of Absence. A person may remain for a limited time if Active, Full-Time work ceases due to disability, or leave of absence. This continuance will end as follows:

For disability leave and leave of absence: The plan requires you utilize sick/vacation time concurrent with Family and Medical Leave (FMLA). Once this time frame is exhausted benefits will end unless COBRA is elected. Please refer to the Continuation of Coverage section for details.

For lay off: Health coverage may be extended for laid off Employees through a severance package given to the affected Employees. Whether a severance package is offered is at the discretion of the Employer.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. This Plan shall at all times comply, if applicable, with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor as amended.

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

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

effect for the Employee and/or his or her Dependents when Plan coverage terminated.

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

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

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

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

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

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

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

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

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

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

(4) The first date that a Dependent child ceases to be a Dependent as defined by the Plan (See Continuation of Coverage).

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

(6) Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan, by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

OPEN ENROLLMENT

Open enrollment is the period designated by the Employer during which the Employee may change benefit elections or enroll in the Plan if he did not do so when first eligible or does not qualify for a Special Enrollment Period. An open enrollment will be permitted once in a calendar year for a designated period. Advance notice will be provided to all Employees informing them of the time period they have to make an election, or change previous elections. A covered Employee who fails to make an election or to change enrollment during the open enrollment period will automatically

retain his or her present coverage. The effective date of coverage as the result of an open enrollment period will be the following January1st.

The Plan Administrator may waive service requirements for Employees and their eligible Dependents when employed by the Plan Sponsor if that employment is the result of a merger or acquisition.

ANCON CONSTRUCTION Co., INC.
SCHEDULE OF BENEFITS

HIGH DEDUCTIBLE HEALTH PLAN	NETWORK PROVIDERS AND OUT-OF-AREA	NON-NETWORK PROVIDERS
MAXIMUM BENEFIT AMOUNT	Unlimited unless otherwise stated below	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total, which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Single Coverage	$600	$1,200
Per Family Unit*	$1,500	$3,000
* The Deductible is Embedded. The $1,500 Network/$3,000 Non-Network Family Deductible must be met by each family member before benefits are paid for the entire family.		
Network and Non-Network deductibles cross apply.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR Includes Deductible, Coinsurance and Copays		
Per Covered Person	$2,500	$5,000
Per Family Unit	$4,800	$9,600
Network and Non-Network Out-of-Pocket maximums cross apply.		
The Plan will pay the designated percentage of Covered Charges until Out-of-Pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the Out-of-Pocket maximum and are never paid at 100%: Cost Containment Penalties, Charges in excess of Allowable Charges, and Ineligible Charges.		
COVERED SERVICES		
Ambulance – Air and Ground *For facility-to-facility air ambulance transports, Precertification is required through Sentinel Air Medical Alliance: 1-877-542-8828.*	80% after deductible	60% after deductible
Bereavement Counseling *15 visit family Maximum*	50% after deductible	
Cardiac Rehabilitation *Limited to 3 Days per Week unless Precertified*	80% after deductible	60% after deductible
Chiropractic Care Office visit / Spinal Manipulations and Adjustments	80% after deductible	
X-rays	80% after deductible	60% after deductible
Weekly visit maximum is 3. The calendar year visit maximum is 50. Per covered person calendar year maximum is $1,500. Per Family Unit calendar year maximum is $3,000.		
Clinical Trials (Routine Patient Costs)	80% after deductible	60% after deductible

HIGH DEDUCTIBLE HEALTH PLAN	NETWORK PROVIDERS AND OUT-OF-AREA	NON-NETWORK PROVIDERS
Convalescent Care- Skilled Nursing Facility *Precertification is required Limited to 60 days per calendar year.*	80% after deductible	60% after deductible
Diagnostic X-ray and Laboratory Including LabCorp providers	80% after deductible	60% after deductible
Dialysis	80% after deductible	60% after deductible
Precertification is required. For Zelis Providers: 100% of the lesser of (i) the Usual, Customary, and Reasonable Outpatient Dialysis Charge as defined in "Outpatient Dialysis Treatment" Section, (ii) the maximum allowable charge after all applicable deductibles and cost-sharing; and (iii) such charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.		
Durable Medical Equipment *Precertification is required for DME greater than $2,500.*	80% after deductible	60% after deductible
Home Health Care *Precertification is recommended. Limited to 100 days per calendar year*	80% after deductible	60% after deductible
Hospice Care *Precertification is recommended*	80% after deductible	60% after deductible
Hospital Care		
Inpatient Room & Board	80% after deductible	60% after deductible
Outpatient Services / Ambulatory Surgical Center	80% after deductible	60% after deductible
Emergency Room Services*	$200 copay, 80% after deductible	$200 copay, 80% after deductible
Use of the Emergency Room for a diagnosis that is not emergent in nature may not be covered. *Inpatient stays, refer to your ID card. Failure to precertify may result in a benefit payment reduction up to a $500.*		
Imaging (CT, PET, MRI, & MRA) *Precertification is required for MRI/CT/PET Scan – excludes Bone Density Studies*	80% after deductible	60% after deductible
Infertility *Covered up to diagnosis. Treatment is not covered.*	80% after deductible	60% after deductible
Injection and Infusion – 30-day supply *Precertification is required for injections/infusions over $1,500*	80% after deductible	60% after deductible
Implants *Precertification is required for select implants. Cochlear and bone anchored hearing aids are covered with no limits.*	80% after deductible	60% after deductible

HIGH DEDUCTIBLE HEALTH PLAN	NETWORK PROVIDERS AND OUT-OF-AREA	NON-NETWORK PROVIDERS
Maternity Charges- Employee & Covered Spouse		
Office Visit	$20 copay	60% after deductible
Routine Prenatal and Postnatal Services	80% after deductible	60% after deductible
Non-Routine Prenatal Services, Delivery and All Inpatient Care	80% after deductible	60% after deductible
Precertification is required for some maternity services. Cost sharing does not apply to certain preventive services. Dependent daughter pregnancy is covered.		
Breast Pump *Over the counter breast pump purchase is covered as deductible and coinsurance through DME.*	80% after deductible	60% after deductible
Mental Health and Substance Use Disorders *Coverage only available when treatment received from Licensed MD, PHD, LCSW, LMHC and other providers acting within the scope of their license.*		
Inpatient Physician and Facility	80% after deductible	60% after deductible
Outpatient Physician and Facility	80% after deductible	60% after deductible
Occupational Therapy	80% after deductible	60% after deductible
Prosthetics, Orthotics, Supplies, and Surgical Dressings *Shoe inserts are covered, custom molded only. Orthopedic shoes are covered if part of a brace or for a person with diabetes*.	80% after deductible	60% after deductible
Physical Therapy	80% after deductible	60% after deductible
Physician Services		
Primary Care Physician or	$20 copay, then 100% (In-network)	60% after deductible
Specialist Office Visit	$20 copay, then 80% after deductible (Out-of-area)	60% after deductible
X-ray and Lab	80% after deductible	60% after deductible
Surgery, Anesthesia, and Inpatient Visits	80% after deductible	60% after deductible
Urgent Care	$35 copay, then 100% (In-network) 80% after deductible (Out-of-area)	60% after deductible

HIGH DEDUCTIBLE HEALTH PLAN	NETWORK PROVIDERS AND OUT-OF-AREA	NON-NETWORK PROVIDERS
Prescription Drugs		
Retail - 30-day supply		
Generic	80% after deductible	Not covered
Formulary Brand	60% after deductible	Not covered
Non-Formulary Brand	60% after deductible	Not covered
Mail Order – 90-day supply		
Generic	80% after deductible	Not covered
Formulary Brand	60% after deductible	Not covered
Non-Formulary Brand	60% after deductible	Not covered
Specialty Drugs – 30-day supply*		
Generic	80% after deductible	
Formulary Brand	60% after deductible	
Non-Formulary Brand	60% after deductible	
Note: *Mail order is excluded from specialty drugs. Specialty Drugs must be filled at a specialty pharmacy.*		
*Brand when generic is available also costs the difference between generic and brand price unless Doctor orders "dispense as written." This additional cost will not apply to the out-of-pocket maximum amount.		
Preventive Care		
Routine Child (Birth to 24 months) • Routine Exams • Preventive Immunizations • ACA preventive services for children	$20 copay, then 100% no deductible (In-network), 80% after deductible (Out-of-area)	60% after deductible
Age 2 years and Older • Routine Exams • Preventive Immunizations • Colon/Prostate Screening including PSA • Colonoscopy *No age limit* • Fecal-Occult Blood Test • Routine Pap • Routine Mammograms *Age 40 and older - One (1) every calendar year* *Woman at risk - One (1) every calendar year for a woman with prior personal or family history of cancer.*	100% no deductible	60% after deductible

