AMY'S KITCHEN, INC.
MEDICAL PLAN AMENDMENT #5

This amendment to the above Plan, is made effective January 1, 2021.

It is agreed that the following be amended as follows:

1. *SECTION, MEDICAL EXCLUSIONS; is amended to **remove** the following:*

   30. Charges for Reconstructive Surgery for breast reduction, unless it is for reconstructive breast reduction following mastectomy on the non-diseased breast to make it equal in size with the diseased breast following Reconstructive Surgery on the diseased breast.

IN WITNESS WHEREOF, this instrument is executed for Amy's Kitchen, Inc. Medical Plan as stated herein, as of the dates set forth above.

Signature: Carme Lewis

Print Name: Carme Lewis

Date: January 1, 2021

AMY'S KITCHEN, INC.
MEDICAL PLAN AMENDMENT #4

This amendment to the above Plan, is made effective August 1, 2021.

It is agreed that the following be amended as follows:

1. *SECTION, COVERED MEDICAL EXPENSES; is amended to add the following:*

   TRANSGENDER SERVICES

   Covered Expenses shall include services that are Medically Necessary based on the standards of care published by the World Professional Association for Transgender Health (WPATH). Transgender benefits are provided for services and supplies in connection with Gender Transition when a Physician has diagnosed a Member with Gender Identity Disorder or Gender Dysphoria. This coverage is provided according to the terms and conditions of the Plan that apply to all other medical conditions, including Medical Necessity requirements, Utilization Review, Reasonable and Allowed Charge, and exclusions for certain services that are not aligned with WPATH standards of care.

   You can find out more information about WPATH's standards of care and services by visiting wpath.org.

   Covered Expenses shall include:

   Genital Surgery: Genital Surgery benefits are covered if the Member is at least 18 years old and diagnosed as having Gender Identity Disorder/Gender Dysphoria. The Member must also provide:

   - Two letters of recommendation or support for surgery, dated within six months of the request for Genital Surgery, from two separate mental health professionals. At least one letter of recommendation must include an extensive report. One master's degree-level professional is acceptable if the second letter is from a psychiatrist or PhD/PsyD clinical psychologist.
   - The evaluations and recommendations must show persistent, well-documented Gender Identity Disorder or Gender Dysphoria, and indicate no medical contraindications to surgery.
   - Each recommendation must state that the surgery is Medically Necessary according to the most current standards of care published by WPATH.

   Breast/Chest Surgery: Breast/Chest Surgery benefits are covered if the Member is at least 18 years old and diagnosed as having Gender Identity Disorder/Gender Dysphoria. The Member must also provide one letter of recommendation for Breast/Chest Surgery from a mental health professional.

   Surgical procedures other than Genital and Breast/Chest Surgery: Services are covered if the Member is at least 18 years old, has been diagnosed with Gender Identity

Disorder/Gender Dysphoria by a mental health profession, and the services are Medically Necessary.

Transgender Services for minors: Non-surgical medical services (such as hormone therapy and mental health) for minors who have been diagnosed with Gender Identity Disorder or Gender Dysphoria are covered subject to all limitations and exclusions contained in this Plan.

Travel Expense Reimbursements: Travel expenses, up to a maximum $10,000 payment per surgery or series of surgeries, will be covered. Travel expenses include the following for the Member and one companion:

- Ground transportation to and from an approved Facility when the Facility is 50 miles or more from the Member's home
- Air transportation by coach is available when the distance is 300 miles or more
- Lodging
- Meals

There is no Member cost sharing for travel reimbursements. Travel expenses, with receipts must be submitted within one hundred and eighty (180) days from the date incurred in order to be reimbursed.

For Transgender Services, a mental health professional is defined as any mental health practitioner with education of a master's degree-level or higher.

2. *SECTION, MEDICAL EXCLUSIONS; is amended to **remove** exclusion #2*:

   Charges for services, supplies or treatment for sexual reassignment, including but not limited to medication, implants, hormone therapy, and/or surgery treatment unless Medically Necessary and required by applicable law.

3. *SECTION, MEDICAL EXCLUSIONS; is amended to remove exclusion #35 and replace with the following:*

   Charges for diversion therapy or recreational therapy unless Medically Necessary.

4. *SECTION, MEDICAL SCHEDULE OF BENEFITS; is amended to add the following to the section titled "Pre-certification is required for the following services:"*

   Genital Surgery
   Breast/Chest Surgery

5. *SECTION, MEDICAL SCHEDULE OF BENEFITS; is amended to replace the following:*

   Physical/Occupational/Speech Therapy/Respiratory Therapy/Post-Cochlear Implant Aural Therapy/Cognitive Therapy /Voice and Communication Therapy (Non-Hospital Based)
   (Limited to 180 visits combined for all therapies and combined with Hospital-Based services)

6. *SECTION, DEFINTIONS; is amended to add the following definition:*

Gender Identity Disorder/Gender Dysphoria

Gender Identity Disorder/Gender Dysphoria means marked incongruence between one's experienced/expressed gender and their assigned gender, displaying consistently for a minimum of six months, and exhibiting at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

This definition will be automatically updated and amended if and when the definition of Gender Identity Disorder/Gender Dysphoria is updated by applicable guidelines, literature, or medical research.

IN WITNESS WHEREOF, this instrument is executed for Amy's Kitchen, Inc. Medical Plan as stated herein, as of the dates set forth above.

Signature: Carme Lewis

Print Name: Carme Lewis

Date: July 23, 2021

AMY'S KITCHEN, INC.
MEDICAL PLAN AMENDMENT #3

This amendment to the above Plan, is made effective June 1, 2021.

It is agreed that the following be amended as noted below:

1. **The Covered Medical Expenses Preventive Care Services section; Covered Preventative Service for Adults Colorectal Cancer screening section is amended to the following;**

    a) Colorectal Cancer screening; including a Virtual Colonoscopy

It is agreed that the following be amended as noted below:

2. **The Covered Medical Expenses Diagnostic Services and Supplies section is deleted in its entirety and is replaced by the following;**

    DIAGNOSTIC SERVICES AND SUPPLIES
    Covered Expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging, radiology and oncology, sleep studies, and x-ray.

    Covered Expenses shall also include the following genetic test;

    a) Genetic testing for homozygousproprotein or compound heterozygous variants in proopiomelanocortin (POMC), proprotein convertasesubtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiencies genes, if such testing is to determine the appropriateness of IMCIVREE (setmelanotide) treatment.

    All other genetic testing is not covered except as specifically stated in the "Preventive Care Services" section under this Plan.

It is agreed that the following be amended as noted below:

3. **The Medical Exclusions section, exclusion #1 is deleted in its entirety and is replaced by the following;**

    1. Charges related to genetic counseling or testing except as specifically stated in the Schedule of Benefits, Covered Medical Expenses "Preventive Care Services" section or "Diagnostic Services and Supplies" section under this Plan.

IN WITNESS WHEREOF, this instrument is executed for Amy's Kitchen, Inc. Medical Plan as stated herein, as of the dates set forth above.

Signature: Carme Lewis

Print Name: Carme Lewis

Date: June 23, 2021

AMY'S KITCHEN, INC
MEDICAL PLAN TEMPORARY AMENDMENT #2

This amendment to the above Plan, is made effective **January 1, 2021 through sixty (60) days following the end of the National Emergency or such other date announced in future notifications**. The Outbreak Period may not exceed a period of one (1) year. "Outbreak Period" began March 1, 2020 in response to the Nation Emergency.

It is agreed that the following be amended as follows:

SECTION, SUMMARY PLAN DESCRIPTION; is amended to add the following:

COVID-19 (Novel Coronavirus)

In response to the Novel Coronavirus (COVID-19) pandemic, under the authority of section 518 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 7508A(b) of the Internal Revenue Code of 1986 (the code) have announced the extension of certain notice and disclosure requirements that impact Employee benefit plans. Under the Final Rule, all group health Plans must disregard the period of March 1, 2020 until sixty (60) days after the announced end of the National Emergency or such other date announced by the Agencies in a further notification ("Outbreak Period"), but no later than a period of one year, for all Covered Persons, Beneficiaries, Qualified Beneficiaries or claimants, in determining the following periods:

- The thirty (30) day (or sixty (60) day period, if applicable to request Special Enrollment under ERISA;
- The sixty (60) day Election Period for COBRA continuation coverage;
- The date for making COBRA premium payments;
- The date for individuals to notify the plan of a Qualifying Event or determination of disability;
- The date in which individuals may file a benefit claim under the Plan's Claims Procedure;
- The date in which Covered Persons may file Appeals of an Adverse Benefit Determination under the Plan's Claims Procedure;
- The date in which Covered Persons may file a request for an External Review after receipt of an Adverse Benefit Determination or Final Adverse Benefit Determination; and
- The date within which a Covered Person may file information to perfect a request for External Review upon a finding that the request was not complete.

IN WITNESS WHEREOF, this instrument is executed for Amy's Kitchen, Inc. Medical Plan as stated herein, as of the dates set forth above.

Signature: Carme Lewis

Print Name: Carme Lewis

Date: 6/20/2021

AMY'S KITCHEN, INC.
MEDICAL PLAN AMENDMENT #1

This amendment to the above Plan, is made effective January 1, 2021.

It is agreed that the following be amended as noted below:

1. **Sections Eligibility, Enrollment, Effective Date of Coverage, Termination of Coverage and Continuation of Coverage are deleted in their entirety and replaced by the following:**

ELIGIBILITY

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

EMPLOYEE ELIGIBILITY

All Employees regularly scheduled to work at least twenty-four (24) hours per work week in any forty-five (45) day period shall be eligible to enroll for coverage under this Plan. Coverage shall be effective on the first of the month following or coincident with forty-five (45) days of employment. Part-time Employees (less than 24 hours), temporary Employees, Interns and seasonal Employees are excluded unless mandated by law unless noted below.

Temporary Employees and Interns working at least thirty (30) hours per week shall be eligible to enroll for coverage under this Plan on the ninety first (91st) day of employment.

Rehired Employees who return to Amy's Kitchen, Inc. within six (6) months of their separation date can elect to have their benefits reinstated on the first of the month following their rehire date. Coverage shall be effective first of the month coincident with or following the date of rehire or return to work.

Employees who have a change in eligibility status by moving from a non-benefits-eligible position into a benefits-eligible position are subject to the new hire benefits waiting period of forty-five (45) days.

Variable Hour (Part-time) Employee – Amy's Kitchen, Inc. uses a twelve-month measurement period, during which time Employees will be ineligible for benefits. Following this period, Amy's Kitchen, Inc. will use an administrative period to calculate whether the Employee worked, on average, 30 or more hours per week. If it is established that the Employee satisfies the above criteria, the Employee will then become eligible for enrollment in the company benefits offering, effective the first day of the month following the administrative period.

DEPENDENT ELIGIBILITY

The following describes Dependent eligibility requirements. The Plan Administrator will require proof of Dependent status.

1. **Spouse.** The term "spouse" means the spouse of the Employee under a legally valid existing marriage, unless court ordered separation exists; or

2. **Domestic Partner.** The term "Domestic Partner" means a person of the opposite sex or same sex with whom the Employee has established a Domestic Partnership. All of the following requirements apply to both persons:
    a. They must be at least 18 years of age and competent to enter into a contract;
    b. They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law;
    c. They must not be legally separated from another person;
    d. They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside;
    e. They must have allowed at least six (6) months to pass since the termination of any previous domestic partnership (this does not apply if the previous domestic partnership ended due to the domestic partner's death); and
    f. They must share a permanent residence.

Employees enrolling a Domestic Partner must provide an Affidavit of Domestic Partnership. Employees terminating a Domestic Partner must provide an Affidavit of Domestic Partnership Termination. Employees should contact the Employer for the required documentation.

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

4. **Qualified Medical Child Support Order (QMCSO)**. An eligible child shall also include any other child of an Employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan, even if the child is not residing in the Employee's household. Such child shall be referred to as an Alternate Recipient. An application for enrollment must be submitted to the Plan Administrator for coverage under this Plan. The Plan Administrator shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the Plan pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a Qualified Medical Child Support Order or a National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

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

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

   Proof of incapacitation must be provided within thirty (30) days of the child's loss of eligibility and thereafter as requested by the Plan Administrator or Claims Administrator, but not more than once every two (2) years.

   Eligibility may not be continued beyond the earliest of the following:
   a. Cessation of the mental and/or physical disability;
   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination;

6. **Newborn Child**. Newborn Children will be considered a Dependent under this Plan for thirty-one (31) days immediately following birth. For coverage under the Plan for the newborn beyond that date, the Employee must submit an application for enrollment within thirty (30) days of birth.

These persons are excluded as Dependents:
- A spouse who is legally separated or divorced from the Employee;
- Children of a Dependent son or daughter;
- Children who are, or become, a full-time member of the armed forces of any country;
- Any person who is covered as a Dependent of another Employee under this Plan;
- Any person who is eligible as an Employee under the Plan; and
- The spouse of a Dependent child.

ENROLLMENT

The benefits of this Plan are based on a Benefit Year. If an Employee or Dependent enrolls for coverage at any time during the Benefit Year, the benefits shall be calculated on a Benefit Year

APPLICATION FOR ENROLLMENT

An Employee must file a written application (or electronic, if applicable) with the Plan Administrator for coverage hereunder for himself and/or his eligible Dependents within thirty (30) days of becoming eligible for coverage. The Employee shall have the responsibility of timely forwarding to the Plan Administrator all applications for enrollment hereunder. Once a properly completed application for enrollment has been submitted to the Plan Administrator and coverage has become effective, as defined in the section titled, Effective Date of Coverage, the Employee's enrollment options shall remain in effect. The only opportunity to change the enrollment option shall be at the annual open enrollment period, or upon a special enrollment option as defined below.

The Plan Administrator must be notified of any change in eligibility of Dependents within thirty (30) days of the change, including the birth of a child that is to be covered and adding or deleting any other Dependents.

Failure to complete the application for enrollment within thirty (30) days shall result in the Late Enrollment provision applying to the individual. An Alternate Recipient can be enrolled in the Plan at any time and shall not be subject to the Late Enrollment provision.

Employee/Spouse or Domestic Partner Enrollment

Every eligible Employee may enroll eligible Dependents. However, if both the Employee and spouse or domestic partner are Employees, each individual will be covered as an Employee. An Employee cannot be covered as an Employee and a Dependent. Eligible children may be enrolled as Dependents of one spouse, but not both.

Transfer of Coverage

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

SPECIAL ENROLLMENT PERIOD: LOSS OF ELIGIBILITY FOR OTHER COVERAGE

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

1. Termination of the other coverage (including exhaustion of COBRA benefits)
2. Cessation of employer contributions toward the other coverage
3. Legal separation or divorce
4. Termination of other employment or reduction in number of hours of other employment
5. Death of spouse who had the coverage under the other plan.
6. Cessation of other coverage because employee or dependent no longer resides or works in the service area and no other benefit package is available to the individual.

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

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

The Employee or Dependent must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The Effective Date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the special enrollment event.

SPECIAL ENROLLMENT PERIOD: DEPENDENT ACQUISITION

An Employee who is currently covered or not covered under the Plan, but who acquires a new Dependent may request a special enrollment period for himself, if applicable, his newly acquired Dependent and his Spouse/Domestic Partner, if not already covered under the Plan and otherwise eligible for coverage. For the purposes of this provision, the acquisition of a new Dependent includes:

1. Marriage or domestic partnership;
2. Birth of a Dependent child;
3. Adoption or placement for adoption of a Dependent child;
4. Obtaining Legal Guardianship or power of attorney of a Dependent child; or
5. A foster child being placed with an Employee.

The Employee must request the special enrollment within thirty (30) days of the acquisition of the Dependent.

The Effective Date of coverage as the result of a special enrollment shall be:

1. In the case of marriage or domestic partnership, the first day of the calendar month following the marriage or domestic partnership.
2. In the case of a Dependent's birth, the date of such birth.
3. In the case of adoption or placement for adoption, the first of the month following the date of such adoption or placement for adoption.
4. In the case of legal guardianship or power of attorney, the first of the month following obtainment of such legal guardianship or power of attorney.
5. In the case of a court order mandating coverage under the Plan, the earlier of the first of the month following receipt of the court order, or the date specified in the court order.
6. In the case of a foster child being placed with the Employee, on the date on which such child is placed with the Employee by an authorized placement agency or by judgement, decree or other order of a court competent jurisdiction.

SPECIAL ENROLLMENT PERIOD: MEDICAID AND CHIP ELIGIBILITY

An eligible Employee, or an Employee’s eligible Dependent, who is currently covered or not covered under the Plan may request a special enrollment period for himself, if applicable, and his dependent. Special enrollment periods will be granted if:

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

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

OPEN ENROLLMENT

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

During this open enrollment period, an employee and his dependents that are not covered under this Plan must complete and submit an enrollment form for coverage. Coverage shall be effective on the following January 1.

LATE ENROLLMENT

With the exception of the provisions identified in Special Enrollment above, applications for Employee or Dependent coverage which are not filed with the Plan Administrator within thirty (30) days of meeting the eligibility requirements of the Plan shall be subject to this late enrollment provision.

Late enrollment applicants shall be eligible to enroll for coverage during the Plan's annual open enrollment period. Coverage shall be effective January 1 provided a properly completed application for enrollment has been received by the Plan Administrator. This late enrollment provision shall not apply to an Alternate Recipient.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

Eligible Employees, as described in Eligibility, are effective under the Plan the first of the month coincident with or following forty-five (45) days of continuous Full-Time employment; provided a properly completed enrollment form was submitted to the Plan Administrator. Temporary Employees and Interns are effective under the Plan on the ninety-first (91st) day of employment.

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

If the Employee does not enroll for coverage within thirty (30) days of meeting the Plan's eligibility requirements, the Effective Date of coverage will be delayed. Refer to Enrollment.

DEPENDENT EFFECTIVE DATE

Eligible Dependents, as described in Eligibility, will become covered under the Plan as specified under the section titled, Special Enrollment Period: Dependent Acquisition, provided the Employee has enrolled them in the Plan within thirty (30) days of meeting the Plan's eligibility requirements. If the Employee does not enroll eligible Dependents within thirty (30) days of meeting the Plan's eligibility requirements, the Dependents' Effective Date of coverage will be delayed. Refer to Enrollment.

TERMINATION OF COVERAGE

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

EMPLOYEE TERMINATION DATE

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

DEPENDENT TERMINATION DATE

1. The date the Plan is terminated.
2. The date the Employee's coverage terminates.
3. The last day of the month such person ceases to meet the eligibility requirements of the Plan.
4. Midnight on the first day after the date any required contribution is due but not paid, unless the Member has received confirmation in writing from a representative of the Plan that coverage will not be terminated.
5. The date the Dependent becomes a full-time, active member of the armed forces of any country.
6. The date the Plan discontinues Dependent coverage for any and all dependents.
7. The last day of the month in which the Plan Administrator receives a cancellation of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).
8. At any time, coverage may be rescinded, or retroactively terminated, effective the date the Employee commits or has committed an intentional act of fraud or material misrepresentation with respect to the Plan, with 30 days' written notice from the Plan.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, but not to exceed eighteen (18) months, contingent upon payment of any required contributions for Employees and/or Dependents, when the Employee is on an authorized Leave of Absence from the Employer. For additional information on Amy's Kitchen, Inc.'s leave policy contact the HR Department.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

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

Contributions

During this leave, the Employer will continue to pay the same portion of the Employee's contribution for the Plan. The Employee shall be responsible to continue payment for eligible Dependent's coverage and any remaining Employee contributions. For further information regarding continued contributions while on leave contact the Plan Administrator.

Reinstatement

If coverage under the Plan was terminated during an approved FMLA leave, and the Employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the Employee returns to active work as if coverage had not terminated, provided the Employee makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

Repayment Requirement

The Employer may require Employees who fail to return from a leave under FMLA to repay any contributions paid by the Employer on the Employee's behalf during an unpaid leave. Contact the Plan Administrator for further information.

EMPLOYEE REINSTATEMENT

Employees and eligible Dependents that lost coverage due to an approved Leave of Absence, Layoff, or termination of employment with the Employer are eligible for reinstatement of coverage as follows:

1. Reinstatement of coverage is available to Employees and Dependents that were previously covered under the Plan.
2. Rehire or return to work must occur within six (6) months of last day worked.
3. The Employee must submit the completed application for enrollment to the Plan Administrator within thirty (30) days of rehire or return to work.
4. Coverage shall be effective from the first of the month coincident with or following the date of rehire or return to work. Prior benefits and limitations, such as Deductible and Maximum Benefit Amount shall be applied with no break in coverage if the Employee returns within the same Benefit Year.

If the provisions of (1) through (3) above are not met, the Plan's provisions for eligibility and application for enrollment shall apply.

An Employee who returns to work after six (6) months of an approved Leave of Absence, Layoff, or separation of employment will be considered a new Employee for purposes of eligibility and will be subject to all eligibility requirements.

CONTINUATION OF COVERAGE

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

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

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

QUALIFYING EVENTS

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

1. Death of the Employee.
2. The Employee's termination of employment or reduction in work hours to less than the minimum required for coverage under the Plan.
3. Divorce, legal separation or termination of Domestic Partnership from the Employee.
4. The Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family Medical Leave Act of 1993.
7. The call-up of an Employee reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered Employee, or a child's loss of Dependent status, the Employee or Dependent must notify the Plan Administrator of that event within sixty (60) days of the event. The Employee or Dependent must advise the date and nature of the qualifying event and the name, address and Social Security number of the affected individual. Failure to provide such notice to the Plan Administrator will result in the person forfeiting their rights to continuation of coverage under this provision.

2. The Plan Administrator has thirty (30) days to notify the Claims Administrator of the qualifying event. Within fourteen (14) days of receiving notice of the qualifying event, the COBRA administrator will notify the Employee or Dependent of his right to continuation of coverage, and what process is required to elect continuation of coverage.

3. After receiving notice, the Employee or Dependent has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the Plan prior to the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. The COBRA Administrator must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:

    a. The date coverage under the Plan would otherwise end; or
    b. The date the person receives the notice from the Plan Administrator of his or her rights to continuation of coverage.

4. Within forty-five (45) days after the date the person notifies the COBRA Administrator that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial

payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.

5. The Employee or Dependent must make payments for the continued coverage.

COST OF COVERAGE

1. The Plan Administrator requires that Members pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the COBRA Administrator, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.
2. For purposes of determining monthly costs for continued coverage, a person originally covered as an Employee or as a spouse will pay the rate applicable to an Employee if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an Employee.

WHEN CONTINUATION COVERAGE BEGINS

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

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

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

SUBSEQUENT QUALIFYING EVENTS

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

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

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

Only a person covered prior to the original qualifying event or a child born to or Placed for Adoption with a covered Employee during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other Dependent acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

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

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

6. The date the Member first becomes covered under any other group health plan after the date of election of COBRA continuation coverage.

EXTENSION FOR DISABLED INDIVIDUALS

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

MILITARY MOBILIZATION

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

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

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

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

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

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

The Employee or the Employee's Dependent coverage will be reinstated without exclusions or a waiting period.

IN WITNESS WHEREOF, this instrument is executed for Amy's Kitchen, Inc. Medical Plan as stated herein, as of the dates set forth above.

Signature: Carme Lewis

Print Name: Carme Lewis

Date: January 1, 2021

AMY'S KITCHEN, INC.
MEDICAL PLAN

Preferred Provider Organization (PPO)/Value Based Plan (VBP) HEALTH PLAN

PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Component Plan of ERISA Plan Name:
Amy's Kitchen, Inc. Employee Benefit Health Plan

Effective Date: 1/1/2021

TABLE OF CONTENTS

INTRODUCTION

Please read this document thoroughly and become familiar with the provisions of the Plan. This Plan describes the benefits available to you and your covered Dependents under the Amy's Kitchen, Inc. Medical Plan (the "Plan") administered by Hawaii Mainland Administrators, LLC (the "Claims Administrator") and describes the main features of the Plan, including:

- Who is eligible for coverage;
- Services that are covered;
- Services that are not covered;
- What to do when you need care;
- How benefits are paid;
- When coverage ends; and
- Your rights and responsibilities under the Plan:

There are terms in this document that have a special meaning under this Plan and are listed in the "Definitions" sections. When reading the provisions of the Plan, it may be helpful to refer to this section. Becoming familiar with the terms defined in this section will give you a better understanding of the procedures and benefits described.

In addition to this document describing your benefits, you will receive a Member identification card that indicates you are eligible for coverage. This card contains your personal identification number, name, Employer number and your Employer Plan name. The reverse of your card contains claims filing information. Always carry this card with you when you or your covered Dependents visit the Hospital, doctor or pharmacy. The card can be used to verify coverage and contains information that must be on every claim form submitted for consideration of payment. The information on the reverse of the card is necessary for proper submission of claims and provides telephone numbers for inquiries. If you lose your card, contact your Claims Administrator to have the card reissued. The identification card itself is not a guarantee of benefits.

PURPOSE AND EFFECTIVE DATE

This document serves as both the written Plan Document and the Summary Plan Description ("SPD") required under ERISA. The purpose of this document is to set forth the provisions of the Amy's Kitchen, Inc. Medical Plan (the "Plan") which provide for the payment of all or a portion of Covered Benefits the Plan Administrator agrees to pay, subject to all the provisions of the Plan, including amendments, on behalf of the Member entitled to such benefits while covered under this Plan, provided claim is duly made.

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

The Plan Administrator intends to continue the Plan indefinitely but reserves the right to amend or terminate the Plan in whole or in part, at any time. Such action may include, but not be limited to the type of benefit, Deductible, Copayments, Coinsurance, Non-Covered Services, Out-of-Pocket maximums, Maximum Payable Amount, limitations and exclusions, and monthly contribution. Any such action will be communicated to Members in writing as soon as reasonably possible and in compliance of applicable law.

PAYABLE AMOUNTS

This Plan offers a network provider option. The chosen Participating Provider Organization (PPO) is comprised of a group of Providers and facilities from whom Members may obtain some of the covered medical services described within this document.

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

- You usually pay less money out of your pocket for health care services;
- The Participating Provider will file claims directly to the Claims Administrator or the network, so you do not have to wait for reimbursement; and
- You only pay Coinsurance, Copayments, Deductible (if you have not completed the required Whole You Annual Exam, or charges not covered by the Plan. You are not responsible for charges for Covered Benefits over the Plan's Maximum Allowable Charge or contracted rate.

This Plan utilizes a network for some providers, but not others. Some Hospital and other Facility charges, as well as Dialysis and Air Ambulance charges, are payable on a Value Based Payment basis, as defined within this Plan. In-network Physician and ancillary care service charges are payable based on a Negotiated Rate when applicable. Out-of-network Physician and ancillary care service charges are payable strictly based upon "Reasonable and Allowed".

For assistance with locating a provider visit www.hmatpa.com/amys/find-a-doctor/ or call HMA Advanta customer service at (833) 396-AMYS (2697).

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

When the Plan has a Negotiated Rate with certain Physicians, the Plan will pay benefits equal to that Negotiated Rate, as indicated in the Plan Exclusions section of this document. When the Plan does not have a Negotiated Rate, the Plan's maximum payment is subject to the "Reasonable and Allowed Amount".

To determine whether a given claim will be paid based on a Negotiated Rate or "Reasonable and Allowed", please refer to the Schedule of Benefits within this document, or contact the Claims Administrator.

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

PLAN NOT A CONTRACT OF EMPLOYMENT

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

GENERAL INFORMATION

Name of Component Plan:	Amy's Kitchen, Inc. Medical Plan
Component Plan under ERISA Plan Number:	502
ERISA Plan Name:	Amy's Kitchen, Inc. Employee Benefit Health Plan
Name, Address and Phone Number of Employer/Plan Sponsor:	Amy's Kitchen, Inc. 1650 Corporate Circle Ste. 100 Petaluma, California 94954 (707) 787-1597
Employer Identification Number:	68-0154899
Type of Plan:	Welfare Benefit Plan: Medical, Prescription Drug Benefits
Name, Address and Phone Number of Plan Administrator and Fiduciary	Amy's Kitchen, Inc. 1650 Corporate Circle Ste. 100 Petaluma, California 94954 707-781-7796
Agent for Service of Legal Process:	Amy's Kitchen, Inc. ATTN: Plan Administrator 1650 Corporate Circle Ste. 100 Petaluma, California 94954 707-781-7796 And Amy's Kitchen, Inc. ATTN: Office of General Counsel 1650 Corporate Circle Ste. 100 Petaluma, California 94954 707-781-7796 Amy's Kitchen, Inc. shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan Documents and make all interpretive and factual determinations as to whether any individuals is entitled to receive any benefit under the terms of this Plan. Any construction of terms of any Plan Documents and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.
Source of Plan Contributions:	Amy's Kitchen, Inc. and Employees covered by the Plan contribute to the cost of the Plan**.** Employee contributions are the Employee's share of costs as determined by the Plan Administrator.

Funding Method:	The Employer pays Plan benefits and administration expenses directly from general assets. Contributions received from Members are used to cover Plan costs and are expended immediately. Plan contributions are made by the Employer and covered Employee. All benefits under the Plan are paid from general assets. Employee required contributions are the Employee's share of costs as determined by the Plan Administrator. From time to time the Plan Administrator will determine the required Employee contributions and will notify Employee in writing. Payments of Plan benefits will be based on the provisions of the Plan.
Initial Effective Date:	January 1, 2021
Benefit Year:	January 1 through December 31
Plan Renewal Date:	January 1
Effective Date of Coverage and Waiting Period:	First day of the month coincident with or following forty-five (45) days of continuous employment.
Termination Date of Coverage:	The last day of the month in which the Member ceases to meet the eligibility requirements or for which required premium was paid.
Type of Administration of the Plan:	The self-funded Plan is administered directly by the Plan Administrator. The Plan Administrator has appointed a Claims Administrator to handle the day-to-day operation of the Plan. The Claims Administrator does not serve as an insurer, but only as a Claims Administrator. The Claims Administrator processes claims, then requests and receives funds from the Plan Administrator for the amount of the claims, and processes payment on the claims to Hospitals and other providers.
Claims Administrator:	Hawaii Mainland Administrators, LLC (HMA) PO Box 22009 Tempe, AZ 85285-2009 (866) 206-7920
Pharmacy Claims Administrator:	Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136
Right to Amend or Terminate the Plan:	The Plan Administrator reserves the right to amend or terminate this Plan at any time. You will be properly notified of any and all changes subject to the Plan's provisions.
Statement of ERISA rights:	The Plan Administrator holds the position that ERISA governs the Plan. The Plan Administrator is guided by ERISA provisions as applicable to its Plan. Accordingly, interpretations of the Plan, including words and phrases, shall be guided by ERISA as applicable to the Plan.

REQUIRED NOTICES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

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

PREGNANCY DISCRIMINATION ACT OF 1978

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

FAMILY AND MEDICAL LEAVE ACT OF 1993 ("FMLA")

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

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 ("OBRA")

OBRA 1993 requires that an eligible Dependent Child of an Employee will include a Child who is adopted by the Employee or placed with him for adoption prior to age eighteen (18) and a Child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law under State law and which satisfies the QMCSO requirements of ERISA (section 609(a)). Members may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy or lumpectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998(WHCRA). For individuals receiving mastectomy or lumpectomy related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy or lumpectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy or lumpectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call your claim administrator at (866) 206-7920.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the

mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MENTAL HEALTH PARITY AND ADDICITION EQUITY ACT OF 2008 ("MHPAEA")

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as Copayments, Deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

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

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

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

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

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP")

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

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 ("CHIPRA")

Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility:

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

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.
This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. *The effective date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

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

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA")

The Patient Protection and Affordable Care Act (Affordable Care Act) adds many protections related to employment-based group health plans for you and your family. These include extending Dependent coverage up to age 26; prohibiting pre-existing condition exclusions for children under age 19 and for all individuals beginning in 2014; and requiring easy-to-understand summaries of a health plan's benefits and coverage.