HIGH DEDUCTIBLE HEALTH PLAN	NETWORK PROVIDERS AND OUT-OF-AREA	NON-NETWORK PROVIDERS
Private Duty Nursing *Limited to 45 days per calendar year.*	80% after deductible	60% after deductible
Second Surgical Opinion	80% after deductible	60% after deductible
Speech Therapy *30 Visit Calendar Year Maximum*	80% after deductible	60% after deductible
Temporomandibular Joint *$1,000 Calendar Year Maximum*	80% after deductible	60% after deductible
Transplant - Organ and Tissue	*This plan has selected a fully insured transplant program. Coverage requirements and benefit limits are provided under a separate certificate of coverage. Details and copies of the Plan can be obtained through your employer.* Transplant Procedure Services, as defined in the Summary Plan Description, are excluded under the terms of this Plan. Transplant procedures may be covered under an ancillary insurance policy issued by Optum Managed Transplant Program. Please reference Optum Managed Transplant Program's certificate of coverage or contact Optum Managed Transplant Program Customer Service at 1-(800) 367- 4436.	
Wig after Chemotherapy *$200 Calendar Year Maximum*	80% after deductible	60% after deductible

HIGH DEDUCTIBLE HEALTH PLAN	NETWORK PROVIDERS AND OUT-OF-AREA	NON-NETWORK PROVIDERS

In the following examples charges for Non-Network Providers will be paid as if In-Network:

1) **Medical Emergency**: Charges for a Non-Network Provider will be reimbursed as if rendered by a Network Provider in the event of a Medical Emergency, only until a Covered Person's condition is stabilized. Once stabilized, any additional health services must be provided by a Network Provider in order to retain benefits at the Network level.

2) **Services received in a Network Facility**: If a Covered Person goes to a Network Facility, and receives care and treatment by a Provider that is not of his choice and is not part of the Network Provider Organization, those charges will be reimbursed as if rendered by a Network Provider.

3) **Services not available in a Network Provider Organization**: Eligible charges for services that are not available by a Network Provider will be reimbursed as if rendered by a Network Provider.

4) **Out of area**: Eligible charges for services rendered to Covered Persons residing more than 50 miles from a Network Provider for appropriate services will be reimbursed as if rendered by a Network Provider. In the event that the Covered Person was traveling outside of the coverage area, and provided that the reason for traveling is not to obtain medical services, Covered Charges for a Non-Network Provider will be reimbursed as if rendered by a Network Provider.

5) **Lab Services.** If a Covered Person has lab work taken from a Network Physician, but the Physician sends it to a Non-Network Facility for evaluation, those charges will be reimbursed as if rendered by a Network Provider.

Continuity of Care: This provision applies in the following situations:

- If the Plan changes networks, or
- a Network Provider terminates participation from the Plan's current Network.

In the event that a Covered Person is currently under active, ongoing care by a Provider that was a Network Provider and is no longer a Network Provider, the charges resulting from services rendered by that Provider will be deemed as having been rendered by a Network Provider until the earlier of:

- The date treatment is concluded (or diagnosis changes), or
- For a period no longer than 90 days, following the date in which the Provider is no longer a Network Provider, whichever occurs first.

MEDICAL BENEFITS

All benefits described in the Schedule of Benefits are subject to the exclusions and limitations described more fully in this document including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Allowable; and that services, supplies and care are not Experimental and/or Investigational. The meanings of the Capitalized terms are in the Defined Terms section of this document.

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

COPAY

Copay is the amount payable by the Covered Person for certain services, supplies or treatment rendered by a Network Provider. The service and applicable copay are shown in the Schedule of Benefits. The Covered Person selects a Network Provider and pays the Network Provider the copay. The Plan pays the remaining Covered Expenses at the Negotiated Rate. The copay must be paid each time a treatment or service is rendered. However, once the maximum out-of-pocket is reached, the copay will no longer apply.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits. A Covered Person with single coverage would need to satisfy their individual deductible amount as shown in the Schedule of Benefits section before benefits are paid. Covered Persons enrolled in family coverage must meet the family deductible before benefits are paid on any Covered Person in that family.

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

Network and Non-Network deductibles cross apply.

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT

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

When a Family Unit reaches the Out-of-Pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded under the Plan) for the rest of the Calendar Year.

Network and Non-Network out-of-pocket maximums cross apply

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator may allocate the deductible amounts to any eligible charges and apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be binding upon the Covered Person and all assignees.

Many times, claims for Covered Charges are not submitted in the same order in which they were incurred. Regardless of the order in which the claims were incurred, the copays, deductible and Out-of-Pocket limits will be applied to Covered Persons in the sequence that the claims were submitted and ready for payment.

COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service or supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care**. The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits.

Daily Room and Board and general nursing services, or confinement in an intensive care unit, not to exceed the applicable maximum limits shown:

Hospital Room and Board Charges	Average Semi-Private
Private Room Charges	Average Semi-Private
Intensive Care Units	Full Maximum Allowable Charge
Medically Necessary Isolation Room	Full Maximum Allowable Charge
Birthing Room	Full Maximum Allowable Charge
Single Bed Hospitals having only Private Rooms	Full Maximum Allowable Charge

(2) **Coverage of Pregnancy**. The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee, and covered Spouse. No Maternity Expense Benefits or benefits for Complications of Pregnancy if the charge was incurred prior to the effective date of coverage; or the charge was incurred after coverage is terminated.

Group health plans generally may not, under the Newborns' and Mothers' Health Protection Act (NMHPA), restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, the NMHPA generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under the NMHPA, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

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

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

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

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

(4) **Physician Care**. The professional services of a Physician for surgical or medical services including office and home visits, Hospital inpatient care, Hospital outpatient visits and exams, clinic care and surgical opinion consultations. Charges for surgical procedures will be a Covered Expense subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the

Allowable Charge for each additional procedure. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Charge percentage for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Allowable Charge.

(d) When anesthesia is used for Surgery and a certified registered nurse anesthetist (CRNA) and an anesthesiologist both charge for the procedure, the Allowable Charges for their individual billings will be reduced by 50% to make the services equal to a provider billing the services alone. Services of a Physician's Assistant (PA) may be further reduced.

(5) **Private Duty Nursing Care**. The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

(a) Inpatient Nursing Care – Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Limited to 45 days per Calendar Year.

(b) Outpatient Nursing Care. Outpatient nursing care is subject to the Home Health Care limitations and maximums. Outpatient private duty nursing care on a shift-basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

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

Charges made by a Home Health Care Agency for Medically Necessary care may include, but are not limited to:

(a) Part-time or intermittent nursing care by a Nurse.

(b) Medical/Social Services.

(c) Diagnostic Services.

(d) Nutritional Guidance.

(e) Home Health Aides.

(f) Medical supplies, drugs or other Medically Necessary services prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

Specifically excluded from coverage under the Home Health Care Plan are the following:

(a) Services and supplies not included in the Home Health Care Plan.

(b) Services of a person who ordinarily resides in the home of the Covered Person, or is a Close Relative of the Covered Person.

(c) Transportation services.

(d) Meals.

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

- Nursing care by a Registered Nurse, a Licensed Practical Nurse, a vocational nurse or a public health nurse who is under the direct supervision of a Registered Nurse.
- Physical therapy and speech therapy when rendered by a licensed therapist.
- Medical supplies, including drugs and biologicals and the use of medical appliances.
- Physician's services; services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

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

(a) **Ambulance**. Local Medically Necessary professional land and air ambulance service will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. Charges for ambulance services for convenience or for non-emergency are not an eligible expense.

(b) **Ambulatory Surgical Center or Minor Emergency Medical Clinic** if treatment has been rendered.

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

(d) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered when:

(i) under the supervision of a Physician;

(ii) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;

(iii) initiated within 12 weeks after other treatment for the medical condition ends; and

(iv) in a Medical Care Facility as defined by this Plan.

(e) **Chemotherapy and Radiation** treatment with radioactive substances. The materials and services of technicians are included.

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

(g) Medically Necessary **Diagnostic Services**, including x-ray examination or laboratory examination recommended by a Physician or surgeon for the diagnosis of a non-occupational Illness or Injury.