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

NON-DISCRIMINATION NOTICE

This Plan, including benefits and policies, does not discriminate on the basis of race, color, national origin, sex, age or disability. It complies with applicable federal civil rights laws. Members needing translation assistance should contact HMA at toll free (866) 206-7920. If you feel you were discriminated in any way, you can file a grievance with Amy's Kitchen, Inc. Human Resources Department at 1650 Corporate Circle, Suite 100, Petaluma, California 94954, or you can contact HMA by phone at toll free (866) 206-7920 or in writing to Grievance Department, 1600 West Broadway Road, Suite 300, Tempe, Arizona 85282. Or you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by phone at toll free (800) 368-1019, TDD users, call toll free (800) 537-7697 or by mail at U.S. Department of Health and Human Services, 200 Independence Ave. SW., Room 509F, HHH Building, Washington, DC 20201.

UTILIZATION REVIEW

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

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

PRE-CERTIFICATION

Pre-certification, also known as prior authorization, is the process of getting approval from your health Plan before you have any health procedures performed.

Pre-certification is the determination that selected medical services meet Medical Necessity criteria under the Member's benefits contract. For the Member to receive maximum benefits, the health Plan must authorize or "pre-certify" these Covered Benefits prior to being rendered. Pre-certification includes a review of both the service and the setting. Care will be covered according to the Member's benefits for the services and/or number of days pre-certified unless our Concurrent Review determines that additional services and/or days do not qualify for coverage. A copy of the approval will be provided to you, the Physician and the Hospital or Facility. For benefits to be paid the Member must be eligible for benefits and the service must be a Covered Benefit under the contract at the time the services are rendered.

To make sure we have enough time to review the request, for in-network services, and depending on the type of service, your doctor should generally contact us at least 14 business days in advance of the date on which you are expected to have the procedure. This typically allows us enough time to review the request and ask for additional information, if it is needed.

Pre-certification requirements are listed on the Schedule of Benefits indicating services that require pre-certification from the Claim Administrator Utilization Review Department in order for the services to be covered under the Plan.

Emergency Hospital admissions are to be reported to the Utilization Review Department within forty-eight (48) hours following admission, or on the next business day after admission.

When reviewing a pre-certification request, the Utilization Review Department is reviewing whether or not the requested service is medically appropriate and SHOULD NOT be considered a guarantee that the requested service is a Covered Benefit under this Plan. We also check the cost-effectiveness of the service and we may communicate with your doctor if necessary. It is your responsibility to make sure the service is pre-certified, so be sure to talk to your doctor about it. Failure to obtain pre-certification may result in additional costs to you beyond the "Reasonable and Allowed Amounts" in addition to your Copayment, Deductible and Coinsurance amounts.

After admission to the Hospital, the Utilization Review Department will continue to evaluate the Member's progress through concurrent telephonic review to monitor the length of Confinement and Medical Necessity of treatment of any admission. If the Utilization Review Department disagrees with the length of Confinement recommended by the Physician, the Member and the Physician will be advised. If the Utilization Review Department determines that continued Confinement is no longer necessary, additional days will not be certified. Benefits payable for days not certified as Medically Necessary by the Utilization Review Department shall be denied. In the event certification of Medical Necessity is denied by the Utilization Review Department, the Member may appeal the decision. The Member may call the Utilization Review Department for more information concerning the appeal process. Additional information is listed in the Appeals Section of this document.

TIMING OF NOTIFICATION

The Member shall be notified of the Plan's benefit determination on review as follows:

We will make a pre-certification decision within a reasonable time period considering the medical circumstances, but not later than ten (10) business days from receipt of the pre-certification request. If we require more time to make a

pre-certification decision, we may extend the time by an additional fifteen (15) days by notifying you, within the initial ten (10) day period of need for an extension, the expected decision date, and any additional information needed for the decision. Based on that plan, we may pre-certify a certain number of visits or services over a certain period of time. You may request precertification for additional periods of care as long as your request is made at least seventy-two (72) hours prior to the expiration of an existing plan of care. We will make a determination as soon as possible in accordance with medical exigencies, but no later than seventy-two (72) hours after receipt of the request.

Urgent: If the Physician classifies the pre-certification request as urgent, the Plan must recognize the request as urgent. Members must be notified of decisions as soon as possible, but no more than seventy-two (72) hours after receipt of the pre-certification request. (Urgent requests are based on the Member's condition and generally not for scheduling reasons.)

Retrospective: The Plan will make a benefit determination no later than thirty (30) days from the received date. If the Retrospective Review (a review completed after the event) determines that the hospitalization or surgery did not exceed that which would have been approved had the pre-certification been completed, no adverse action will be taken by the Plan and the amount of any Deductible and/or Coinsurance will count towards the satisfaction of the Member's maximum Out-of-Pocket expense. However, should a portion of the hospitalization or surgery be determined to be in excess of what would have been approved had the pre-certification been completed, the Plan may deny that portion of the services as not Covered Expenses.

In the event that a pre-certification request is denied by the Utilization Review Department, the Member may appeal the decision. The Member may call the Customer Service Department for more information concerning the appeal process. Additional information is listed in the Appeals Section of this document.

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the Member's condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or Case Management services from a professional qualified to perform such services. The Plan Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

The Utilization Review Department ***may*** recommend (or change) alternative methods of medical care or treatment, equipment or supplies that are not Covered Benefits under this Plan; or are Covered Benefits under this Plan but on a basis that differs from the alternative recommended by the Utilization Review Department. The Plan will recognize such alternative services as Covered Benefits. The use of Case Management or alternate treatment is a voluntary program to the Member; however, the Plan will generally provide a greater benefit to the Member by participating in the program.

If the Plan should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Member and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.

Alternative 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 Member or any other Member.

VALUE-BASED PAYMENT (VBP)

Your benefit Plan includes a Value-Based Payment (VBP) reimbursement model for certain types of providers and Covered Benefits.

Services subject to VBP include, but are not limited to Facilities, Dialysis, Air Ambulance and Non-Network Providers.

For services obtained under the VBP model the Member may utilize any provider as there is no network. However, there may be Providers that are directly contracted with the Plan. Please call HMA Advanta toll free at (833) 396-2697 for additional information. These providers will be reimbursed for covered and approved services based on VBP. VBP establishes a "Reasonable and Allowed" reimbursement amount for facilities based on Medicare and other published costs and pricing data applying either an additional amount on top of the Medicare amount or an additional amount on top of the Facility costs (Medicare-plus or Cost-plus) for Facility patient care.

VBP establishes the prevailing prices for medical services using objective and normative data such as Medicare Rates, cost data, average reimbursements/payments, Medicare Provider Reimbursement Manual et al, and other public and private data sources. The reference price considers prevailing area charges and other objective data to evaluate the reasonableness of the charges and validates the Medicare Allowable Prices specific to the services rendered.

The Plan Sponsor and Claims Administrators will work on your behalf to eliminate or minimize the potential for Member liabilities other than those due to Copayments, Coinsurance, Deductibles or amounts in excess of the VBP amounts. However, for services subject to VBP, the Member will be solely responsible for all amounts not paid by the Plan should the provider not accept the VBP amount as payment in full. The Member has the right to request an estimated reimbursement prior to services being rendered including during the pre-certification process. Your Plan Sponsor and Claims Administrators intend to work with the providers prior to the services being rendered to ensure all parties have a better understanding of the VBP amounts as well as the providers' intentions to accept the VBP amounts.

REASONABLE AND ALLOWED AMOUNT/REASONABLE AND ALLOWABLE AMOUNT

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

1. For Inpatient and Outpatient Facility claims, an amount equivalent to 150% of Medicare equivalent allowable amount; and
2. For all other non-facility claims, an amount equivalent to 125% of the Medicare equivalent amount.

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

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

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

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

HMA ADVANTA

It is the Plan's position that the Provider should not balance bill the Member for amounts in excess of the "Reasonable and Allowable Amount". It is the Plan's position that these Excess Charges are clearly excessive and exorbitant. However, balance billing for such amounts can occur for out of network claims and the Plan has no control over the actions of the Providers or their desire to pursue you for such amounts.

In the event you receive a balance-bill for an amount in excess of the "Reasonable and Allowable Amount" payable, please immediately email advanta@hmatpa.com or call HMA Advanta toll free at (833) 396-2697.

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

PROVIDER-BASED PAYMENT

Other than facilities, Dialysis Services, and air ambulance providers as set forth above, Members have the choice of using either a Participating Provider or a Non-Participating Provider for Physician and certain ancillary services. The Schedule of Benefits indicates Covered Benefits and what the benefit differential is between the use of Participating and Non-Participating Providers as it relates to Physicians and certain ancillary service providers.

PARTICIPATING PROVIDERS

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

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

How to use the Participating Provider

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

For assistance with locating a provider visit www.hmatpa.com/amys/find-a-doctor/ or call HMA Advanta customer service at (833) 396-AMYS (2697).

NON-PARTICIPATING PROVIDERS

A Non-Participating Provider does not have an agreement in effect with the Participating Provider Organization. This Plan will allow only the "Reasonable and Allowed Amount" as a Covered Benefit. The Plan will reimburse the "Reasonable and Allowed Amount" based on Maximum Payable Amount for the Non-Participating Provider services, supplies and treatment. The Member is responsible for the remaining balance. This results in greater Out-of-Pocket expenses to the Member. For Non-Participating Providers, the Member is responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the billed amount.

Non-Participating Providers are reimbursed based on a “Reasonable and Allowed” reimbursement model for the services they render. “Reasonable and Allowed” reimbursement amount is based on Medicare and other published costs and pricing data applying either an additional amount on top of the Medicare amount or an additional amount on top of the Facility costs (Medicare-plus or Cost-plus).

“Reasonable and Allowed” establishes the prevailing prices for medical services using objective and normative data such as Medicare Rates, cost data, average reimbursements/payments, Medicare Provider Reimbursement Manual et al, and other public and private data sources. The reference price considers prevailing area charges and other objective data to evaluate the reasonableness of the charges and validates the Medicare Allowable Prices specific to the services rendered.

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

It is the Plan's position that the Provider should not balance-bill the Member for amounts in excess of the "Reasonable and Allowable Amount". It is the Plan's position that these Excess Charges are clearly excessive and exorbitant. However, balance-billing for such amounts can occur and the Plan has no control over the actions of the Providers or their desire to balance-bill you for such amounts.

REFERRALS

Referrals to a Non-Participating Provider for Covered Benefits are covered as Non-Participating Provider, supplies and treatments. It is the responsibility of the Member to assure services to be rendered are performed by Participating Providers in order to receive the Participating Provider level of benefits.

THE WHOLE YOU ANNUAL EXAM WELLNESS PROGRAM

Employer shall credit, in each Benefit Year, the amount equivalent to the individual Deductible or the amount equivalent to the family unit Deductible (for any other tier greater than Employee only), as elected under the Amy's Kitchen, Inc. Medical Plan, on behalf of each Employee and any participating spouse or domestic partner when the Employee and participating spouse or domestic partner satisfy the following the Whole You Annual Exam Wellness Program requirements:

1. Obtain an annual exam with basic metabolic blood panel; and
2. Submit an affidavit to the Plan Administrator or the Claims Administrator by November 30 of the year preceding the beginning of the Benefit Year.

For purposes of this section, the Employer shall provide Deductible credit accordingly:

1. Employee completes (1) and (2) above; Spouse or domestic partner does not: Employer credits the amount equivalent to the individual Deductible.
2. Spouse or domestic partner completes (1) and (2) above; Employee does not: Employer credits the amount equivalent to the individual Deductible.
3. Employee completes (1) and (2) above; Dependent children participate in the Plan; Spouse or domestic partner does not: Employer credits the amount equivalent to the family unit Deductible. (Children are not required to obtain an exam or blood panel).
4. Employee **and** spouse or domestic partner complete (1) and (2) above; Employer credits the amount equivalent to the family unit Deductible.

For Employees hired prior to August 31, the Employer shall credit for that Benefit Year, the amount equivalent to the individual Deductible or equivalent to the family unit Deductible (any other tier greater than Employee only) on behalf of each Employee and any participating spouse or domestic partner automatically, without applying the Wellness Program requirements set forth above. For the following Benefit Year, Employees (and any spouse or domestic partner, if applicable,) will need to satisfy the Wellness Program requirements set forth above to obtain the Deductible credit for the subsequent Benefit Year.

For Employees hired after August 31, the Employer shall credit for that Benefit Year and the subsequent Benefit Year the amount equivalent to the individual Deductible or equivalent to the family unit Deductible (any other tier greater than Employee only) on behalf of each Employee and any participating spouse or domestic partner automatically, without applying the Wellness Program requirements set forth above.

MEDICAL EXPENSE BENEFITS

This section describes the Covered Benefits of the Plan. All Covered Benefits are subject to applicable Plan provisions including, but not limited to, any applicable Deductible, Copayment or Coinsurance, as outlined within the Schedule of Benefits. All expenses Incurred by the Member for services, supplies or treatment provided will not be considered Covered Benefits by this Plan if they are greater than the Maximum Payable Amount, as applicable. The Covered Benefits for services, supplies or treatment provided must be recommended by a Physician or Professional Provider and be Medically Necessary care and treatment for the Illness or Injury suffered by the Member. Specified preventive care expenses will be covered by this Plan.

COPAYMENT

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

The Copayment will not be applied toward the following:

1. The calendar year Deductible;
2. The common accident Deductible;
3. The multiple birth Deductible.

COINSURANCE

The Plan pays a specified percentage of Covered Benefits at the "Reasonable and Allowed Amount" for Non-Participating Providers, or the percentage of the Negotiated Rate for Participating Providers. The percentage specified in the Schedule of Benefits is the percentage the Member is responsible for of the "Reasonable and Allowed Amount".

BENEFIT YEAR DEDUCTIBLE

Individual Benefit Year Deductible

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

Family Benefit Year Deductible

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

Common Accident Deductible

If two or more covered members of a family are injured in the same accident and, as a result of that accident, incur Covered Expenses, only one (1) individual Deductible amount will be deducted from the total Covered Expenses of all covered family members related to the accident for the remainder of the Benefit Year.

Multiple Birth Deductible

When two (2) or more Dependents are born in a multiple birth, only one (1) individual Deductible will be taken from the total Covered Expenses Incurred in a Benefit Year for those Dependents if the Covered Expenses are Incurred in the same Benefit Year as the birth and are due to:

1. Premature birth;
2. Abnormal congenital conditions; or
3. Injury which is received at birth or Illness which starts not more than thirty (30) days after birth.

BENEFIT YEAR OUT-OF-POCKET EXPENSE LIMIT

Individual Benefit Year Out-of-Pocket Expense Limit

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

Family Benefit Year Out-of-Pocket Expense Limit

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

Out-of-Pocket Expense Limit Exclusions

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

1. Expenses for services, supplies and treatments not covered by this Plan, including but not limited to charges in excess of the Reasonable and Allowed amount.
2. Charges in excess of the Maximum Payable Amount.
3. Prescription drug Copayments and DAW penalties.
4. Contribution amounts.
5. Balance-billed charges.
6. Expenses Incurred as a result of failure to obtain pre-certification.

MEDICAL SCHEDULE OF BENEFITS

Claims must be received by the Claims Administrator within ***365 days*** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied. The Member must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Member seek a second medical opinion.	
ANNUAL DEDUCTIBLE	
Per Member	**$1,500**
Per Family Unit	**$3,000**
ANNUAL OUT-OF-POCKET MAXIMUM	
Per Member	**$2,500**
Per Family Unit	**$5,000**
Amounts in Excess of Negotiated Rates/Reasonable and Allowed Charges: • For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate for Participating Providers. • For Non-Participating Providers, the Member is responsible for the amounts listed as well as the difference between the Reasonable and Allowed Charge reimbursement level and 100% of the billed amount. **Amounts in excess of the Reasonable and Allowed Charge payable to Non-Participating Providers DO NOT apply to the Annual Deductible OR the Annual Out-of-Pocket Maximum.**	

MEDICAL SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
PHYSICIAN SERVICES		
Primary Care Office Visits	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Specialist Care Office Visits	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Other Physician services performed in the office (Diagnostic Services, Office Surgery, Laboratory and Radiology Services).	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Physician services in a Facility (Hospital, Outpatient Surgery, Emergency Room, etc.)	0% Coinsurance after Deductible	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Physician services for the Surgical Treatment of Obesity	0% Coinsurance after Deductible	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Epidural/Facet & Trigger Point Injections performed in the office	0% Coinsurance after Deductible	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.

Urgent Care	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
MATERNITY CARE - PHYSICIAN SERVICES		
Initial Visit to confirm Pregnancy	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
All subsequent prenatal visits	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Physician's Delivery Charges (1.e. global maternity fee)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Postnatal Visits (Initial 90 days after delivery)	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Postnatal Visits (as of 91st day after delivery)	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
PREVENTIVE CARE		
Benefits For Children		
Newborn Circumcision	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Well Child Care Office Visits 0 to 11 months (6 well baby visits) 1 to 4 years (7 well child visits) 5 to 17 years (1 well child visit per Benefit Year)	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Well Child Care Immunizations	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Well Child Care Lab Tests	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Adult Preventive Screening/Testing		
Adults, physical exam to obtain recommended preventive and diagnostic services	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Immunization Services for Adults Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.

Prostate Specific Antigen Men, one per Benefit Year, age ≥ 50	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Screenings such as; Obesity, Blood Pressure, Cholesterol, Colorectal Cancer, HIV, Alcohol Misuse	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Counseling such as; Alcohol Misuse, Sexually Transmitted Infection (STI) Prevention, Nutritional Counseling, Tobacco Use	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Women's Preventive Care Services		
Prescribed contraceptive methods, sterilization procedures and patient education. (Supply and administration of Contraceptive IUDs, Implants and Injectables). (Pharmacy - birth control pills, diaphragms, emergency contraceptive pill through your Pharmacy Benefits)	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Well Woman exam per benefit year to obtain recommended preventive and diagnostic services	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Screenings such as Pap Smears, Mammography, Domestic and interpersonal violence screening, Osteoporosis screening	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
HOSPITAL/FACILITY SERVICES		
Inpatient Room & Care – semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute setting	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
Inpatient Room & Care - Skilled Nursing Facility, Rehabilitation Facility or Sub-Acute Facility (Limited to a combined 180 days per Benefit Year)	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
Outpatient/Ambulatory Surgery Services & Birthing Centers	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
Other Outpatient Hospital Services (such as Cardiac, Pulmonary, PT/OT/ST) Physical/Occupational/Speech Therapy/Respiratory Therapy/Post-Cochlear Implant Aural Therapy/Cognitive Therapy. (Limited to 180 visits combined for all therapies and combined with Non-Hospital Based services)	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
Emergency Room Services	$100 Copayment, then 0% Coinsurance after Deductible Copayment waived if admitted to Inpatient status	
DIAGNOSTIC SERVICES		
Laboratory Services		
Non-Hospital Based	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Hospital Based	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
Radiology & Radiation Oncology Services		

Non-Hospital Based	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Hospital Based	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
CT/MRI/MRA/PET Scan		
Non-Hospital Based	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Hospital Based	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
MENTAL HEALTH/BEHAVIORAL HEALTH/SUBSTANCE ABUSE DISORDER		
Inpatient		
Hospital & Facility Services; semi-private room rate	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Psychiatrist & Psychologist Services	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
Outpatient		
Psychiatrist & Psychologist Services (Office setting)	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Psychological Testing	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
OTHER SERVICES		
Allergy Treatment / Injections	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Allergy Serum (dispensed by the physician in the office)	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Ambulance (Ground & Air)	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
Chemotherapy	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Dialysis and Supplies	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
Durable Medical Equipment	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Enteral Nutrition Therapy	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.

Home Health Services - Including Home Birth & Private Duty Nursing (Limited to 180 visits per benefit year)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Hospice/Respite Care Services (Limited to 180 days per benefit year)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Infusion Services & Injectable Medications	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Nutritional Counseling	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Orthotics & Prosthetics (including intra-oral orthotics or prosthetic devices to treat Orthognathic Disorders)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Temporomandibular Joint Dysfunction (TMJ) Treatment	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
HEARING SERVICES		
Hearing Aid Evaluation	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Hearing Aids (Limited to a maximum of $4,000 every four (4) years)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Cochlear Implants (Limited to a lifetime maximum of $30,000 per device/per ear)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
ORGAN TRANSPLANT SERVICES		
Organ Transplant Facility & Hospital Services	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.	
Organ Transplant Physician Services (including transportation services) (Travel & Lodging limited to $25,000 per Benefit Year per family unit)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Some limitations & exclusions apply. See the Covered Medical Expenses Transplant section of the plan document.		
REHABILITATION THERAPY		
Physical/Occupational/Speech Therapy / Respiratory Therapy / Post-Cochlear Implant Aural Therapy / Cognitive Therapy (Non-Hospital Based) (Limited to 180 visits combined for all therapies and combined with Hospital-Based services)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
FAMILY PLANNING SERVICES		
Office Visit, Tests and Counseling	No Charge	Amounts that exceed the Reasonable and Allowed Charge. Deductible waived.

Laboratory & Radiology Services	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Surgical Vasectomy	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Surgical Tubal Ligation Reversal (Limited to 1 reversal per lifetime) (Limited to $5,000 per Benefit Year combined with Infertility Treatment and Physician Services related to Infertility Treatment)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Infertility Treatment (In-Vitro, GIFT, ZIFT, artificial insemination, etc.) Facility/Hospital Services (Limited to $5,000 per Benefit Year combined with Surgical Tubal Ligation Reversals and Physician Services related to Infertility Treatment)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
Infertility Treatment (In-Vitro, GIFT, ZIFT, artificial insemination, etc.) Physician Services (Limited to $5,000 per Benefit Year combined with Surgical Tubal Ligation Reversals and Facility/Hospital Services related to Infertility Treatment)	0% Coinsurance after Deductible.	0% Coinsurance after Deductible plus amounts that exceed the Reasonable and Allowed Charge.
ALTERNATIVE CARE SERVICES		
Acupuncture, Biofeedback Therapy & Naturopathic Services (Limited to 24 visits per Benefit Year)	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Chiropractic Care (Limited to 24 visits per Benefit Year)	$10 Copayment per visit, Deductible waived.	$10 Copayment per visit, plus amounts that exceed the Reasonable and Allowed Charge. Deductible waived.
Coinsurance amount is based on an approved negotiated rate for Participating Providers or Reasonable and Allowed reimbursement level for Non-Participating Providers as established by the Plan.		

Pre-certification is required for the following services:

- **Acute Care;**
- **Advanced Radiology (MRI, PET, CT, MRA. EBCT);**
- **Bariatric Surgery;**
- **Birthing Center Services;**
- **Chemotherapy;**
- **Clinical Trials for Cancer;**
- **Colonoscopy (if diagnostic and if in hospital setting);**
- **Concurrent Review;**
- **Dialysis and Supplies;**
- **Discharge Planning;**
- **Durable Medical Equipment over $2,500;**
- **Endoscopic Procedures;**
- **Enteral Nutrition Therapy;**
- **Epidural/Facet & Trigger Point Injections;**
- **High Risk Maternity Care Services;**
- **Home Health Services;**
- **Hospice/Respite Care Services;**
- **Infertility Services;**

Pre-certification is required for the following services (continued):

- **Infusion Services on any drug over $1,500;**
- **Injectable Medications on any drug over $1,500;**
- **Inpatient Hospitalizations;**
- **Inpatient Maternity Stay in excess of Federal Mandate**
- **Inpatient Mental/Behavioral Health Services;**
- **Inpatient Substance Abuse Services and Chemical Dependency (including Detox);**
- **Inpatient Rehabilitation;**
- **Non-emergent Ambulance Services;**
- **Observation Stay**
- **Organ Transplant Services;**
- **Orthotics & Prosthetics;**
- **Outpatient Services at Day Treatment Centers;**
- **Outpatient Surgery Services;**
- **Outpatient Therapy Services that exceed 12 visits;**
- **Retrospective Review;**
- **Skilled Nursing Facility;**
- **Specialty Drugs;**
- **Spinal Procedures;**
- **Surgical Sterilization Procedures;**
- **Surgical Treatment of Obesity; and**
- **Temporomandibular Joint Dysfunction (TMJ) Treatment.**

PRESCRIPTION DRUG BENEFIT SCHEDULE

Your prescription drug coverage and network are provided through CVS Caremark.

PHARMACY PROVISIONS		
Annual Pharmacy Deductible	$0	
Annual Pharmacy Out-of-Pocket Maximum	$2,000 per Member	
	PARTICIPATING PHARMACIES	**NON-PARTICIPATING PHARMACIES**
Pharmacy Retail Option - 30 Day Supply	**Member Pays**	
Generic Drugs/Certain Brand Name Drugs	$10 Copayment/drug	$20 Copayment/drug
Preferred Brand Name Drugs	$20 Copayment/drug	$40 Copayment/drug
Non-Preferred Brand Name Drugs	$40 Copayment/drug	$80 Copayment/drug
Specialty Drugs	No cost when you enroll in the PrudentRx Copay Program. **If you do not enroll in the program, you will pay 30% of the cost of the medication.**	

PrudentRx Copay Program for Specialty Medications

The PrudentRx Copay Program assists Members by helping them enroll in manufacturer copay assistance programs. If you or a covered family member are not currently taking, but will start taking, a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx, or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1-800-578-4403.

To view the PrudentRx program list, visit the Amy's benefits website at benefits.filice.come/amys. You can also request a list by contacting the Amy's Benefits Help Desk at (707) 787-1597 Amy's Ext. 7762 or at benefitshelp@amys.com

Pharmacy Retail or Mail Order Option - 90 Day Supply (Maintenance Medication Only)		
Generic Drugs/Certain Brand Name Drugs	$20 Copayment/drug	Not Covered
Preferred Brand Name Drugs	$40 Copayment/drug	Not Covered
Non-Preferred Brand Name Drugs	$80 Copayment/drug	Not Covered

Dispensed-As-Written (DAW) Penalties: Applied when multi-source brand (MSB) medications are chosen over generic equivalents. This Plan implements DAW 1 and DAW 2 penalties.

- DAW 1: Physician prescribes multi-source brand drug over generic drug
- DAW 2: Covered Person requests multi-source brand drug over generic drug

When DAW penalties apply, the Covered Person will pay:

- Usual copay and;
- The difference between the cost of the multi-source brand name drug and the cost of the generic drug.

The Prescriber may complete a written request for Covered Person to receive the prescribed multi-source brand name medication instead of a generic alternative. The Prescriber's written request must show clinical necessity for the brand name medication. DAW penalty will be waived if the written request is approved and the Covered Person will pay only the brand copayment. The appropriate request form can be obtained directly from CVS Pharmacy or the Plan Administrator.

Health Center Prescription Drug Option *Applies when prescription is written by an Amy's Family Health Center Provider.*	**Participating Pharmacies Only**
Pharmacy Retail - 30 Day Supply	**Member Pays**
Generic Drugs/Certain Brand Name Drugs	$5 Copayment/drug
Preferred Brand Name Drugs	$10 Copayment/drug
Non-Preferred Brand Name Drugs	$20 Copayment/drug
Pharmacy Retail/Mail Order - 90 Day Supply (Maintenance Medication Only)	
Generic Drugs/Certain Brand Name Drugs	$10 Copayment/drug
Preferred Brand Name Drugs	$20 Copayment/drug
Non-Preferred Brand Name Drugs	$40 Copayment/drug

Maintenance Prescription Drug Program (Generic mandated when available)	Participating Pharmacies	Non-Participating Pharmacies
Diabetes	**Member Pays**	
Metformin Basaglar Tresiba Novolog Amaryl (glimepiride) Gluburide Glipizide/Glucotrol	$5 Copayment/drug	Refer to Prescription Drug Plan
Hypertension		
Lisinopril Atenolol Carvedilol Metoprolol Amlodipine Doxazosin Chlorthalidone Hydrochlorothiazide Furosemide/Lasix Diltiazem Verapamil	$5 Copayment/drug	Refer to Prescription Drug Plan
Cholesterol		
Simvastatin Lovastatin Pravastatin Lipitor (atorvastatin)	$5 Copayment/drug	Refer to Prescription Drug Plan
Asthma		
ProAir (albuterol) Advair (fluticasone/salmeterol) Budesonide/formoterol Flovent (fluicasone diskus) Qvar (beclomethasone)	$5 Copayment/drug	Refer to Prescription Drug Plan
Behavioral Health		
Citalopram Sertraline Escitalopram/Lexapro Venlafaxine (Standard and XR)	$5 Copayment/drug	Refer to Prescription Drug Plan
This summary provides a condensed explanation of Plan benefits. Certain limitation, restrictions and exclusions may apply. Please refer to the Prescription Drug Program section for complete information on benefits.		

COVERED MEDICAL EXPENSES

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

ALTERNATIVE CARE SERVICES

ACUPUNCTURE

Acupuncture and/or electro-acupuncture for therapeutic purposes. Subject to the limitation specified on the Schedule of Benefits.

BIOFEEDBACK THERAPY

Should be performed in a clinical setting by a licensed health professional in a health-related field (such as social worker, Nurse, psychology, medicine) and the licensed health professional should be certified by the Biofeedback Certification International Alliance (BCIA). Subject to the limitation specified on the Schedule of Benefits.

CHIROPRACTIC CARE

Covered Expenses include initial consultation, x-rays and treatment. Massage therapy provided prior to and in conjunction with an adjustment by a chiropractor on the same day shall be a Covered Expense. Subject to the limitation specified on the Schedule of Benefits.

NATUROPATHY

Naturopathy is a holistic approach to the diagnosis, treatment, and prevention of Illness and Injury. Covered Expenses include office visits/examinations, laboratory tests, a fully explained treatment plan by a naturopathic doctor (ND). Subject to the limitation specified on the Schedule of Benefits.

AMBULANCE SERVICES

Ambulance services must be by a regularly scheduled airline, railroad, or by a licensed air or ground Ambulance.

Covered Expenses shall include:

1. Ambulance services for air or ground transportation for the Member from the place of Injury or serious medical incident to the nearest Hospital where treatment can be given.
2. Ambulance service is covered in a non-emergency situation only to transport the Member to or from a Hospital or between Hospitals for required treatment when such treatment is certified by the attending Physician as Medically Necessary. Such transportation is covered only from the initial Hospital to the nearest Hospital qualified to render the special treatment.
3. Emergency services provided by an advance life support unit, even though the unit does not provide transportation.

APPLIANCES AND EQUIPMENT

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly, of necessary Durable Medical Equipment which is prescribed by a Physician and required for therapeutic use by the Member shall be a Covered Expense. The Plan reserves the right to pay a monthly rental not to exceed the purchase price of the equipment. Equipment ordered prior to the Member's effective date of coverage is not covered, even if delivered after the effective date of coverage. Repair or replacement of purchased Durable Medical Equipment which is Medically Necessary due to normal use or physiological change in the patient's condition will be considered a Covered Expense. Maintenance contracts for purchased equipment will be considered a Covered Expense.

Non-Preventive Service Breast Pumps are covered but limited to the rental of a hospital-grade breast pump if an infant is unable to nurse directly on the breast due to a medical condition, such as prematurity, congenital anomaly and/or an infant is hospitalized.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the Member's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment, which is less costly than the equipment furnished, will be covered based on the "Reasonable and Allowed Amount" for equivalent equipment which meets the Member's medical needs.

PROSTHESES

Benefits for the initial provision and replacement of the following appliances and Durable Medical Equipment:

1. Hearing aids (*Refer to the Schedule of Benefits for Plan limitations);*
2. Cardiac pacemakers;
3. Artificial limbs, eyes, and hips, and similar non-experimental appliances;
4. Casts, splints, trusses, braces, and crutches;
5. External breast prostheses (limited to once every three (3) Benefit Years and the first permanent internal breast prosthesis necessary due to a mastectomy);
6. Oxygen and rental of equipment for its administration;
7. Rent or purchase of wheelchair and hospital-type bed (rental will be covered up to the purchase price); and
8. Charges for use of an iron lung, artificial kidney machine, pulmonary resuscitator, and similar special medical equipment.