(h) **Dialysis –** treatment of acute renal failure or chronic irreversible renal insufficiency, for removal of

waste materials from the body. This includes hemodialysis and peritoneal dialysis.

(i) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. Reimbursement for rental to purchase will never exceed the purchase price. Charges for durable medical equipment must be:

(i) Medically Necessary and prescribed by the attending Physician;

(ii) For therapeutic use or specifically used for treatment of an Injury or Illness;

(iii) Suitable for use in the home; and

(iv) Exclusively for the Covered Person.

Repair or replacement of purchased durable medical equipment which is Medically Necessary due to normal use, or growth of a child is also covered. Routine maintenance or duplicate durable medical or surgical equipment rental is not an eligible expense.

Specifically excluded from coverage are expenses incurred for the rental or purchase of any type of air quality items such as an air conditioner or air purifier; bed related items such as therapeutic mattresses; bath related items; chairs, lifts and standing devices; fixtures to real property; car/van modifications; blood related items; and any other equipment or appliances.

(j) Treatment of **Mental Health and Substance Use Disorders**. Covered Charges for care, supplies and treatment of Mental Health and Substance Use Disorders including hospitalization, outpatient treatment and outpatient counselling provided by: Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.), Masters of Social Work (M.S.W.) or Licensed Mental Health Counselors (L.M.H.C.) or other Mental Health or Substance Use Disorder providers who are certified and licensed by the state in which they practice.

(k) **Injury to or care of the mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for oral surgical procedures such as, but not limited to:

- excision of tumors and cysts of the jaw, cheeks, lips, tongue
- repair due to injury of sound natural teeth within 6 months of injury
- surgery needed to correct accidental injuries to the jaws, cheeks, lips or tongue
- excision of benign bony growths of the jaw and hard plate
- external incision and drainage of cellulitis
- incision of sensory sinuses, salivary glands or ducts
- removal of partially or completely unerupted impacted teeth
- excision of tooth root without extraction

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(l) The initial purchase, fitting and repair of fitted **orthotic devices** which replace body parts. The charge for the repair or replacement will be considered a Covered Expense when the expense for the repair or replacement of the appliance was incurred as a result of the maturation of a covered Dependent child; or when the expense for the repair or replacement of the appliance is deemed Medically Necessary.

(m) Prosthetics, Orthotics, Supplies and Surgical Dressings. Prosthetic devices (other than dental)

to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices but excluding orthopedic shoes and other supportive devices for the feet.

(n) **Oxygen.** Charges for oxygen and other gasses and their administration.

(o) **Prescription Drugs** (as defined). Please refer to Prescription Drug Section for coverage and exclusions. All prescription drugs are subject to limitation specified in the Prescription Drug section. FDA-approved drugs, including self-injectable drugs, are covered under the medical portion of this Plan unless specifically covered under the Prescription Drug program or specifically stated elsewhere in this Plan.

(p) **Rehabilitation Therapy – Occupational, Physical and Speech.** Inpatient and outpatient occupational, physical and speech therapy for Medically Necessary treatment or acute Illness or Injury are covered only if and to the extent that significant potential exists for progress toward a previous level of functioning. Acute is defined as having rapid onset, severe symptoms and a defined course.

(q) **Respiratory/Inhalation Therapy.** The introduction of dry or moist gases into the lungs, for treatment purposes.

(r) **Routine Preventive Care**. Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

(s) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts. The charge for the repair or replacement will be considered a Covered Expense when the expense for the repair or replacement of the appliance was incurred as a result of the maturation of a covered Dependent child; or when the expense for the repair or replacement of the appliance is deemed Medically Necessary.

(t) **Pulmonary Rehabilitation Therapy.** Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

(u) **Reconstructive Surgery**. Charges for cosmetic and reconstructive surgery when such surgery resulted from:

(i) An injury;

(ii) A Congenital Birth Defect; or

(iii) Surgical removal of breast tissue as a result of Illness.

Under the Women's Health and Cancer Rights Act (WHCRA) for a Covered Person who is receiving benefits under the Plan as a result of a mastectomy and who elects breast reconstruction, charges for the following procedures will be considered Covered Expenses:

(i) Reconstruction of the breast on which a mastectomy has been performed;
(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(iii) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

(v) **Spinal Manipulation/Chiropractic** services by a licensed M.D., D.O. or D.C. Chiropractic therapy is intended to correct by manual or mechanical means structural imbalance or subluxation to remove

nerve interfaces from or related to distortion, misalignment or subluxation of the vertebral column. X-rays and manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Chiropractic Therapy.

(w) **Sterilization** procedures.

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

(y) **Temporomandibular Joint (TMJ)** is payable the same as any other illness up to the limits listed on the Schedule of Benefits.

(z) **Urgent Care Services.** Urgent Care is the treatment of an unexpected Sickness or Injury that is not life or limb threatening, but requires prompt medical attention. Urgent Care services are not the same as an Emergency Illness and do not call for the use of a Hospital Emergency room. This benefit should be used for minor medical Emergencies and is not meant to replace the Covered Person's family Physician. **NOTE:** Emergency Services rendered at an Urgent Care Facility will be paid according to the "Hospital Care/Emergency Room" benefit payment level.

(aa) **Well Newborn Nursery/Physician Care.**

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

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

The benefit is limited to Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth. Charges for covered **Routine Nursery Care** will be applied toward the Plan of the newborn child.

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth. Charges for covered **Routine Physician Care** will be applied toward the Plan of the newborn child.

(bb) Charges associated with the purchase of a **wig after chemotherapy**.

COST MANAGEMENT SERVICES

PRECERTIFICATION AND COST MANAGEMENT SERVICES PHONE NUMBER
(877) 608-2200

Please refer to the Employee ID card for the Cost Management Services phone number.

The patient or family member must call this number to receive certification of certain Cost Management Services. To avoid a reduction of benefits please call at least 5 business days before hospitalization or within 48 hours of emergency admission.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket limit.

UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

- **In-Patient Hospitalizations**

The Plan shall be deemed to automatically be amended to conform to any updates in the precertification list as determined by the precertification company.

(b) Retrospective review of the Medical Necessity of Hospital services,

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

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

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

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

NOTE: Precertification determines the Medical Necessity of a procedure and length of Hospital Stay required. Precertification does not guarantee eligibility or payment of benefits. It is the Covered Person's responsibility to verify benefits are covered under the Plan before services are rendered. Questions regarding eligibility and benefit coverage should be directed to the Claims Administrator.

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

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card at least 5 days before services are scheduled to be rendered with the following information:

(a) The name of the patient and relationship to the covered Employee
(b) The name, unique ID number and address of the covered Employee
(c) The name of the Employer
(d) The name and telephone number of the attending Physician
(e) The name of the Medical Care Facility, proposed date of admission, and proposed length of stay and
(f) The diagnosis and/or type of surgery

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility employee or attending Physician must contact the utilization review administrator within 48 hours of the first business day after the admission, however no penalty will be assessed for failure to comply.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. Failure to follow this procedure may reduce reimbursement received from the Plan.

If the Covered Person does not receive authorization or approval as explained in this section, the benefit payment will be reduced by $500, except for a medical emergency.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facility and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND SURGICAL OPINION

If a Physician recommends that a Covered Person have a surgical procedure, the Covered Person may elect to obtain a second opinion from another Physician. The Physician rendering the second opinion must be qualified to render such a service, either through conference, specialist training, education or similar criteria and must not be affiliated in any way with the other Physician. The cost of the second surgical opinion will be paid as shown on the Schedule of Benefits.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients, explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

(1) personal support to the patient;

(2) contacting the family to offer assistance and support;

(3) monitoring Hospital or Skilled Nursing Facility care;

(4) determining alternative care options; and

(5) assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient or patient's legal representative when patient is incapacitated, must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

An alternate treatment plan should meet the following criteria:

(1) The treatment must be medically indicated and necessary for the condition being treated.

(2) The treatment must not be experimental or investigational.

(3) The treatment must be cost-effective to both the member and the Plan.

(4) The treatment must be provided as an alternative to an otherwise covered expense under the Plan.

The Plan shall have the right to waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrifice to the quality of patient care. Alternate treatment will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Covered Person or any other Covered Person.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient chooses not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

PLAN EXCLUSIONS

Note: Generally, exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

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

(1) **Abortion**. Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy, a spontaneous miscarriage or the Pregnancy is the result of rape or incest.

(2) **Charges missed appointments / completion of forms.** Charges for: failure to keep a scheduled visit. completion of a claim form; attending Physician statements; or requests for information omitted from an itemized billing.