Equipment must be ordered by a Physician and approved by the Plan as Medically Necessary for the treatment of the Illness or Injury before the item will be considered a Covered Expense. The purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a Covered Expense. A prosthesis ordered prior to the Member's Effective Date of coverage is not covered, even if delivered after the Effective Date of coverage. Repair or replacement of a Medically Necessary prosthesis due to normal use or physiological change in the patient's condition will be considered a Covered Expense.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device, which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a Covered Expense. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered. Replacement will be covered only after five (5) years from the date of original placement, unless growth and development of a child necessitates earlier replacement. Shoe inserts are not a Covered Expense unless the Member is diagnosed with diabetes.

Covered Expenses include therapeutic shoes or inserts for people with diabetes who have diabetic foot disease when prescribed by a podiatrist or other qualified doctor. A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes. Coverage is limited to one pair of therapeutic shoes or inserts per Benefit Year. Shoe modifications may be substituted for inserts.

SPECIAL EQUIPMENT AND SUPPLIES

Covered Expenses shall include Medically Necessary special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; ostomy supplies; catheters; syringes and needles for diabetes; other diabetic supplies, including insulin, test strips and blood sugar measurement devices; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of Illness or Injury of the eye; support stockings, such as Jobst stockings, limited to two (2) pair per Benefit Year; initial purchase of a hearing aid if hearing loss is the result of an accidental Injury or a surgical procedure. (**Note:** This hearing aid benefit is in addition to the Hearing Services benefit) surgical dressings and other medical supplies ordered by a Professional Provider in connection with medical treatment, but not common first aid supplies.

CLINICAL TRIALS

Benefits for an Approved Clinical Trial, Pre-certification is required.

Covered Expenses will include charges made for routine patient costs associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

1. The clinical trial is registered on the National Institute of Health (NIH) maintained web site www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial for cancer treatment.
2. The Member meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
3. The Member has signed an informed consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed informed consent;

4. The trial is approved by the Institutional Review Board of the Institution administering the treatment.
5. Routine patient costs will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Member would receive whether or not he or she were participating in a clinical trial.

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

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

BIRTHING CENTER

Covered Expenses shall include services, supplies and treatments rendered at a Birthing Center provided the Physician in charge is acting within the scope of his license and the Birthing Center meets all legal requirements. Services of a midwife are a Covered Expense.

CONTRACEPTIVE IUDS, CONTRACEPTIVE IMPLANTS, CONTRACEPTIVE INJECTABLES

Covered Expenses shall include:

Food and Drug Administration (FDA) approved contraceptive methods, when prescribed. Sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).

The methods covered by the pharmacy benefit are hormonal (e.g. birth control pills), barrier (i.e. diaphragms), emergency contraceptives (i.e. "morning after pill") and select over-the-counter (OTC) contraceptives, when prescribed by a health care provider. In addition, Covered Expenses shall include the supply of and administration of contraceptive IUDs, implants, and injectables when dispensed by a Physician. Coverage for contraceptives is limited to one contraceptive method per period of effectiveness.

COSMETIC/RECONSTRUCTIVE SURGERY

Cosmetic Surgery or Reconstructive Surgery shall be a Covered Expense provided:

1. A Member receives an Injury as a result of an accident and, as a result requires surgery. Cosmetic Surgery or Reconstructive Surgery and treatment must be for the purpose of restoring the Member to his normal function immediately prior to the accident.
2. It is required to correct a congenital anomaly, for example, a birth defect.
3. It is for reconstructive breast surgery necessary because of a mastectomy. A breast reduction surgery for any other reason is not a Covered Expense.
4. It is reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast following Reconstructive Surgery on the diseased breast.

COVID-19 SERVICES

As required by applicable law, cost sharing (Deductible, Copayment and Coinsurance) will be reduced to zero dollars ($0.00) for Medically Necessary screening, testing (including antibody testing) and vaccinations for COVID-19 including the visit and associated laboratory testing, in a medical office, Hospital, Emergency or urgent care setting. If a Member is diagnosed with COVID-19, all treatment including but not limited to Hospital, transportation and pharmacy services will be covered in accordance with applicable Plan provisions.

DENTAL SERVICES

Covered Expenses shall include charges for Injury to or care of the mouth, teeth and gums. Covered Medical Expenses include treatment for the following oral surgical procedures:

1. Removal of sound natural teeth (including dental implants) or surrounding tissue provided it is a result of an Injury.
2. Closed or open reduction of fractures or dislocations of the jaw, and/or excision of teeth, if related to such fracture or dislocation.
3. Osseous surgery and other incision or excision procedures performed on the gums and tissues of the mouth when not performed in conjunction with the extraction of teeth.
4. Surgical removal of partial or bony impacted teeth.

Facility charges for oral surgery or dental treatment that ordinarily could be performed in the provider's office will be covered only if the Member has a concurrent hazardous medical condition that prohibits performing the treatment safely in an office setting.

Treatment must begin within ninety (90) days of the date of such Injury and be completed within twelve (12) months after the Injury. Damage to the teeth as a result of chewing or biting shall not be considered an Injury under this benefit.

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

DIAGNOSTIC SERVICES AND SUPPLIES

Covered Expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging, radiology and oncology, sleep studies, and x-ray.

DIALYSIS

Covered Expenses include Dialysis Services, whether rendered in a Facility setting or in the home (hemodialysis or peritoneal Dialysis), diagnostic testing, laboratory tests, equipment and supplies provided by a Dialysis provider.

Dialysis Services, diagnostic testing, laboratory tests, equipment and supplies are a Covered Expense under the Plan only to the extent they are Medically Necessary, and only insofar as their cost does not exceed the maximum benefits specified on the Schedule of Benefits, specific to Dialysis Services.

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

EMERGENCY SERVICES

Coverage is provided for health care services that are provided to a Member in an Emergency. As defined in Federal legislation, the "prudent layperson" perception of what is an Emergency is used in determining Coverage under this Benefit. The use of emergency room services is only for Injury or Illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health.

The Plan will not pay charges Incurred for use of the Hospital's emergency room facilities, outpatient operating room, supplies, and equipment in connection with **non-emergency** surgical or medical services. If your condition requires immediate or urgent, but **non-emergency** care, contact your doctor or use an urgent care center. The Plan will waive the Emergency Room Copayment if admitted as an Inpatient status.

ENTERAL NUTRITION THERAPY

Enteral Nutrition Therapy is subject to pre-certification.

Covered Expenses shall include enteral nutrition therapy for the treatment. Medicare classifies enteral nutrition therapy under the prosthetic device benefit. Coverage is only for therapy required due to the absence or malfunctioning body part which normally permits food to reach the digestive tract. Enteral therapy may be given by nasogastric, jejunostomy, or gastrostomy tubes.

EXTENDED CARE FACILITY

Extended Care Facility Confinement is subject to pre-certification.

Extended Care Facility services, supplies, and treatments shall be a Covered Expense provided the Member is under a Physician's continuous care and the Physician certifies that the Member must have twenty-four (24) hours-per-day nursing care.

Covered Expenses shall include:

1. Room and Board (including regular daily services, supplies and treatments furnished by the Extended Care Facility) limited to the Facility's average Semiprivate room rate; and
2. Other services, supplies and treatment ordered by a Physician and furnished by the Extended Care Facility for Inpatient medical care. Extended Care Facility benefits are subject to the limitation specified on the Schedule of Benefits.

HEARING SERVICES

Covered Expenses include charges for examination to determine hearing deficiency or the use of audiometric testing to determine the level of deafness in order to determine the need for a hearing aid or cochlear implant. The maintenance of and the testing of the functionality of a cochlear implant shall be a Covered Expense. Surgery to place a cochlear implant is also covered by the Plan. Cochlear Implants are a Covered Expense, subject to the lifetime maximum specified on the Schedule of Benefits.

Hearing aids including the fitting, purchase, repair or replacement of a hearing aid shall be a Covered Expense, subject to the limitation specified on the Schedule of Benefits.

HOME HEALTH CARE

Home health care enables the Member to receive treatment in his home for an Illness or Injury instead of being confined in a Hospital or Extended Care Facility. The "treatment period" shall mean each separate continuous home health care regimen as directed by the attending Physician.

Covered Expenses shall include:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent Home Health Aide Services for a Member who is receiving covered nursing or therapy services;
4. Medical social service consultations; and/or
5. Nutritional guidance by a registered dietician and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be Medically Necessary.

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Facility settings for a Member suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the Member's attending Physician certifies that:

1. The Member is terminally ill; and
2. The Member has a life expectancy of six (6) months or less.

Covered Expenses shall include:

1. Confinement in a Hospice to include ancillary charges and Room and Board.
2. Services, supplies and treatment provided by a Hospice to a Member in a home setting.
3. Physician services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse.
4. Physical therapy, occupational therapy, or speech therapy.
5. Nutrition services to include nutritional advice by a registered dietician, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.
6. Counseling services provided through the Hospice.
7. Homemaker services.
8. Respite care by an aide who is employed by the Hospice for four (4) hours per day. (Respite care provides care of the Member to allow temporary relief to family members or friends from the duties of caring for the Member.)

9. Bereavement counseling as a supportive service to Members in the terminally ill Member's immediate family. Benefits will be payable, provided:
    a. On the date immediately before death, the terminally ill person was covered under the Plan and receiving Hospice care benefits; and
    b. Services are Incurred by the Member within twelve (12) months of the terminally ill person's death and shall be limited to a maximum of twelve (12) visits.

Charges Incurred during periods of remission are not eligible under this provision of the Plan. Any Covered Expense paid under Hospice benefits will not be considered a Covered Expense under any other provision of this Plan.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Covered Expenses shall include:

1. Room and Board for treatment in a Hospital, including Intensive Care Units, cardiac care units and similar necessary accommodations. Covered Expenses for Room and Board shall be limited to the "Reasonable and Allowed Amount". A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the Member.

2. Miscellaneous Hospital services, supplies, and treatments including, but not limited to:
    a. Admission fees, and other fees assessed by the Hospital for rendering Medically Necessary services, supplies and treatments;
    b. Use of operating, treatment or delivery rooms;
    c. Anesthesia, anesthesia supplies and its administration by an employee of the Hospital;
    d. Medical and surgical dressings and supplies, casts and splints;
    e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
    f. Drugs and medicines (except drugs not used or consumed in the Hospital);
    g. X-ray and diagnostic laboratory procedures and services;
    h. Oxygen and other gas therapy and the administration thereof;
    i. Therapy services.

3. Services, supplies and treatments described above furnished by an Ambulatory Surgical Facility, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Pre-Admission Testing.

    Charges for pre-admission testing (x-rays and lab tests) performed within seven (7) days prior to a Hospital admission, which are related to the condition which is necessitating the Confinement. Such tests shall be payable even if they result in additional medical treatment prior to Confinement or if they show that Hospital Confinement is not necessary. Such tests shall not be payable if the same tests are performed again after the Member has been admitted. This extent of coverage is contingent on the following conditions are met:

    a. The tests are related to the performance of the scheduled surgery or treatment;
    b. The tests have been ordered by a Physician after a condition requiring surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital;
    c. The Member is subsequently admitted to the Hospital, or Confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the Confinement is unnecessary; and
    d. The tests are performed in the Hospital where the Confinement will take place and accepted in lieu of duplicate tests rendered during Confinement.

5. Second Surgical Opinion

    If a Physician recommends surgery for a Member, the Member may request a second opinion as to whether the surgery is Medically Necessary.

    In addition, the Plan recommends that a second opinion be obtained prior to the following Surgeries:

a. Adenoidectomy;
b. Bunionectomy;
c. Cataract removal;
d. Coronary Bypass;
e. Cholecystectomy (removal of gallbladder);
f. Dilation and curettage;
g. Hammer Toe repair;
h. Hemorrhoidectomy;
i. Herniography;
j. Hysterectomy;
k. Laminectomy (removal of spinal disc);
l. Mastectomy;
m. Meniscectomy (removal of knee cartilage, including arthroscopic approach);
n. Nasal surgery (repair of deviated nasal septum, bone or cartilage);
o. Prostatectomy (removal of all or part of prostate);
p. Release for entrapment of medial nerve (Carpal Tunnel Syndrome);
q. Tonsillectomy; and
r. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay 100% of the "Reasonable and Allowed Amount" Incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician without application of the Deductible.

Second opinions for Cosmetic Surgery, normal obstetrical delivery and surgeries that require only local anesthesia are not covered.

If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

INFERTILITY SERVICES

Covered Expenses shall include expenses for infertility testing and infertility treatment for Employees and their covered spouse/domestic partner. Treatment of infertility shall be subject to the limitation as shown on the Schedule of Benefits.

MASTECTOMY

Covered Expenses shall include the following:

1. Medically Necessary mastectomy or lumpectomy, including complications from a mastectomy, including lymphedemas.
2. Reconstructive breast surgery necessary because of a mastectomy or lumpectomy.
3. Reconstructive breast surgery on the non-diseased breast to make it equal in size with the diseased breast following Reconstructive Surgery on the diseased breast.

MENTAL HEALTH/BEHAVIORAL HEALTH /SUBSTANCE ABUSE DISORDER

Inpatient or Partial Confinement

Covered Expenses shall include Confinement in a Hospital or Treatment Center including residential Treatment Centers for services, supplies and treatment related to the treatment of mental health disorders, eating disorders, substance abuse, Chemical Dependency, alcoholism or drug addiction.

Covered Expenses shall include:

1. Inpatient Hospital Confinement;
2. Individual psychotherapy/counseling;
3. Group psychotherapy/counseling;
4. Psychological testing;
5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same Professional Provider.
6. Services, supplies or treatment for attention deficit disorders, behavior or conduct disorders, developmental delay, hyperactivity, learning disorders, intellectual disability, autistic disease, or senile deterioration, including the initial examination, office visit and diagnostic testing to determine the Illness.

Outpatient

Covered Expenses shall include Outpatient services, supplies and treatment related to the treatment of mental health disorders, eating disorders, substance abuse, Chemical Dependency, alcoholism or drug addiction. Covered Expenses also include psychological testing.

Covered Expenses shall include services, supplies or treatment for attention deficit disorders, behavior or conduct disorders, developmental delay, hyperactivity, learning disorders, intellectual disability, autistic disease, or senile deterioration, including the initial examination, office visit and diagnostic testing to determine the Illness.

NUTRITIONAL COUNSELING

Covered Expenses shall include medically appropriate nutritional counseling by a Licensed Dietician (L.D. or L.D.N.) or a Registered Dietician (R.D.) for nutrition-related and weight-related medical conditions.

ORTHOGNATHIC DISORDERS

Surgical and non-surgical treatment of orthognathic disorders shall be a Covered Expense, but shall not include orthodontia.

Covered Expenses for intra-oral orthotics or prosthetic devices are subject to pre-certification requirements as set forth by the Plan.

PATIENT EDUCATION

Covered Expenses shall include Medically Necessary patient education programs including, but not limited to diabetic education and ostomy care. Covered Expenses for patient education for contraception or lactation training shall be considered under the Preventive Care Services section.

PHYSICIAN SERVICES

Covered Expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, Inpatient visits, home visits.

2. Surgical treatment. Separate payment will not be made for Inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

3. For related operations or procedures performed through the same incision or in the same operative field; Covered Expenses shall include the surgical allowance for the highest paying procedure, plus fifty percent (50%) of the surgical allowance for each additional procedure.

   When two (2) or more unrelated operations or procedures are performed at the same operative session, Covered Expenses shall include the surgical allowance for each procedure.

4. Surgical assistance provided by a Physician or professional Provider if it is determined that the condition of the Member or the type of surgical procedure requires such assistance.

5. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office.

6. Consultations requested by the attending Physician during a Hospital Confinement. Consultations do not include staff consultations which are required by a Hospital's rules and regulations.

7. Radiologist, Laboratory, or Pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

8. Radiologist, Laboratory, or Pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

9. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

10. Services received in an urgent care or walk-in facility.

PODIATRY SERVICES

Covered Expenses shall include diagnosis, treatment and prevention of conditions of the feet, including surgical services, incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures of dislocations of bones of the foot.

PREGNANCY

Covered Expenses for Pregnancy or Complications of Pregnancy shall be provided for a covered female Employee, a covered female spouse/domestic partner of a covered Employee, and dependent female children.

In the event of early discharge from a Hospital or Birthing Center following delivery, the Plan will cover two (2) Registered Nurse home visits.

The Plan shall cover home births for low-risk, healthy pregnancies with the participation of Certified Nurse Midwives (CNM). Services of a midwife are a Covered Expense provided that the midwife is a licensed Certified Nurse Midwife (CNM) practicing within the scope of practice as designated by his/her State's Board of Nursing. CNMs must have a supervising Physician or Facility (where the Physician has admitting privileges) designated in the event of an Emergency. The American Congress of Obstetrics & Gynecologists (ACOG) contraindicates home births in the following situations: prior cesarean section, vaginal birth after cesarean, post-term (greater than 42 weeks gestation), carrying twins or a breach presentation.

Note: Although the risk is low, planned home births are associated with a 2 to 3-fold increase risk of neonatal death when compared with a planned Hospital or Birthing Center birth.

The Plan shall cover services, supplies and treatments for elective abortions for a covered female Employee, covered female spouse/domestic partner of a covered Employee or covered dependent female child of an Employee. Complications from an abortion shall also be a Covered Expense.

Medical services Incurred by the newborn of a Dependent covered under this Plan shall not be considered Covered Expenses.

PRESCRIPTION DRUGS

The Plan shall cover prescription drugs that are approved for general use by the Food and Drug Administration and must be dispensed by a licensed pharmacist, Physician or Dentist.

PREVENTIVE CARE SERVICES

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

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

For the most current list of U.S. Preventative Services Task Force A & B recommendations that are relevant to the Affordable Care Act, please see:

https://www.uspreventiveservicestaskforce.org **or** https://www.healthcare.gov/coverage/preventivecare-benefits/

for more details.

Covered Preventative Service for:	
Adults	▪ **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked ▪ **Alcohol Misuse** screening and counseling ▪ **Aspirin** use for men and women of certain ages (covered under prescription drug plan) ▪ **Blood Pressure** screening for all adults ▪ **Cholesterol** screening for adults of certain ages or at higher risk ▪ **Colorectal Cancer** screening for adults over 50

Covered Preventative Service for:	
	▪ **Depression** screening for adults ▪ **Type 2 Diabetes** screening for adults with high blood pressure ▪ **Diet** counseling for adults at higher risk for chronic disease ▪ **HIV** screening for all adults at higher risk ▪ **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary: • Hepatitis A • Hepatitis B • Herpes Zoster • Human Papillomavirus • Influenza (Flu Shot) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Tetanus, Diphtheria, Pertussis • Varicella ▪ **Obesity** screening and counseling for all adults ▪ **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk ▪ **Tobacco Use** screening for all adults and cessation interventions for tobacco users ▪ **Syphilis** screening for all adults at higher risk
Women, Including Pregnant Women	• **Anemia** screening on a routine basis for pregnant women • **Bacteriuria** urinary tract or other infection screening for pregnant women • **BRCA** counseling about genetic testing for women at higher risk • **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40 • **Breast Cancer Chemoprevention** counseling for women at higher risk • **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women • **Cervical Cancer** screening for sexually active women • **Chlamydia Infection** screening for younger women and other women at higher risk • **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs • **Domestic and interpersonal violence** screening and counseling for all women • **Folic Acid** supplements for women who may become pregnant (covered under prescription drug plan) • **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes • **Gonorrhea** screening for all women at higher risk • **Hepatitis B** screening for pregnant women at their first prenatal visit • **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women • **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older • **Osteoporosis** screening for women over age 60 depending on risk factors • **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk • **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users • **Sexually Transmitted Infections (STI)** counseling for sexually active women • **Syphilis** screening for all pregnant women or other women at increased risk

Covered Preventative Service for:	
	• **Well-woman visits** to obtain recommended preventive services for women under 65
Children	▪ **Alcohol and Drug Use** assessments for adolescents ▪ **Autism** screening for children at 18 and 24 months ▪ **Behavioral** assessments for children of all ages ▪ **Blood Pressure** screening for children ▪ **Cervical Dysplasia** screening for sexually active females ▪ **Congenital Hypothyroidism** screening for newborns ▪ **Depression** screening for adolescents ▪ **Developmental** screening for children under age 3, and surveillance throughout childhood ▪ **Dyslipidemia** screening for children at higher risk of lipid disorders ▪ **Fluoride Chemoprevention** supplements for children without fluoride in their water source (covered under prescription drug plan) ▪ **Gonorrhea** preventive medication for the eyes of all newborns ▪ **Hearing** screening for all newborns ▪ **Height, Weight and Body Mass Index** measurements for children ▪ **Hematocrit or Hemoglobin** screening for children ▪ **Hemoglobinopathies** or sickle cell screening for newborns ▪ **HIV** screening for adolescents at higher risk ▪ **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary: • Diphtheria, Tetanus, Pertussis • Hemophilus influenzae type b • Hepatitis A • Hepatitis B • Human Papillomavirus • Inactivated Poliovirus • Influenza (Flu Shot) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Rotavirus • Varicella ▪ **Iron** supplements for children ages 6 to 12 months at risk for anemia (covered under prescription drug plan) ▪ **Lead** screening for children at risk of exposure ▪ **Medical History** for all children throughout development ▪ **Obesity** screening and counseling ▪ **Oral Health** risk assessment for young children ▪ **Phenylketonuria (PKU)** screening for this genetic disorder in newborns ▪ **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk ▪ **Tuberculin** testing for children at higher risk of tuberculosis ▪ **Vision** screening for all children

PRIVATE DUTY NURSING

Private duty nursing services in the Member's home are subject to pre-certification.

Medically Necessary services of a private duty Nurse shall be a Covered Expense. Coverage for Medically Necessary private duty nursing shall be subject to the limitation specified on the Schedule of Benefits.

REHABILITATIVE PROGRAMS

Covered Expenses shall include charges for qualified cardiac/pulmonary rehabilitation programs.

REHABILITATIVE SERVICES

Therapy services must be ordered by a Physician to aid restoration of normal function lost due to Illness or Injury or for congenital anomaly.

Covered Expenses shall include:

- **Physical Therapy** – physical therapy services are covered when ordered by a Physician to aid restoration of normal function lost due to Illness or Injury, where significant improvement is expected within a predictable period of time. Pre-certification is required, and benefit limitations apply.
- **Post-Cochlear Implant Aural Therapy -** post-cochlear implant aural therapy is covered when ordered by a Physician to improve hearing and speech skills after cochlear implant surgery. Pre-certification is required, and benefit limitations apply.
- **Occupational Therapy** – occupational therapy is covered when it is prescribed by a Physician to relearn or to improve the level of independence in performing activities of daily living;(e.g., eating, bathing, dressing) or to provide task-oriented therapeutic activities designed to improve or restore physical functions lost or impaired as a result of Illness or Injury where significant improvement is expected within a predictable period of time. Pre-certification is required, and benefit limitations apply.
- **Respiratory Therapy** – respiratory therapy is covered when it has been ordered by a Physician to restore or improve respiratory function. Pre-certification is required, and benefit limitations apply.
- **Speech Therapy** – speech therapy is covered when it has been ordered by a Physician to restore or improve speech in Member's who have speech/language disorders that are the result of an Illness or Injury where significant improvement is expected within a predictable period of time. Pre-certification is required, and benefit limitations apply.
- **Inpatient - Inpatient re**habilitative services are subject to pre-certification. Inpatient rehabilitative services shall also include Room and Board, including regular daily services and supplies furnished by the Facility, Physician and Professional Providers. Pre-certification is required, and benefit limitations apply.
- **Outpatient - Outpatient rehabilitative** services shall also include daily services and supplies furnished by the Facility, Physician and Professional Providers. Pre-certification is required, and benefit limitations apply.
- **Cognitive therapy.**
- **PUVA therapy.**
- **Vision therapy (orthoptics).**

Covered Expenses shall include:

1. Room and Board (including regular daily services, supplies and treatments furnished by the skilled care facility) limited to the Facility's average Semiprivate room rate; and
2. Other services, supplies and treatment ordered by a Physician and furnished by the skilled care facility for Inpatient medical care.

SLEEP DISORDERS

Covered Expenses shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

STERILIZATION

Covered Expenses shall include elective sterilization procedures for the covered Employee or covered spouse/domestic partner. Reversal of surgical tubal ligation sterilization is a Covered Expense, limited to one reversal per the Member's lifetime, and subject to the limitationspecified in the Schedule of Benefits. Covered Expenses for elective surgical sterilization procedures for women shall be considered under the subsection, Preventive Care Services.

SURGICAL TREATMENT OF OBESITY

Charges for services, supplies or treatment for bariatric surgery, including the initial examination, office visit, and diagnostic testing to determine readiness or ability, psychological and surgical consultations and evaluations shall be a Covered Expense except where notated as an exclusion or limitation of services.

Services and supplies in connection with Medically Necessary surgery for weight loss, only for morbid obesity, are subject to pre-certification.

TRAVEL

Coverage for travel, meals and lodging associated with an approved, specified bariatric surgery shall be a Covered Expense only when the surgery is being performed at a Facility fifty (50) miles or more from the Member's place of residence, provided the expenses are authorized by the Plan in advance.

The lifetime Maximum Amount for travel, meals, and lodging expenses directly related to services rendered in connection with approved bariatric surgery procedure shall not exceed $2,500 per Member.

The following amounts and limits apply to the expenses of the patient and persons eligible to accompany the patient:

- For the Member (limited to pre-surgical and post-surgical visits, as well as the initial surgery)
    - For transportation to the surgical procedure…….up to $130 per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
    - For transportation to the surgical procedure…….up to $130 per trip
- For the Member and one companion (for each pre-surgical visit and each follow-up visit)
    - Hotel accommodations……up to $200 per day, for up to 2 days per trip, limited to one room, double occupancy
- For one companion (for the duration of the Member's initial surgery stay)
    - Hotel accommodations……up to $200 per day, for up to 4 days, limited to one room, double occupancy
- For the Member and one companion
    - Food / meals (excluding tobacco, alcohol, and drug expenses)…..up to $75 per day, per person, for up to 4 days per trip.

TELEHEALTH

This Plan provides benefits for Covered Expenses that are appropriately provided through Telehealth, subject to the terms and conditions of the Plan. In-person contact between a Professional Provider and the Member is not required for these services, and the type of setting where these services are provided is not limited. "Telehealth" is the means of providing health care services using information and communication technologies, including by telephone, in the consultation, diagnosis, treatment, education, care management and self-management of a Member's physical and mental health care. Telehealth does not include consultations between the Member and the Professional Provider by facsimile machine, or email.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) or myofascial pain syndrome shall be a Covered Expense, but shall not include orthodontia. Covered Expenses for intra-oral orthotics or prosthetics devices are subject to pre-certification requirements as set forth by the Plan.

THERAPY SERVICES- CHEMOTHERAPY/RADIATION THERAPY/ IV INFUSION

Covered Expenses shall include Facility charges and services of a Professional Provider for; chemotherapy; and IV infusion therapy whether rendered on an Inpatient or Outpatient basis.

TRANSPLANTS

Transplant procedures are subject to pre-certification.

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered Covered Expenses subject to the following conditions:

1. When the recipient is covered under this Plan, the Plan will pay the recipient's Covered Expenses related to the transplant.
2. When the donor is covered under this Plan, the Plan will pay the donor's Covered Expenses related to the transplant, provided the recipient is also covered under this Plan. Covered Expenses Incurred by each person will be considered separately for each person.
3. Expenses Incurred by the donor who is not ordinarily covered under this Plan according to Eligibility requirements will be Covered Expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan.
4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than

donated, the purchase price of such organ or tissue shall not be considered a Covered Expense under this Plan.

Coverage for travel, meals and lodging associated with the specific organ transplants shall be a Covered Expense only when associated with the following types of transplants:

- Human heart transplants.
- Human lung transplants.
- Human heart and lunch transplants in combination.
- Pancreas transplants.
- Human kidney and pancreas transplants in combination.
- Human liver transplants.
- Human bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational.
- Pediatric human small bowel transplants.
- Pediatric and adult human small bowel and liver transplants in combination.

Transportation, meals and lodging shall only be provided when services are rendered by a Center of Excellence contracted with the Claims Administrator, directly with the Plan, or as otherwise approved by the Plan Administrator. A "Center of Excellence" is a licensed healthcare Facility having met strict quality standards and excellent surgical outcomes that has entered into a participation agreement with a national transplant network or directly with the Plan to provide approved transplant services at a Negotiated Rate to which the Plan has access.

The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admissions taking place at a Center of Excellence. Members should contact the Claims Administrator to discuss this benefit by calling:

HMA/Advanta
(833) 396-2697

The travel, meal and lodging benefits shall start five (5) days prior to the transplant and shall extend through the Member's episode of care.

TRAVEL

Travel refers to the cost of transportation to and from the transplant facility for the patient and another person eligible to accompany the patient. If the patient is under the age of 18, this provision is extended to include the patient, plus two (2) eligible persons. If one of the accompanied, eligible individuals are the patient's organ donor, a third individual would be permitted to accompany the patient as well.

MEALS

Meals; refers to the reasonable and necessary costs of meals for the patient and person(s) eligible to accompany the patient.

LODGING

Lodging refers to reasonable and necessary costs of lodging for the patient (when in route to transplantation facility if greater than 100 miles from residents or care facility) and for person(s) eligible to accompany the patient until discharge from care.

EXCLUSIONS

Unless protected by the Americans with Disabilities Act, Fair Employment and Housing Act or other state or federal law, the following items are excluded from this Covered Expense:

- Alcoholic beverages
- Car maintenance
- Cards, stationary, stamps
- Clothing
- Dry cleaning
- Entertainment (books, movies, etc.)
- Flowers

- Household products
- Household utilities
- Kennel fees
- Laundry services
- Security deposits
- Toiletries
- Toys

Travel expenses must be submitted within one hundred and eighty (180) days following the transplantation event; otherwise, expenses will no longer be covered.

Reimbursement for travel expenses shall be coded as one of the following CPT Codes:

- A0090 Interest escort in non-emergency
- A0160 Case worker/social worker travel per mile (allow gas or mileage, not both)
- A0170 Transport ancillary; parking fees, tolls, other up to $50 per day combined with other miscellaneous expenses
- A0180 Non-emergency transport, lodging
- A0190 Non-emergency transport, meals
- A0200 Non-emergency transport, ancillary
- A0210 Non-emergency transport, meals

These codes are recommended codes for use under IRS Publication 502 to distinguish personal from medical travel expenses reimbursable under the health Plan.

The Maximum Amount for travel, meals, and lodging expenses directly related to services rendered during the approved organ transplant shall not exceed $25,000.

The following per day amounts apply to the expenses of the patient and persons eligible to accompany the patient:

- $60 per day for travel via ground transportation (per person)
- $100 per day for lodging (per person). Lodging limited to one room, double occupancy.
- $75 per day for meals (per person)
- Airfare to and from the transplant facility when the Facility is 300 miles or more from the recipient's or donor's residence.

Reimbursement for air, transit including train and ground/bus transport, will be based on coach class tickets only.

The Member does not share a responsibility in the costs associated with travel, meals, or lodging, nor shall they be considered eligible expenses as it pertains to the health Plan's Deductible or out-of-pocket expense.

Members who choose to elect to receive services for a non-covered service shall bear 100% of the costs associated with these services. These services are not considered to be eligible expenses as it pertains to the health Plan's Deductible or out-of-pocket expense.

If a Member's transplant procedure is not performed as scheduled due to intended recipient's medical condition or death, benefits will be paid for organ and tissue procurement as described above.

URGENT CARE CENTER

Covered Expenses shall include charges for treatment in an urgent care center, payable as specified on the Schedule of Benefits.

WELL NEWBORN CARE

The Plan shall cover well newborn care as part of the mother's claim while the mother is confined for delivery not to exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean delivery. Such care shall include, but is not limited to:

1. Physician services
2. Hospital services
3. Circumcision

Newborn Children will be considered a dependent under this Plan for thirty-one (31) days immediately following birth. For coverage under the Plan for the newborn beyond that date, the employee must submit an application for enrollment within thirty (30) days of birth.