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

(4) **Court Ordered testing/treatment.** Court ordered testing/treatment/rehabilitation regardless of whether or not the Covered Person is found guilty or any wrongdoing. This exclusion applies whether or not the Covered Person is charged or convicted of the activity or offense. It also applies for any medical condition, mental nervous disorders, substance use disorders, or chemical dependency.

(5) **Cosmetic Surgery and Procedures**. Charges in connection with surgery or therapy performed mainly to change a person's appearance unless such treatment is the result of an Injury sustained while covered under this Plan; or to correct a congenital anomaly of a child; or is for breast reconstruction following a mastectomy.

(6) **Custodial care**. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care. This includes services of personal care attendants.

(7) **Educational**. Unless Medically Necessary and otherwise covered under a specific provision of the Plan, charges for services or supplies that are primarily educational or behavioral, including but not limited to, services or supplies used to treat conditions, learning disabilities, behavioral problems, intellectual disabilities, or senile deterioration beyond the period necessary for diagnosis.

(8) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Maximum Allowable Charge. The Plan Administrator has the discretion to examine and audit billed charges and determine what amounts are excluded due to being above the Plan's Maximum Allowable Charge. The Plan Administrator may perform such examination or audit personally or may enlist the services of a third party to perform these services.

(9) **Experimental or not Medically Necessary**. Care and treatment that is experimental, investigational or not Medically Necessary. This includes services:

- not accepted as standard medical treatment for the illness, injury or sickness being treated by physicians practicing the suitable medical specialty,
- which are the subject of scientific or medical research or study to determine the treatment's effectiveness and safety,
- which have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services Food and Drug Administration, or any comparable state governmental agency and the Center for Medicare and Medicaid Services as approved for reimbursement under Medicare, or
- are performed subject to the Covered Person's informed consent under a treatment protocol that

explains the treatment or procedures as being conducted under a human subject study or experiment.

(10) **Eye care**. Radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to initial purchase of eyeglasses or contact lenses following cataract surgery.

(11) **Foot care**. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(12) **Foreign travel**. Care, treatment or supplies out of the United States if travel is for the sole purpose of obtaining medical services.

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

(14) **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a hazardous hobby or activity. A hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature that the Plan Administrator determines to be unusual or exceptional, characterized by a significant threat of danger or risk of bodily harm. Examples include, but are not limited to, reckless operation of machinery, travel to countries with advisory warnings, and use of weapons and explosives. A hobby or activity may also be considered hazardous if it is a hobby or activity rendered hazardous by the use of mind-altering substances, recklessness, or other aggravating factors.

(15) **Hearing aids and exams**. Charges for services, supplies in connection with hearing aids, exams and there fitting, or such similar ad devices, unless the loss of hearing is a result of a surgical procedure. However, such expense will be considered a Covered Expense only to the extent of the least expensive service, supply or procedure which will correct the condition.

(16) **Illegal acts**. For any Injury or Sickness which is incurred while taking part, while attempting to take part, or as the result of taking part in any illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. The Plan Administrator has the sole discretion to determine whether a particular act constitutes an illegal act. This exclusion does not apply if the Injury or Sickness (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

(17) **Illegal drugs or medications**. Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from or incurred during that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. A person will be considered under the influence of an illegal drug if use of the drug by the Covered Person is established by a laboratory test. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the Injury or Sickness (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions.

(18) **Incarcerated.** For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

(19) **Infertility**. Care, supplies, services and treatment for infertility, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, gamete intrafallopian transfer (GIFT) or any similar procedure.

(20) **Maintenance Therapy.** Expenses for maintenance therapy of any type when the individual has reached the maximum level of improvement.

(21) **Medicare Responsible.** For which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Covered Person had applied for Parts A, B and/or D, except, as specified elsewhere in the document or as otherwise prohibited by federal law. If the Covered Person has not enrolled in Medicare Part B, we will calculate benefits as if they had enrolled when allowed by federal law.

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

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

(24) **Non-Network Provider Fee Forgiveness.** Covered Persons are required under this Plan to pay the applicable cost sharing which includes the Deductible, Copay or Coinsurance as shown on the Schedule of Benefits. If a non-network: medical provider; manufacturer; service provider; or other third party (other than family) waives or reduces the Covered Person's cost sharing portion, the cost sharing accumulators shall be adjusted to reflect the actual amount paid by the Covered Person.

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

(26) **No Physician recommendation**. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(27) **Not specified as covered**. Non-traditional medical services, treatments or supplies which are not specified as covered under this Plan.

(28) **Obesity**. Weight control, malabsorption syndrome, or the result of Morbid Obesity, including surgery for construction, reconstruction, or repair of a gastric bypass as a result of such condition.

(29) **Occupational**. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment regardless of whether or not the Covered Person is covered by workers compensation insurance or liability insurance.

(30) **Orthopedic Shoes.** For orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet

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

(32) **Provider Error**. Charges for care, supplies, treatment, and/or services that are required as a result of unreasonable or preventable Provider error.

(33) **Reasonably Preventable**. Care, treatment, services, or supplies for any adverse event that is reasonably preventable which occurs while the Covered Person is under the care of a Physician or facility. Such events include, but are not limited to, surgery on the wrong body part, a foreign object left in patient after surgery, an intravascular air embolism, blood incompatibility, stage 3 or 4 pressure ulcers, electric shock, burn, or fall while confined to facility. The Plan Administrator retains the sole discretion to determine when an event is reasonably preventable.

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

(35) **Replacement or duplicate equipment**. Replacement or duplication of durable medical equipment such as braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional, as set forth in the Medical Benefits Section.

(36) **Routine care**. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(37) **Self-Inflicted**. Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury of Sickness (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

(38) **Services before or after coverage**. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(39) **Sex changes**. Care, services or treatment for non-congenital transsexualism, gender dysphoria, sexual reassignment, sexual dysfunctions or inadequacies. This exclusion includes medications, implants, hormone therapy, Surgery, or medical treatment.

(40) **Surrogate parenting.** Maternity charges incurred by a Covered Person acting as a surrogate mother are not Covered Charges. For the purpose of this plan, the child of a surrogate mother will not be considered a Dependent of the surrogate mother or her Spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth.

(41) **Transplant procedures.** Transplant Services covered under the Transplant Policy are excluded under this Plan. For purposes of reference, for all questions regarding Transplant and Rescue Procedures, including all prior authorizations for these services, please contact Optum Managed Transplant Program Customer Service at 1-(800) 367-4436, For Transplant-related health services received before and after the "benefit period" as defined in the Optum Managed Transplant Program Certificate of Coverage; any other transplant-related expenses not covered under the Optum Managed Transplant Program Certificate of Coverage; and Health care services, received at any time, which are not related to a transplant, such services may be considered according to the terms, limits, exclusions and conditions of this health plan.

Transplant Drugs. Transplant Procedure Services, as defined in the Summary Plan Description are excluded under the terms of this Plan. Transplant drugs may be covered under an ancillary insurance policy issued by Optum Managed Transplant Program. Please reference Optum Managed Transplant Program's certificate of coverage or contact Optum Managed Transplant Program Customer Service at 1-(800) 367-4436.

(42) **Vocational.** Vocational testing and training.

(43) **War**. Charges incurred in connection with the care or treatment of any sickness contracted or injury sustained subsequent to the effective date of the Plan which results from war, declared or undeclared, or any act of war, invasion, hostility, riot, rebellion, insurrection or aggression.

With respect to any Injury, Illness, or Sickness which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment to the victim of the Injury, Illness, or Sickness if the Injury, Illness, or Sickness results from an act of domestic violence or a documented medical condition.

PRESCRIPTION DRUG BENEFITS

Charges for Prescription Drugs that are not indicated as covered items nor as Expenses Not Covered under this Prescription Drug Benefits section and also are not listed under the Plan Exclusions section, may be considered under the Medical Benefits section.

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

Percentages Payable

The percentage payable about is applied to each covered pharmacy drug of mail order drug as shown in the Schedule of Benefits. Any one retail prescription is limited to a thirty (30) day supply and any one mail order prescription is limited to a ninety (90) day supply.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Personal Importation Program

The Personal Importation Program provides international prescription drugs for individual U.S. consumer use. This approach is completely voluntary by the Covered Person and is available for many of the brand name prescription drugs, many of which are manufactured in other countries already.