MEDICAL EXCLUSIONS

In addition to Plan Exclusions, no benefit will be provided under this Plan for medical expenses for the following:

1. Charges related to genetic counseling or testing for breast cancer except as shown as covered in the Schedule of Benefits. This exclusion does not apply to the BRCA risk assessment and genetic counseling/testing requirement of the women's preventive care mandate of the ACA.
2. Charges for services, supplies or treatment for sexual reassignment, including but not limited to medication, implants, hormone therapy, and/or surgery treatment unless Medically Necessary and required by applicable law.
3. Charges for treatment or surgery for sexual dysfunction.
4. Charges for Hospital admission on Friday, Saturday or Sunday unless the admission is an Emergency situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, Hospital Expenses will be payable commencing on the date of actual surgery.
5. Charges for Inpatient Room and Board in connection with a Hospital Confinement primarily for diagnostic tests, unless it is determined by the Plan that Inpatient care is Medically Necessary.
6. Charges for services, supplies or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care, except as specifically provided herein.
7. Charges for services, supplies or treatments provided by your Employer.
8. Charges for services, supplies or treatments provided by an educational institution as required by law, except as specifically stated in the "Patient Education" section under this Plan.
9. Charges for or in connection with the treatment of or relating to the Injury or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants except as specifically stated as a benefit in the Covered Medical Expense "Dental Services" section under this Plan.
10. Charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses, except as specifically stated under Medical Expense Benefit, Special Equipment and Supplies; dispensing optician's services.
11. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.
12. Except as Medically Necessary for the treatment of metabolic or peripheral-vascular Illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.
13. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a Physician, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment or other items considered "luxury medical equipment", such as, motorized wheelchairs or other vehicles, bionic or computerized artificial limbs.
14. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.
15. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost are included in the orthotists charge) or shoe inserts, when prescribed by a Professional Provider.
16. Expenses for a Cosmetic Surgery or procedure and all related services, except as specifically stated in Medical Expense Benefit, Cosmetic Surgery.
17. Charges Incurred as a result of, or in connection with, Cosmetic Surgery or any procedure or treatment excluded by this Plan which has resulted in medical complications.
18. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutrisystem, Weight Watchers or similar programs; and Hospital Confinements for weight reduction programs, except as specifically provided herein.
19. Charges for surgical weight reduction procedures and all related charges, even if resulting from morbid obesity, except as specifically provided herein.
20. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches; except as mandated under PPACA, Preventive Care.
21. Charges for employment physical, premarital lab work or any related charges and other care not associated with treatment or diagnosis of an Illness or Injury, except as specified herein.

22. Charges for Custodial Care, domiciliary care or rest cures.
23. Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically provided herein.
24. Charges for wigs, artificial hair pieces, artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness. This exclusion does not apply when baldness is the result of burns, chemotherapy, radiation therapy, or surgery. Under these conditions, purchase of a wig or artificial hair piece is limited to two (2) while covered by this Plan.
25. Charges for expenses related to hypnosis.
26. Charges for prescription drugs that are covered under the Prescription Drug Program.
27. Charges for professional services billed by a Physician or Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse who is an employee of a Hospital or any other Facility and who is paid by the Hospital or other Facility for the service provided.
28. Charges for environmental change including hospitalization or Physician charges connected with prescribing an environmental change.
29. Charges for Room and Board in a Facility for days on which the Member is permitted to leave (a weekend pass, for example).
30. Charges for Reconstructive Surgery for breast reduction, unless it is for reconstructive breast reduction following mastectomy on the non-diseased breast to make it equal in size with the diseased breast following Reconstructive Surgery on the diseased breast.
31. Except as specifically stated in Covered Medical Expenses, Temporomandibular Joint Dysfunction, charges for treatment of temporomandibular joint (TMJ), myofascial pain syndrome or orthognathic treatment, including but not limited to charges to alter vertical dimension or to restore abraded dentition or orthodontia whether treatment is provided by a Hospital, Physician, Dentist, physical therapist or oral surgeon. Charges for orthodontia or prosthetic devices prescribed by a Physician or Dentist.
32. Charges for a power wheelchair or scooter that is only needed and used outside of the home.
33. Amounts in excess of the "Reasonable and Allowed" with respect to Non-Participating Provider claims.
34. Marriage, relationship, family, career, legal or financial counseling.
35. Charges for sex therapy, diversion therapy or recreational therapy unless Medically Necessary and required by applicable law.
36. Robotic surgery must be pre-certified and subject to the Plan's Pre-certification penalty, if not pre-certified. Also, the surgery for which Robotic surgery is used shall not be greater than reimbursement of the amount covered when performed without Robotic surgery.
37. Any charges Incurred by a dependent child of a covered dependent child are not Covered Expenses under this Plan.
38. Charges for chelation therapy, except as treatment of heavy metal poisoning.
39. Charges for procurement and storage of one's own blood, unless Incurred within three (3) months prior to a schedule surgery.
40. Charges related to primal therapy, rolfing, psychodrama, megavitamin therapy and visual perceptual training.
41. Charges for any services, supplies and treatment not specifically provided herein.
42. Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not a Member under this Plan.
43. Charges for immunizations required for travel.
44. Charges for human growth hormone replacement therapy.
45. Non-Approved Clinical Trials; Phase I, Phase II or Phase III clinical trial, being conducted in relation to the detection or treatment of non-life threatening cardiovascular disease (cardiac/stroke), surgical musculoskeletal disorders of the spine, hip and knees, and/or other clinical trials.
46. Approved Clinical Trials;
    a. Laboratory tests and imaging studies done at a frequency dictated by the study protocol and not consistent with signs and symptoms and other standards of care for that diagnosis or treatment type.
    b. Items and services provided by the research sponsors free of charge for any person enrolled in the trial
    c. Travel and transportation expenses are excluded from coverage. These include, but are not limited to, the following examples:
        i. Fees for all types of transportation. Examples include, but are not limited to: personal vehicle, taxi, medical van, ambulance, commercial airline, and train.
        ii. Rental car expenses.
        iii. Mileage reimbursement for driving a personal vehicle.
        iv. Lodging.
        v. Meals.

d. Routine patient costs obtained out-of-network where non-network benefits do not exist under the Plan.
e. The Investigational item, device or service itself. Services inconsistent with widely accepted and established standards of care for a particular diagnosis
f. Services related to an Approved Clinical Trial received outside of the United States.

PLAN EXCLUSIONS

The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a Physician or Professional Provider.

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

1. Charges for services, supplies or treatment from any Hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
2. Charges for an Injury sustained or Illness contracted while on active duty in military service, unless payment is legally required.
3. Charges for services, supplies or treatment for treatment of Illness or Injury which is caused by or attributed to by war or any act of war (whether declared or undeclared, civil or international, or any substantial armed conflict between organized forces of a military nature), participation in a riot, civil disobedience or insurrection.
4. Any condition for which benefits of any nature are payable or found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the Member fails to claim rights to such benefits or fails to enroll or purchase such coverage.
5. Charges in connection with any Illness or Injury arising out of or in the course of any employment intended for wage or profit, including self-employment; or related to professional or semi-professional athletics, including practice.
6. Charges made for a service, supply and treatment which is not Medically Necessary for the treatment of Illness or Injury, or which are not recommended and approved by the attending Physician, except as specifically stated herein.
7. Charges in connection with any Illness or Injury sustained while taking part or attempting to take part in an illegal act, including but not limited to misdemeanors and felonies; or for any Injury or Illness that arises from or is caused during the commission of any illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result for the Plan Administrator to determine that an act constitutes an illegal act. Proof beyond a reasonable doubt is not required to be deemed an illegal act. The Plan Administrator has the sole discretion to determine whether a particular act constitutes an Illegal Act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both Physician and mental health conditions).
8. Any charges that are for services, supplies, and/or treatment of any Member that Incurred while confined and/or arising from Confinement in a prison, jail or other penal institution with said Confinement exceeding seventy-two (72) hours.
9. Any charges that are Incurred in connection with the care and/or treatment of surgical procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primary to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an accident; (b) because of infection or Illness; (c) because of congenital disease, developmental condition or anomaly of a covered dependent child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons; (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).
10. Any charges for care, supplies or treatment, and/or services that do not restore health, unless specifically mentioned otherwise.
11. Any charges for care, supplies, treatment, and/or services that are not payable due to the application of any specified Deductible provisions contained herein.
12. Any charges for care, supplies, treatment and/or services that are required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Member was under, and due to, the care of a Professional Provider wherein such Illness, Injury, infection or complication is not reasonable expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

13. Any charges for care, supplies, treatment and/or services that are not payable under the Plan due to application of any Plan maximum or limit.
14. Any charge in connection with any Illness or Injury that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Plan Member's customary occupation or if it involves leisure time activities considered by the Plan Administrator, taking all circumstances into account, as involving unusual or exceptional risks, characterized by a threat of danger or risk of bodily harm. Hazardous pursuits, hobbies, or activities include, but are not limited to, reckless operation of machinery, travel to countries with advisory warnings, and use of weapons and explosives.
15. To the extent that payment under this Plan is prohibited by any law of the jurisdiction in which the Member resides at the time the expense is Incurred.
16. Charges for services rendered and/or supplies received prior to the Effective Date or after the termination date of a Member's coverage.
17. Any services, supplies or treatment for which the Member is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
18. Any charges for care, supplies, treatment, and/or services:
    a. That are furnished to the Member in any veteran's Hospital, military Hospital, Institution or Facility operated by the United States government or by any state government or any agency or instrumentally of such governments; and
    b. That can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

    NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This exclusion does not apply where otherwise prohibited by law.
19. Any charges that are related to conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.
20. Any charge for care, supplies, treatment, and/or services for expenses actually Incurred by other persons.
21. Any charges for care, supplies, treatment, and/or services for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.
22. Charges for services, supplies or treatment that is considered Experimental/Investigational. The Plan Administrator has the sole discretion to make this determination.
23. Charges Incurred outside the United States if the Member traveled to such a location for the sole purpose of obtaining services, supplies or treatment.
24. Charges for services, supplies or treatment rendered by any individual who is a Close Relative, as determined by the Plan Administrator, of the Member or who resides in the same household as the Member.
25. Charges for services, supplies or treatment rendered by Facilities, Physicians or Professional Providers beyond the scope of their license; for any treatment, Confinement or service which is not recommended by or performed by an appropriate Professional Provider.
26. Charges for Illnesses or injuries sustained by a Member due to the action or inaction of any party if the Member fails to provide any information as specified in Subrogation section or as requested by the Plan in connection with any third-party recovery.
27. Any charges for care, supplies, treatment, and/or services that are of an Injury or Illness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.
28. Claims not submitted within the Plan's filing limit deadlines as specified in Claim Filing Procedures.
29. Charges for email consultations, completion of claim forms, charges associated with missed appointments.
30. If the primary plan has a restricted list of healthcare providers and the Member chooses not to use a provider from the primary plan's restricted list, this Plan will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits.
31. If the primary plan provides coverage through the services of an HMO and the Member chooses not to use the HMO, this Plan will not pay for any charges disallowed by the primary plan due to failure to utilize the HMO, if shown on the primary carrier's explanation of benefits.
32. This Plan will not pay for any charge which has been refused by another plan covering the Member as a penalty assessed due to non-compliance with the Plan's rules and regulations, if shown on the primary carrier's explanation of benefits.
33. Benefits which are payable under any one section of this Plan shall not be payable as a benefit under any other section of this Plan. For example, if a benefit is eligible under both the Medical Expense Benefits

section and the Prescription Drug Program section, and is paid under the Medical Expense Benefit, the remaining balance will not be paid under the Prescription Drug Program Benefit.

34. Excess Charges - Except as specifically stated otherwise, no benefits will be payable for charges in excess of the "Reasonable and Allowed" charges for services or supplies provided.
35. Charges Incurred for which the Plan has no legal obligation to pay.
36. Court ordered treatment or services - charges for services, treatment or care of any kind that are provided due to a court order, or are required by a court of law and/or are imposed as an alternative to, or in addition to, fine or imprisonment. This exclusion shall not apply to expenses for the Illness or Injury that would be covered under the Plan in the absence of a court order, and for which the Member is legally obligated to pay.
37. Private duty or shift care services of a health care provider, except as specifically provided herein.
38. Examinations - charges for examinations, testing, vaccinations or other services related to employment, licensing, insurance, adoption, marriage license, sports, or camp applications, or travel outside the United States.
39. Administrative or Adjunctive Charges – charges for administrative fees; completion, filing or copying of claim forms, itemized billed or medical reports; reports or appearances in legal proceedings, mailing, postage, or shipping and handling, missed appointments; late fees; sales tax; interest or penalties; travel time or expenses.
40. Charges for the release and review of medical records.
41. Duplicate Item - You are not covered for duplicate Durable Medical Equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that is intended to be used as a backup device, for multiple residences, or for traveling, e.g., a second wheeled mobility device specifically for work or school use or a backup manual wheelchair when a power wheelchair is the primary means of mobility. Note: ventilators at home are not included in this exemption).
42. A dependent child of a covered dependent child shall not be covered by this Plan.
43. Charges based on billing mistakes, improprieties, or illegitimate billing entries, including but not limited to up-coding, duplicate charges, charges for care, supplies, treatment and/or services not actually rendered or performed or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard; it is in the Plan Administrator's sole discretion to determine what constitutes an Error under the terms of this Plan.
44. Charges (a) that are found to be based on Errors (as defined in this Plan Document); unbundling, misidentification, or unclear description; (b) charges for fees or services determined not to be Medically Necessary or Reasonable; (c) charges found by the Plan Administrator to be in excess of the Maximum Allowable Charge or the Reasonable and Allowed Amount; or (d) charges that are otherwise determined by the Plan Administrator to be invalid or impermissible based on any applicable law, regulation rule for professional standard.
45. Charges for an item billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT (Current Procedural Terminology), the Healthcare Common Procedure Coding System (HCPCS) code used by CMS, or any industry standard guidelines in effect at the time services were rendered.
46. Any charges for care, supplies, treatment, and/or services for treatment of any Injury where it is determined that a Member was involved in a motorcycle (including but not limited to all-terrain vehicles and off-road motor vehicles) accident while not wearing a helmet or in an automobile accident while not wearing a seatbelt.
47. Any charges for care, supplies, treatment, and/or services that are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).
48. Any charges for, supplies, treatment, and/or services that are not actually rendered.
49. Any charges for, supplies, treatment, and/or services that are not specifically covered under this Plan.
50. Any charges for, supplies, treatment, and/or services that are other than those certified by a Physician who is attending the Member as being required for the treatment of Injury or disease, and performed by an appropriate Professional Provider.
51. Any charges for care, supplies, treatment, and/or services that are to the extent that payment under this Plan is prohibited by law.

PRESCRIPTION DRUG PROGRAM

There are three (3) aspects of the Prescription Drug Program for Preventive Prescription Services and Non-Preventive Prescription Services.

RETAIL OPTION

Participating pharmacies have contracted with the Plan to charge Members reduced fees for covered prescription drugs.

The Copayment is applied to each covered pharmacy drug charge and is shown on the Schedule of Benefits. The Copayment amount is not a Covered Benefit under the Medical Expense Benefit. Any one prescription is limited to a thirty (30) day supply. Maintenance drugs (drugs which are prescribed for long-term usage) may be dispensed in a ninety (90) day supply.

If a drug is purchased from a Participating Pharmacy or a Non-Participating Pharmacy when the Member's ID card is not used, the Member must pay the entire cost of the prescription, including Copayment, and then submit the receipt to the prescription drug card vendor for reimbursement. If the Plan covers services from nonparticipating pharmacies and a Non-Participating Pharmacy is used, the Member will be responsible for the Copayment, plus the difference in cost between what the Plan would have paid to a Participating Pharmacy less the Program's Copayment and the cost the Member Incurred at the Non-Participating Pharmacy, including the Program's Copayment. Please review the Prescription Drug Benefit Schedule to determine if services by a Non-Participating Pharmacy are covered or not covered.

DISPENSE AS WRITTEN (DAW) PENALTY

If you or your doctor requests a brand-name medicine when a generic alternative is available, your prescription cost will be higher.