Specialty Pharmacy

The Specialty Pharmacy is available to Participants who use Specialty Drugs. "Specialty Drugs" are Prescription Legend Drugs which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a Physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Specialty Drug Prescriptions are limited to a thirty (30) day supply and are subject to the applicable benefit percentage as shown in the Schedule of Benefits.

Covered Prescription Drugs

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law.

(2) Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Injectable drugs and the charge for administration when in lieu of an office visit charge. diabetic test strips when prescribed by a Physician.

(4) Allergy serum and the physician charge for the injection (when in lieu of an office visit charge).

Limits To This Benefit

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

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Rebates, Coupons or Discounts

Covered Persons are required under this Plan to pay the applicable cost sharing, which includes the Deductible, Copays or Coinsurance as shown on the Schedule of Benefits. The requirement to pay the applicable cost sharing (Deductible, Copays or Coinsurance) cannot be waived by a Provider, a Pharmacy or anyone else under any fee forgiveness, zero out-of-pocket program, discount program, copay assistance, rebates or similar arrangement. If a Provider, Pharmacy, or third party (other than family) waives, discounts, reduces, rebates or directly/indirectly pays the Covered Person's required cost sharing (Deductible, Copays, Coinsurance) for a particular service, product or prescription, such claims shall be adjusted to reflect the actual amount paid by the Covered Person. If at the end of the Plan's Benefit Year there are no additional claims submitted for processing, no further deductible or coinsurance will apply.

Expenses Not Covered

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

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

(2) **Appetite suppressants**. A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

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

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

(5) **Drugs used for cosmetic purposes**. Charges for drugs used for cosmetic purposes such as medications for hair growth or removal.

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

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

(8) **Growth hormones**. Charges for drugs to enhance physical growth, or athletic performance or appearance.

(9) **Impotence.** A charge for impotence medication.

(10) **Infertility**. Drugs for the treatment of infertility.

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

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

(14) **Medical exclusions**. A medication prescribed to treat a condition excluded under Medical Plan Exclusions.

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

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

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

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

DEFINED TERMS

Accident means a sudden and unforeseen event which:

- Causes injury to the physical structure of the body; or
- Results from an external agent or trauma; or
- Is definite as to the time and place; or
- Happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences. An accident does not include harm resulting from a disease or sickness and will be determined by the Plan Administrator.

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

Actively at Work is an Employee who is capable of carrying out their regular job duties and who is present at their place of work. Additionally, Employees who are absent from work due to a health-related absence or disability and those on maternity leave, scheduled vacation, or Company approved leave of absence are considered Actively At Work.

Adverse Benefit Determination – A denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, or to provide or make payment that is based on a determination of Participant's or beneficiary's eligibility to participate in a plan, with respect to the Employee Benefit Plan. Included is failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as 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.

Allowable Expense or **Allowable Charges** means any medically necessary item of expense, the charge for which is reasonable, regular and customary, at least a portion of which is covered under at least one (1) of the Plans covering the person for whom claim is made. When a Plan provides Benefits in the form of services, rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a paid Benefit.

Alternate Recipient – Any child of a Participant who is recognized under a medical child support order as having a right to enrollment under the Employee Benefit Plan. A person who is an Alternate Recipient under a QMCSO shall be considered a beneficiary under the Plan.

Ambulance - Emergency transportation in a specially equipped certified vehicle from the Covered Person's home, the scene of an accident or a medical emergency to a Hospital, between Hospitals, between a Hospital and an extended care facility or from a Hospital or an extended care facility to the Covered Person's home.

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

Amendment means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person, or persons, as designated by the Plan Administrator.

Assignment of Benefits means an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Plan Participant, 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. A Participant can only assign the right to payment, but cannot assign any other rights, including but not limited to, any rights under ERISA, the right to request information, the right to appeal and/or the right to sue for benefits or payment.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Benefit Year means the 12-month accumulation period for deductibles, out-of-pocket limits and maximum dollar or visit

limits on the Plan. For Ancon Construction Co., Inc., the benefit year is the calendar year.

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

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

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Claims Administrator refers to the person or firm contracted by the Plan Sponsor, to provide administration services to the Plan, in connection with the operation of the Plan, or any other functions, including processing and payment of claims. The Claims Administrator is not a fiduciary of the Plan and simply follows the directives of the Plan's sponsor in performing services to the Plan.

Clean Claim means one that can be processed without obtaining additional information from the provider of the service or from a third party.

Close Relative is the Employee's spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the Employee's spouse.

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

Coinsurance means:

- Plan Coinsurance: The Plan's benefit percentage payable of the Provider's Reasonable Charge for eligible expenses. This amount is the Plan's responsibility.
- Patient Coinsurance: The remaining percentage of the Provider's Reasonable Charge for eligible expenses not payable by the Plan. This amount is the Covered Person's responsibility.

Complications of Pregnancy is a disease, disorder or condition which is diagnosed as distinct from pregnancy, but is adversely affected by or caused by pregnancy. Some examples are: Intra-abdominal surgery (but not elective Cesarean Section), Ectopic pregnancy, Toxemia with Convulsions (Eclampsia), Pernicious vomiting (Hyperemesis gravidarum), Nephrosis, Cardiac Decompensation, Missed Abortion, and Miscarriage. These conditions are not included: false labor, occasional spotting, rest during pregnancy even if prescribed by a physician; morning sickness, or like conditions that are not medically termed as complications of pregnancy.

Confinement or Concurrent Care is a continuous stay in a hospital, treatment center, extended care facility, hospice, or birthing center due to an Illness or Injury diagnosed by a Physician. Later stays shall be deemed part of the original confinement unless there was either complete recovery during the interim from the Illness or Injury causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the Illness or Injury causing the initial stay.

Copay is a cost sharing arrangement whereby a Covered Person pays a set amount for a specific service at the time the service is provided.

Cosmetic Procedures refers to a procedure performed solely for the improvement of a covered person's appearance, rather than for the improvement or restoration of bodily function.

Covered Expenses or **Covered Charges** are medically necessary services, supplies or treatments that are recommended or provided by a Physician, professional provider, or covered facility for the treatment of an Illness or Injury and that are

not specifically excluded from the coverage herein. Covered Expenses shall include specified preventive care services.

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

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

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

Deductible means a specified dollar amount of Covered Expense not payable under the Plan which must be incurred in each Deductible accumulation period before Covered Expenses in excess of such amount can be considered for payment at the Benefits Percentage.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent means:

(1) The term "Spouse" shall mean the person who is legally recognized as the marital partner of the covered Employee. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A Covered Employee's child who meets all of the following conditions:

- Is a natural child, foster child, a legally adopted child, step-child in the custody of the covered Employee, child placed under the legal guardianship of the covered Employee or a child placed in the home of the covered Employee by the relevant agency prior to the date the adoption of the child by the covered Employee becomes final;

  A child shall be considered placed in the home of the covered Employee on the date the covered Employee assumes, and for the period the covered Employee retains, a legal obligation for support of the child in anticipation of adoption by the covered Employee.

- Is within the age limit specified in this Plan Document.

  The age limitation above is also waived for any intellectually or physically disabled child covered under the Plan on the attainment of the otherwise limiting age while the child continues to be incapable of self-sustaining employment, thereby meeting the definition of Totally Disabled, is chiefly dependent upon the covered Employee for support and maintenance and is unmarried. Proof of such incapacity must be furnished by the covered Employee to the Plan Administrator within thirty-one (31) days of such limiting age and as frequently thereafter as required by the Plan Administrator, but not more frequently than annually after the two (2) years period following the child's attainment of that limiting age.

Diagnosis means a medical condition estimated by written opinion of a Physician, and as classified in the International Classification of Disease.

Dialysis Facility is a facility (other than a hospital) whose primary function is the provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

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

appropriate for use in the home.

Effective Date of Coverage shall mean the date coverage is effective with respect to a Covered Person.

Emergency Illness is a medical condition that is not accident related and that is characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in (1) permanently placing the Covered Person's health in jeopardy, (2) causing other serious medical consequences; (3) causing serious impairment of bodily function; or (4) causing serious and permanent dysfunction of any bodily organ or part.

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

Employer or Company is Ancon Construction Co., Inc. and affiliates, if any, as designated by the Plan Administrator who are participating in this Employee Benefit Plan.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day after the Waiting Period.

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

Essential Health Benefits means, to the extent covered under the Plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services
including oral and vision care.

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

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

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

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

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

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

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the

written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure. Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

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

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

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

Genetic Information means information about the genetic tests of an individual or their family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

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

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

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

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

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

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

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

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by the Centers for Medicare and Medicaid Services (CMS) as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a

staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

(1) A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

(2) A facility operating primarily for the treatment of Substance Use Disorders if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (RN.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy for a covered Employee or covered Spouse.

Incurred Expense is a charge which the Covered Person is legally obligated to pay and shall be deemed to be incurred on the date the purchase is made or on the date the service is rendered for which the charge is made. Anticipated expenses are not incurred expenses. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Infertility means incapable of producing offspring.

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

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes coronary care unit or an acute care unit. It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Leave of Absence means any absence authorized by the Employer, under the Employer's standard personnel practices, provided that all persons under similar circumstances are treated alike in the granting of such Leaves of Absence, and provided further that the Participant returns within the period of authorized absence, as specified by the Employer.

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

Life Threatening Illness means a chronic, usually incurable, illness which has the effect of considerably limiting a Covered Person's life expectancy. Examples include, but are not limited to, cancer, diabetes, neurological conditions and heart disease.

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

Maximum Allowable Charge or **Allowable Charge** means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) may be the lesser of:

- The Usual and Customary amount,
- The Reasonable amount,
- The Allowable Charge specified under the terms of the Plan,
- The negotiated rate established in a contractual arrangement with a Provider, or
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

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

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

Medically Necessary (Medical Necessity): A service, supply, or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A service, drug, or supply shall not be considered as Medically Necessary if it:

- is Experimental, investigational, or furnished in connection with medical research;
- is provided solely for the convenience of the patient, the patient's family, Physician, Hospital or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;
- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration, except as permitted by regulations drafted in accordance with applicable federal law; or
- involves a service, supply or drug not approved for reimbursement by the Centers for Medicare and Medicaid Services or any successor organization.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medical Record Review is a formal examination of patient data and personal medical records for purposes, including but not limited to, validating a diagnosis, settling billing disputes, or to facilitate paying a health claim.

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

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

Morbid Obesity is a diagnosed condition which is defined as weight in excess of two (2) times the ideal weight for frame, age, height and gender, as specified in the 1983 Metropolitan Life Insurance Tables; or a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes; or a body mass index of at least forty (40) kilograms per meter

squared without comorbidity.

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

Network Provider means any health care provider designated as such by the Plan Administrator. A list of Network Providers will be provided to any Plan member who is eligible for this coverage.

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

Non-Network Provider means any health care provider who is not designated as a Network Provider by the Plan Administrator.

Occupational Therapy is treatment rendered as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. Benefits are not provided for diversion, recreational and vocational therapies (such as hobbies, arts, and crafts).

Orthotic Appliance means an external device intended to correct any defect in form or function of the human body.

Out-Of-Pocket Limit is the Covered Person's responsibility to pay a specified dollar amount of Covered Expense incurred each Calendar Year, which is the accumulation of the Covered Person's applicable Patient Coinsurance, and may also include other expenses as stated in the Schedule of Benefits. When the Out-Of-Pocket Limit is met, unless specified otherwise, any remaining Covered Expenses will then have a Plan Coinsurance payable of 100%, except for those expenses listed in the Schedule of Benefits as not applicable to the Out-Of-Pocket Amount.

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

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

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

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

Plan means Ancon Construction Co., Inc. Employee Benefit Plan, which is a benefits plan for certain employees of Ancon Construction Co., Inc., and is described in this document.

Plan Administrator is Ancon Construction Co., Inc. and is the entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other services for the Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year, which is a short Plan Year.

Pre-Admission Testing means a test performed on an outpatient basis prior to scheduled Hospitalization for inpatient or

outpatient Surgery, provided each of the following requirements are satisfied: (1) such tests are done within a reasonable period of time prior to Hospitalization; (2) admission is to Hospital performing the tests; (3) tests are related to the Surgery; (4) tests are recent enough to be useful upon admission; and (5) the Hospital bill itemizes the pre-admission tests.

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

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

Provider means Physician or Medical Care Facility as defined in this section.

Qualified Medical Child Support Order (QMCSO) means a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction, and satisfies all of the following requirements:

(a) The order specifies your name and last known address, and the child's name and last known address;

(b) The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

(c) The order states the period to which it applies; and

(d) The order specifies each plan that it applies to.

The QMCSO may not require the Plan to provide coverage for any type or form of benefit not otherwise provided under the Plan.

Qualifying Payment Amount (QPA) means the median of contracted rates for a specific service in the same geographic region within the same benefit market as of January 1, 2019. The rate will be adjusted annually per the Consumer Price Index for All Urban Consumers (CPI-U).

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

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) in the provision of service or in billing, and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan,

to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Reasonably Preventable Event is a serious reportable adverse event that is reasonably preventable through application of evidence-based guidelines. These errors include, but are not limited to, the following: Surgery on wrong body part, foreign object left in patient after surgery, intravascular air embolism, blood incompatibility, stage 3 or 4 pressure ulcers, electric shock, burn, or fall while confined to a facility.
Rescission means a discontinuance of coverage under the benefit plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the benefit plan if: (a) The cancellation or discontinuance of coverage has only a prospective effect; or (b) the cancellation or discontinuance of coverage is effective retroactively to the extent attributable to a failure to timely pay required contributions towards the cost of coverage.

Sickness means the condition upon which the following applies:

- When the body's organs do not function normally;
- When a temporary ailment reduces the body's ability to function normally;
- Pregnancy of a Covered Employee or Covered Spouse.

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

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

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

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

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

(5) It has an effective utilization review plan.

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

(7) It is approved and licensed by Medicare.

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

Specialty Drugs are prescription legend drugs which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a Physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Speech Therapy is active treatment for improvement of an organic medical condition causing speech impairment. Treatment must be either post-operative or for the convalescent stage of an Illness or Injury.

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

or subluxation of, or in, the vertebral column.

Spouse means the wife or husband of the covered Employee, not legally separated or divorced from the covered Employee.

Substance Use Disorder is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Surgery means any of the following medical procedures:

(1) To incise, excise, or electrocauterize any organ or body part, except for dental services.

(2) to repair, revise, or reconstruct any organ or body part.

(3) To reduce by manipulation a fracture or dislocation.

(4) Use of endoscopy to explore for or to remove a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or ureter.

(5) To puncture or aspirate.

Temporomandibular Joint (TMJ) Syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to, orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means in the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer. In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care means a serious medical condition, or the existence of symptoms, which:

- arise suddenly and unexpectedly; and
- are neither life threatening nor likely to cause permanent damage or disability; and
- would lead an ordinarily prudent person to seek medical advice or treatment for the condition.

Urgent Care Center is a facility whose primary function is the provision of Urgent Care, other than a Physician's office; an emergency facility; a facility physically attached to a Hospital emergency room.

Usual and Customary Charge means Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a Physician, therapist, nurse, Hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Workers Compensation is a fund administered under any Workers’ Compensation, Occupational Disease Act or Law or any other act or law of similar purposes to which the Company contributes, which provides the Employee with coverage for job-related accidental Injuries and Illnesses.

With respect to any Injury, Illness, or Sickness which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment to the victim of the Injury, Illness, or Sickness if the Injury, Illness, or Sickness results from an act of domestic violence or a documented medical condition.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Assignments. For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copays and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Participant and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copays, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will 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 may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, 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. **A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.**

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

(1) Obtain a claim form from the Personnel Office or the Plan Administrator.

(2) Complete the Employee portion of the form. **ALL QUESTIONS MUST BE ANSWERED**.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. **ALL BILLS MUST SHOW**:

- Name of Plan
- Group Number 8080
- Employee's name and Unique ID#
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services and charges

(5) Send Non-Network claims to:

PHP TPA Services
PO Box 9648
Fort Wayne, Indiana 46899
(260) 436-9495

When Claims Should be Filed. All claims for benefits under this Plan shall be submitted to the Plan Administrator on forms furnished for that purpose by the Plan Administrator. Such claim form, along with a billing statement or invoice of the Covered Charges, must be submitted within six (6) months after the occurrence or commencement of any loss covered by this Plan. Failure to submit written proof of loss with respect to a claim for Covered Charges before the deadline for submission of claims shall invalidate that claim, unless the affected Covered Person demonstrates to the satisfaction of the Plan Administrator that it was not reasonably possible to furnish such proof within the required time and that proof was furnished as soon as was reasonably possible.

Appointment of Authorized Representative. A claimant 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 claimant, 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.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a claimant's treating health care practitioner to act as the claimant's authorized representative without completion of the authorized representative form.

Should a claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the claimant, unless the Plan Administrator is otherwise notified in writing by the claimant. A claimant can revoke the authorized representative at any time. A claimant 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 of a similar form. An assignment of benefits by a claimant shall not be recognized as a designation of the Provider as an authorized representative.

CLAIM PROCEDURES

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

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

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

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

Notification to claimant of benefit determination	72 hours

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

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours

Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

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

Pre-Service Claim

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

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

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days

Ongoing courses of treatment:

Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	30 days

Post-Service Claim

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

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

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim, the following timetable applies:

Response by claimant	45 days
Review of adverse benefit determination	60 days

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be orally followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination.
(2) Reference to the specific Plan provisions on which the determination was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an

explanation of why such material or information is necessary.

(5) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 or ERISA following an adverse benefit determination on review.

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

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

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

Internal Appeals (This section applies to all claims)

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

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

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

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

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

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

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

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

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care

professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

External Review

As defined by the No Surprises Act, External Review provisions apply only to non-network emergency services claims; non-network ancillary provider claims when services are performed at a network facility; and non-network air ambulance claims.

Federal law requires that group health care plans provide a Participant the right to request an external review after receiving a notice of final internal adverse benefit determination. This section describes the External review standards implemented by this Plan.

Right for External Review. A Participant shall have the right to request an external review after receiving a final internal adverse benefit determination. The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

(1) Any eligible Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a Plan 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; its determination that a treatment is Experimental or Investigational; its determination whether a claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a Plan is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

(2) An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

(3) A Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).

Deadline to Request. The Participant must request an external review within four months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination. If the last filing date would fall on a Saturday, Sunday or a federal holiday, the last filing date is extended to the next date that is not Saturday, Sunday or a federal holiday.

Preliminary Review. Within five business days following the receipt of external review request, the Plan Administrator, or its delegee, will complete a preliminary review of the external review request to determine whether:

(1) The Participant 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;

(2) The final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(3) The claimant has exhausted the Plan's internal review process (unless the claimant was not required to exhaust); and

(4) That the claimant has provided all information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan Administrator will issue a notice and notification in writing to the claimant. If the request is complete, but not eligible for external review, such notice will

include the reasons for ineligibility. If the request is not complete, such notification must describe the information or materials needed to make the request complete. The Plan must allow the Participant to perfect the request for external review within the four-month filing period or 48 hours after receipt of the notice, whichever is later.

Independent Dispute Resolution

Independent Dispute Resolution as authorized in the No Surprises Act is a process in which a non-network emergency services provider, non-network ancillary provider (for example radiologist, pathologist, anesthesiologist providing services in a network facility) or non-network air ambulance provider can dispute a payment amount made by a Plan for emergency services provided. This process can be started after a 30 day negotiation period has been exhausted with no resolution. Timelines to act within each step of the process as well as any determination of payments or refunds owed are governed by the terms of the interim final regulations of the No Surprises Act.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the claimant or Dependent on whose behalf such payment was made.

A claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a claimant, Provider or other person or entity to enforce the provisions of this section, then that claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

(1) In error.

(2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act.

(3) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.

(4) With respect to an ineligible person.

(5) In anticipation of obtaining a recovery if a claimant fails to comply with the Plan's Third Party Recovery Provision.

(6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a claimant or by any of his covered Dependents if such payment is made with respect to the claimant or any person covered or asserting coverage as a Dependent of the claimant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the claimant for any outstanding amount(s).

Limitation of Action

Requests for reimbursement are subject to the provisions of this Plan Document. No legal proceeding or action may be brought prior to the exhaustion of the internal appeal process and is barred if an appeal of an adverse benefit determination or any other matter under the Plan is not timely filed as set forth above. Any legal proceeding must be filed within two (2) years from the date the claim was incurred.

Balance-Billing

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

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

The Participant is responsible for payment of Copays, Coinsurances, Deductibles, and Out-of-Pocket Maximums and may be billed for any or all of these.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not

be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

COORDINATION OF BENEFITS

This provision shall apply to all benefits provided under any section of this Plan.

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges. In no event will total payment by the Plan exceed the amount which would have been paid as primary plan.

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

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

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

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

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

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

(7) Workers' Compensation or other liability insurance by whatever name called.

Allowable charge. For a charge to be allowable under this section it must be a Usual and Customary Charge and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

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

Excess insurance. If at the time of Injury, Illness or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits shall be excess to any of the following:

(1) The responsible party, its insurer, or any other source on behalf of that party.

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.

(3) Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.

(4) Workers' compensation or other liability insurance company.

(5) Any other source of coverage, including, but not limited to, the following:

- Crime victim restitution funds
- Civil restitution funds
- No-fault restitution funds such as vaccine injury compensation funds
- Any medical, applicable disability or other benefit payments
- School insurance coverage

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made.

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

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

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

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

Special Rule: If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), then Plan B will pay before Plan A.

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

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

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

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

(ii) If both parents have the same birthday (month & day), the benefits of the benefit plan which

has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

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

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

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

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

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out in (d) above as long as paternity has been established.

(f) When a person is covered under this Plan and another plan as a Dependent child on one and a Dependent spouse on another, the benefits of the plan under which the person has been covered for a longer period of time are determined before those of the plan which has covered the person for a shorter period of time. The length of coverage time is measured based on current coverage time; the date of re-enrollment after any lapse in coverage for any reason will be considered to be the starting date of coverage.

(g) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should

have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid, to the extent of such excess, from any one or more of the following as the Plan Administrator shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Such repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that a person is eligible for or is provided medical assistance through Medicaid when enrolling a person in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

Payment Condition. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement

Subrogation. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

(1) The responsible party, its insurer, or any other source on behalf of that party.

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.

(3) Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.

(4) Workers' compensation or other liability insurance company.

(5) Any other source of Coverage, including, but not limited to, the following:

- Crime victim restitution funds
- Civil restitution funds
- No-fault restitution funds such as vaccine injury compensation funds
- Any medical, applicable disability or other benefit payments
- School insurance coverage

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits incurred, that have been paid and/or will be paid by the Plan, or were otherwise incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, or disability.

Participant is a Trustee Over Plan Assets. Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

(1) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

(2) Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.

(3) In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.

(4) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability. The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Excess Insurance. If at the time of Injury, Illness or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

(1) The responsible party, its insurer, or any other source on behalf of that party.

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.

(3) Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.

(4) Workers' compensation or other liability insurance company.

(5) Any other source of Coverage, including, but not limited to, the following:

- Crime victim restitution funds
- Civil restitution funds
- No-fault restitution funds such as vaccine injury compensation funds
- Any medical, applicable disability or other benefit payments
- School insurance coverage

Separation of Funds. Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death. In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations. It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

(1) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

(2) To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.

(3) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

(4) To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

(5) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

(6) To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

(7) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

(8) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

(9) To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

(10) In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

(11) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset. If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

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

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

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

Severability. In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or 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.

CONTINUATION OF COVERAGE

A federal law, the **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),** requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an Employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

(i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in

which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. if on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary. Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(i) The death of a covered Employee.

(ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours of a covered Employee's employment.

(iii) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation and a divorce or legal separation occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(iv) A covered Employee's enrollment in the Medicare program.

(v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the **Family and Medical Leave Act of 1993 ("FMLA")** does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day after the leave ends if the Employee does not return to work in an eligible class.
The Trade Act of 2002 provides a second 60-day COBRA election period for certain individuals who become eligible for trade adjustment assistance (TAA) pursuant to the Trade Act of 1974. A TAA-eligible individual who did not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, may elect continuation coverage during a 60-day period that begins on the first day of the month in which he or she is determined to be a TAA-eligible individual, provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. The individual may elect coverage for both himself or herself and his or her family. Any continuation coverage elected during the second election period will begin with the first day of the second election period, and not on the date on which coverage originally lapsed. The Trade Act of 2002 also created a new tax credit for

certain individuals who become TAA-eligible (further amended by the Trade Preferences Extension Act of 2015 with its Adjustment Assistance program to restore the Health Coverage Tax Credit). Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator in writing of the occurrence of a Qualifying Event that is:

(i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.

(ii) The divorce or legal separation of the covered Employee.

(iii) A second qualifying event after a qualified beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months.

(iv) The disability of Qualified Beneficiary for the purpose of a disability extension, or cessation of disability extension.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.

(ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

(iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other group health plan.

(v) The date, after the date of the election, the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

(iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to

an 18 month or 29 month maximum coverage period is followed, within that 18 or 29 month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the event.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Keep the Plan Administrator informed of address changes. In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. Also, keep a copy for your records of any notices you send to the Plan Administrator.

Continuation During FMLA Leave

Regardless of the established leave policies mentioned in this document, the Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

The Family and Medical Leave Act is a Federal law that applies, generally, to Employers with 50 or more Employees, and provides that an eligible Employee may elect to continue coverage under this Plan during a period of approved FMLA

Leave at the same cost as if the leave had not been taken.

If provisions under the Plan change while an Employee is on FMLA Leave, the changes will be effective for him or her on the same date as they would have been had he or she not taken leave.

Eligible Employees

Employees are eligible for FMLA Leave if all of the following conditions are met:

(1) The Employee has been employed with the Participating Employer for at least 12 months;

(2) The Employee has been employed with the Participating Employer at least 1,250 hours during the 12 consecutive months prior to the request for FMLA Leave; and

(3) The Employee is employed at a worksite that employs at least 50 Employees within a 75-mile radius.

Qualifying Circumstances for FMLA Leave

Coverage under FMLA Leave is limited to a total of 12 workweeks during any 12-month period that follows:

(1) The birth of, and to care for, a Son or Daughter;

(2) The placement of a Child with the Employee for adoption or foster care;

(3) The Employee's taking leave to care for his or her Spouse, Son or Daughter, or Parent who has a Serious Health Condition;

(4) The Employee's taking leave due to a Serious Health Condition which makes him or her unable to perform the functions of his or her position; or

(5) A Qualifying Exigency arising out of the fact that a Spouse, Son or Daughter, Parent, or Next of Kin of the Employee is a regular or reserve component in the Armed Forces.

Coverage under FMLA Leave is limited to a total of 26 workweeks during any 12-month period for the following situations:

To care for a service member following a Serious Illness or Injury to that service member, when the Employee is that service member's Spouse, Son or Daughter, Parent, or Next of Kin; or to care for a veteran who is undergoing medical treatment, recuperation, or therapy for a Serious Illness or Injury that occurred any time during the five years preceding the date of treatment, when the Employee is that veteran's Spouse, Son or Daughter, Parent, or Next of Kin.

This leave may be considered as a paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid leave. The Participating Employer has the right to require that all paid leave be used prior to providing any unpaid leave.

An Employee must continue to pay his or her portion of the Plan contribution, if any, during the FMLA Leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

Notice Requirements

An Employee must provide at least 30 days' notice to his or her Participating Employer prior to beginning any leave under FMLA. If the nature of the leave does not permit such notice, the Employee must provide notice of the leave as soon as possible. The Participating Employer has the right to require medical certification to support the Employee's request for leave due to a Serious Health Condition for the Employee or his or her eligible family members.

Length of Leave

During any one 12-month period, the maximum amount of FMLA Leave may not exceed 12 workweeks for most FMLA related situations. The maximum periods for an Employee who is the primary care giver of a service member with a Serious Illness or Injury that was incurred in the line of active duty may take up to 26 weeks of FMLA Leave in a single 12-month period to care for that service member. The Participating Employer may use any of four methods for determining this 12-month period.

If the Employee and his or her Spouse are both employed by the Participating Employer, FMLA Leave may be limited to a combined period of 12 workweeks, for both Spouses, when FMLA Leave is due to:

(1) The birth or placement for adoption or foster care of a Child; or

(2) The need to care for a Parent who has a Serious Health Condition.

Termination of FMLA Leave

Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

(1) When the Employee informs his or her Participating Employer of his or her intent not to return from leave;

(2) When the employment relationship would have terminated but for the leave (such as during a reduction in force);

(3) When the Employee fails to return from the leave;

(4) If any required Plan contribution is not paid within 30 days of its due date; or

(5) The Participating Employer and/or Plan Administrator is advised and/or determines that no FMLA Qualifying Circumstance occurred.

If an Employee does not return to work when coverage under FMLA Leave ends, he or she will be eligible for COBRA continuation of coverage at that time, in accordance with the parameters set forth by this Plan and applicable law.

Recovery of Plan Contributions

The Participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if an Employee does not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles the Employee to FMLA Leave (in which case the Participating Employer may require medical certification) or other circumstances beyond the Employee's control.

Reinstatement of Coverage after FMLA Leave

The law requires that coverage be reinstated upon the Employee's return to work following an FMLA Leave whether or not the Employee maintained coverage under the Plan during the FMLA Leave. On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Ancon Construction Co., Inc., Employee Benefit Plan is the benefits plan of Ancon Construction Co., Inc., the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by Ancon Construction Co., Inc. to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Ancon Construction Co., Inc. shall appoint a new Plan Administrator as soon as reasonably possible.

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

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS. The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. Any error that occurs regarding the administration of eligibility, benefits or claims shall not set a precedent for the administration of future eligibility, benefits or claims for any Covered Person under the Plan.

AMENDING AND TERMINATING THE PLAN. If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

COMPLIANCE WITH APPLICABLE LAWS. The Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provision of this Plan. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

FRAUD. Fraud is against the law. It is a felony that can and will be prosecuted by the Plan Administrator. Any Employee who willfully and knowingly engages in an activity intended to defraud the Plan will face disciplinary action by the Employer that may include termination of employment and termination of Plan Benefits. Furthermore, any Employee who receives money from the Plan to which he or she is not entitled will be required to fully reimburse the Plan.

Employee Responsibility Guidelines. In addition to having rights under the Plan, you also have responsibilities with regard to proper filing of claims. The following sets forth guidelines that clarify your responsibilities:

(1) You are responsible for filing accurate claims, regardless if someone on your behalf, such as your Spouse or another family member files them for you.

(2) You should review the explanation of benefits (EOB) form when it is sent to you to make certain that benefits have been correctly paid based on your knowledge of the expenses incurred and the services rendered.

(3) You should never allow another person to seek medical treatment under your identity or a member of your Family Unit. If your Plan identification card is lost or stolen, you should report the loss to the Claims Administrator.

(4) You are responsible for providing complete and accurate information on claim forms including other insurance coverage information. You should attempt to answer all questions to the best of your ability.

Reporting Provider Fraud. To maintain the integrity of the Plan, you are requested to notify the Claims Administrator whenever a provider of medical services bills you for services or treatment that you have never received.

MENTAL HEALTH PARITY. Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA). GINA prohibits group health plans and employers from discriminating on the basis of genetic information.

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

(1) Such individual's genetic tests.

(2) The genetic tests of family members of such individual.

(3) The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary

and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of the Ancon Construction Co. workforce are designated as authorized to receive Protected Health Information from Ancon Construction Co. Employee Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: Personnel designated in writing by the Employer.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA. Plan Participants in this Plan are entitled to certain rights and protections under the **Employee Retirement Income Security Act of 1974 (ERISA).** ERISA specifies that all Plan Participants shall be entitled to:

(1) Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

(3) Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or Dependents may have to pay for such coverage.

(4) Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator, if the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in state or federal court. In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible

for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan, and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

ANCON CONSTRUCTION Co., Inc. Employee Benefit Plan

PLAN NUMBER (FOR ERISA REPORTING PURPOSES): 501

GROUP NUMBER (AS ASSIGNED BY PRO-CLAIM PLUS, INC.): 8080

TAX ID NUMBER: 35 – 1361712 – ANCON CONSTRUCTION Co., Inc.

RESTATED EFFECTIVE DATE: 1/1/26

PLAN YEAR ENDS: 12/31

EMPLOYER INFORMATION

ANCON CONSTRUCTION Co., Inc.
2121 W Wilden Ave
Goshen, IN 46528
(574) 533-9561

PLAN ADMINISTRATOR / NAMED FIDUCIARY and AGENT FOR SERVICE OF LEGAL PROCESS

ANCON CONSTRUCTION Co., Inc.
2121 W Wilden Ave
Goshen, IN 46528
(574) 533-9561

LEGAL ENTITY; SERVICE OF PROCESS: The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

CLAIMS ADMINISTRATOR

PHP TPA Services
PO Box 9648
Fort Wayne, Indiana 46899
(260) 436-9495

BY THIS AGREEMENT, ANCON CONSTRUCTION Co., Inc. Employee Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for ANCON CONSTRUCTION Co., Inc. on or as of the day and year first below written.

By Sherrie L. Byler
ANCON CONSTRUCTION Co., Inc.

Date 3/20/2026

Witness

Date 3/20/26