The Dispense As Written (DAW) Penalty is the amount you pay for a brand name drug when a Generic Drug is available. In these instances, you will pay the difference between the brand name drug and the Generic Drug plus the appropriate Copayment (depending on whether the prescription is a Preferred Brand drug or Non-Preferred Brand Drug. See the Prescription Drug Benefits Schedule for additional information.

If the Member purchases a brand name drug when a Generic Drug equivalent is available, the Dispense As Written (DAW) Penalty will be applied and the Member will be required to pay the brand name Copayment, plus the difference between generic and brand name; unless the Physician has issued a DAW.

MAIL ORDER 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, cholesterol, etc.).

The Copayment is applied to each covered mail order prescription charge and is shown on the Schedule of Benefits. The Copayment is not a Covered Benefit under the Medical Expense Benefit. Any one prescription is limited to a ninety (90) day supply.

PRUDENTRX COPAYMENT PROGRAM FOR SPECIALTY MEDICATIONS

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, Amy's Kitchen, Inc. Medical Plan has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists Members by helping them enroll in manufacturer Copayment assistance programs. Medications in the specialty tier will be subject to a 30% Coinsurance. However, enrolled Members who get a Copayment card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

Copayment assistance is a process in which drug manufacturers provide financial support to Members by covering all or most of the Member cost share for select medications - in particular, specialty medications. The PrudentRx Copay Program will assist Members in obtaining Copayment assistance from drug manufacturers to reduce a Member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these Copayment assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible Members will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the Copayment assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copayment program. PrudentRx will also contact you if you are required to enroll in the Copayment assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any Copayment assistance as required by a manufacturer you will be responsible for the full amount of the 30% Coinsurance on specialty medications that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your Plan, or a manufacturer's copay assistance program, will not count toward your Plan Deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, Member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's Maximum Out-of-Pocket Amount. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The Specialty Pharmacy Program is available for select specialty drugs including select injectable and oral medications used in certain branches of medicine or for certain medical conditions, as follows:

1. Allergic Asthma
2. Crohn's Disease
3. Enzyme replacement for Lysosomal Storage Disorder
4. Gaucher's Disease
5. Growth hormone disorders
6. Hematopoietics
7. Hemophilia, Von Willebrand disease and related bleeding disorders
8. Hepatitis C
9. Hormonal therapies
10. Immune deficiencies
11. Multiple Sclerosis
12. Oncology
13. Osteoarthritis
14. Psoriasis
15. Pulmonary Arterial Hypertension
16. Pulmonary disease
17. Renal disease
18. Respiratory Syncytial Virus
19. Rheumatoid Arthritis
20. Other Disorders

To take advantage of this program, the covered Member will need to transfer the related prescription to Caremark. To transfer a prescription, call (800) 237-2767. A representative of Caremark will call the covered Members Physician and take care of the appropriate paperwork.

The medication will be shipped to a location of the covered Members choice from the Caremark specialty pharmacy. For details regarding the applicable Copayment and supply limitations, please refer to the Prescription Drug Benefit Schedule, Prescription Drug Program, Pharmacy Option and Mail Order Option.

MAINTENANCE PRESCRIPTION DRUG PROGRAM

The Maintenance Prescription Drug Program option is available for certain maintenance medications that may be prescribed for diabetes, high blood pressure, behavioral health or asthma. Covered Members should refer to the section, Schedule of Benefits, Maintenance Prescription Drug Program for a listing of eligible drugs and applicable Copayments.

COVERED PRESCRIPTION DRUGS

The following drugs and items are covered under the Prescription Drug Program when they are prescribed by an appropriately licensed practitioner:

1. All drugs prescribed by a Physician that require a prescription either by federal or state law, including injectables and insulin, except drugs excluded by the Plan.

2. All compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin, insulin needles and syringes and diabetic supplies, including blood sugar measurement devices.

4. Drugs used in the treatment of erectile dysfunction.

5. Drugs used in the treatment of infertility, subject to the limitation specified on the Schedule of Benefits.

6. Growth hormones.

7. Anorexiants.

8. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a qualified prescriber.

ROUTINE PREVENTIVE DRUGS

Covered Expenses shall include the following preventive therapy drugs recommended by the United States Preventive Services Task Force (USPSTF):

1. Generic prescription or over-the-counter aspiring to prevent cardiovascular disease (CVD) for Members age forty-five (45) and older when the potential benefit of a reduction in myocardial infarction or ischemic stroke outweighs the potential harm of an increase in gastrointestinal hemorrhage.

2. Generic or brand prescription, or over-the-counter iron supplements for asymptomatic children age twelve (12) months and younger who are at increased risk for iron deficiency anemia.

3. Generic or brand prescription for oral fluoride supplements at currently recommended doses to preschool children age six (6) years and younger whose primary water source is deficient in fluoride.

4. Generic or brand prescription, or over-the-counter folic acid supplements for all women age fifty-five (55) and younger planning and capable of Pregnancy.

5. Generic prescription nicotine replacement products (nicotine patch, gum and lozenges) and treatment with generic Zyban or Chantix for Members who use tobacco products. Benefits include prescription and over-the-counter tobacco cessation products.

6. The full range of FDA-approved prescription contraceptive methods for covered women, including oral contraceptives, emergency contraceptives, injectable contraceptives, intrauterine devices, subdermal rods, vaginal rings, transdermal patches, and barrier methods (diaphragms and cervical caps). Benefits are limited to Generic Drug products. If no generic is available, Covered Expenses shall include single sourced brand name drugs and products.

Covered Expenses for routine preventive drugs shall be payable as specified in the Schedule of Benefits. Routine preventive drugs that may be legally purchased over-the-counter must have a written prescription from the Physician in order to e be a Covered Expense under this benefit.

LIMITS TO THIS BENEFIT

This benefit applies only when a Member 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.

PRESCRIPTION DRUG EXCLUSIONS

The following items are excluded from coverage in the Prescription Drug Program

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.

2. 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.

3. Immunization agents or biological sera, blood or blood plasma.

4. A drug or medicine labeled: "Caution - limited by federal law to investigational use."

5. Experimental drugs and medicines, even though a charge is made to the Member.

6. Any charge for the administration of a covered prescription drug.

7. Any drug or medicine that is consumed or administered at the place where it is dispensed.

8. A drug or medicine that is to be taken by the Member, in whole or in part, while Hospital confined. This includes being confined in any institution that has a Facility for dispensing drugs.

9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

10. A charge for minerals.

11. A charge for medications that is cosmetic in nature (i.e. treating hair loss, wrinkles, etc.).

12. A charge for Hematinics.

13. A charge for non-legend drugs, other than as specifically listed herein.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

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

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

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

APPEALING A DENIED POST-SERVICE PRESCRIPTION DRUG CLAIM

The "named fiduciary" for purposes of an appeal of a denied Post-Service Prescription Drug Claim, as described in U.S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the Claims Administrator.

A covered Member or the covered Members authorized representative may request a review of a denied claim by making a written request to a named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the covered Member feels the claim should not have been denied.

The following describes the review process and rights of the covered Member:

1. The covered Member has the right to submit documents, information and comments and to present evidence and testimony.

2. The covered Member has the right to access, free of charge, relevant information to the claim for benefits.

3. The appeal should be addressed to:

   Prescription Claim Appeals MC 109
   P.O. Box 52084
   Phoenix, AZ 85072-2084

4. Before a final determination on appeal is rendered, the covered Member will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the covered Member a reasonable opportunity to respond prior to that date.

5. The review takes into account all information submitted by the covered Member, even if it was not considered in the initial benefit determination.

6. The review by a named fiduciary will not afford deference to the original denial.

7. The named fiduciary will not be:

   a. The individual who originally denied the claim, nor
   b. Subordinate of the individual who originally denied the claim.

8. If original denial was, in whole or in part, based on medical judgment:

   a. The named fiduciary will consult with a Professional Provider who has appropriate training and experience in the field involving the medical judgment; and
   b. The Professional Provider utilized by the named fiduciary will be neither:

      i. An individual who was consulted in connection with the original denial of the claim, nor
      ii. A subordinate of any other Professional Provider who was consulted in connection with the original denial.

9. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG APPEAL

The Plan Administrator (or its designee) shall provide the covered Member (or authorized representative) with written Notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.

2. Reference to specific Plan provisions on which the denial is based.

3. A statement that the covered Member has the right to access, free of charge, relevant information to the claim for benefits.

4. A statement of the covered Members right to request an external review and a description of the process for requesting such a review.

5. A statement that if the covered Members appeal is denied, the Member has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:

    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the denial was based on medical necessity, Experimental/Investigational treatment or similar exclusion or limit, the Plan Administrator (or its designee) will supply either:

    a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

EXTERNAL APPEAL

The covered Member (or authorized representative) may request a review of a denied appeal (if the claim determination involves medical judgment or a rescission) by making written request to the named fiduciary within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

1. Medical necessity;
2. Appropriateness;
3. Experimental or Investigational treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a Covered Expense.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday. The Plan may charge a filing fee to the Member requesting an external review, subject to applicable laws and regulations.

RIGHT TO EXTERNAL APPEAL

Within five (5) business days of receipt of the request, the Claims Administrator will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

1. Medical judgment; or
2. Rescission of coverage under this Plan.

NOTICE OF RIGHT TO EXTERNAL APPEAL

The Plan Administrator (or its designee) shall provide the covered Member (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at (866) 444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the covered Member to perfect the external review request by the later of the following:
    a. The four (4) month filing period; or
    b. Within the forty-eight (48) hour time period following the covered Members receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify the covered Member in writing of the request's eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

The assigned IRO shall provide the Plan Administrator (or its designee) and the covered Member (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the covered Member, the Plan and Claims Administrator, except to the extent that other remedies may be available under State or Federal law.

EXPEDITED EXTERNAL REVIEW

The Plan Administrator (or its designee) shall provide the covered Member (or authorized representative) the right to request an expedited external review upon the covered Members receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the covered Member or the covered Members ability to regain maximum function and the covered Member has filed an internal appeal request.
2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the covered Member or the covered Members ability to regain maximum function or if the final determination involves any of the following:
    a. An admission,
    b. Availability of care,
    c. Continued stay, or
    d. A health care item or service for which the covered Member received emergency services, but has not been discharged from a Facility.

Immediately upon receipt of the request for Expedited External Review, the Plan will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, Right to External Appeal.

2. Send notice of the Plan's decision, as described in the subsection, Notice of Right to External Appeal.

Upon determination that a request is eligible for external review, the Plan will do all of the following:

1. Assign an IRO as described in the subsection, Independent Review Organization.
2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the covered Member's medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, Notice of External Review Determination. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the Plan Administrator (or its designee) and the covered Member (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

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

ELIGIBILITY

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

EMPLOYEE ELIGIBILITY

All Employees regularly scheduled to work at least twenty-four (24) hours per work week in any forty-five (45) day period shall be eligible to enroll for coverage under this Plan. Coverage shall be effective on the first of the month following or coincident with forty-five (45) days of employment. Part-time Employees (less than 24 hours), temporary Employees, Interns and seasonal Employees are excluded unless mandated by law unless noted below.

Temporary Employees and Interns working at least thirty (30) hours per week shall be eligible to enroll for coverage under this Plan on the ninety first (91st) day of employment.

Rehired Employees who return to Amy's Kitchen, Inc. within six (6) months of their separation date can elect to have their benefits reinstated on the first of the month following their rehire date. Coverage shall be effective first of the month coincident with or following the date of rehire or return to work.

Employees who have a change in eligibility status by moving from a non-benefits-eligible position into a benefits-eligible position are subject to the new hire benefits waiting period of forty-five (45) days.

Variable Hour (Part-time) Employee – Amy's Kitchen, Inc. uses a twelve-month measurement period, during which time Employees will be ineligible for benefits. Following this period, Amy's Kitchen, Inc. will use an administrative period to calculate whether the Employee worked, on average, 30 or more hours per week. If it is established that the Employee satisfies the above criteria, the Employee will then become eligible for enrollment in the company benefits offering, effective the first day of the month following the administrative period.

DEPENDENT ELIGIBILITY

The following describes Dependent eligibility requirements. The Plan Administrator will require proof of Dependent status.

1. **Spouse.** The term "spouse" means the spouse of the Employee under a legally valid existing marriage, unless court ordered separation exists; or

2. **Domestic Partner.** The term "Domestic Partner" means a person of the opposite sex or same sex with whom the Employee has established a Domestic Partnership. All of the following requirements apply to both persons:
    a. They must be at least 18 years of age and competent to enter into a contract;
    b. They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law;
    c. They must not be legally separated from another person;
    d. They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside;
    e. They must have allowed at least six (6) months to pass since the termination of any previous domestic partnership (this does not apply if the previous domestic partnership ended due to the domestic partner's death); and
    f. They must share a permanent residence.

    Employees enrolling a Domestic Partner must provide an Affidavit of Domestic Partnership. Employees terminating a Domestic Partner must provide an Affidavit of Domestic Partnership Termination. Employees should contact the Employer for the required documentation.

3. **Child/Children.** The term "Child/Children" means the Employee's or the Employee's covered spouse's/domestic partner's natural child, stepchild, legally adopted child, foster child, and a child for whom the Employee or covered spouse has been appointed legal guardian or power of attorney for medical expenses, provided the child has not reached the end of the month of his or her twenty-sixth (26th) year of age.

4. **Qualified Medical Child Support Order (QMCSO)**. An eligible child shall also include any other child of an Employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as

being entitled to enrollment for coverage under this Plan, even if the child is not residing in the Employee's household. Such child shall be referred to as an Alternate Recipient. An application for enrollment must be submitted to the Plan Administrator for coverage under this Plan. The Plan Administrator shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the Plan pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a Qualified Medical Child Support Order or a National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

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

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

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

   Proof of incapacitation must be provided within thirty (30) days of the child's loss of eligibility and thereafter as requested by the Plan Administrator or Claims Administrator, but not more than once every two (2) years.

   Eligibility may not be continued beyond the earliest of the following:
   a. Cessation of the mental and/or physical disability;
   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination;

7. **Newborn Child**. Newborn Children will be considered a Dependent under this Plan for thirty-one (31) days immediately following birth. For coverage under the Plan for the newborn beyond that date, the Employee must submit an application for enrollment within thirty (30) days of birth.

These persons are excluded as Dependents:

- A spouse who is legally separated or divorced from the Employee;
- Children of a Dependent son or daughter;
- Children who are, or become, a full-time member of the armed forces of any country;
- Any person who is covered as a Dependent of another Employee under this Plan;
- Any person who is eligible as an Employee under the Plan; and
- The spouse of a Dependent child.

ENROLLMENT

The benefits of this Plan are based on a Benefit Year. If an Employee or Dependent enrolls for coverage at any time during the Benefit Year, the benefits shall be calculated on a Benefit Year

APPLICATION FOR ENROLLMENT

An Employee must file a written application with the Plan Administrator for coverage hereunder for himself and his eligible Dependents within thirty (30) days of becoming eligible for coverage; and within thirty (30 days of marriage or the acquiring of children or birth of a child. The Employee shall have the responsibility of timely forwarding to the Plan Administrator all applications for enrollment hereunder. Once a properly completed application for enrollment has been submitted to the Plan Administrator and coverage has become effective, as defined in the section titled, Effective Date of Coverage, the Employee's enrollment options shall remain in effect. The only opportunity to change the enrollment option shall be at the annual open enrollment period, or upon a special enrollment option as defined below.

The Plan Administrator must be notified of any change in eligibility of Dependents within thirty (30) days of the change, including the birth of a child that is to be covered and adding or deleting any other Dependents. Forms are available from the Plan Administrator for reporting changes in Dependents' eligibility as required.

Failure to complete the application for enrollment within thirty (30) days shall result in the Late Enrollment provision applying to the individual. An Alternate Recipient can be enrolled in the Plan at any time and shall not be subject to the Late Enrollment provision.

Employee/Spouse or Domestic Partner Enrollment

Every eligible Employee may enroll eligible Dependents. However, if both the Employee and spouse or domestic partner are Employees, each individual will be covered as an Employee. An Employee cannot be covered as an Employee and a Dependent. Eligible children may be enrolled as Dependents of one spouse, but not both.

Transfer of Coverage

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

SPECIAL ENROLLMENT PERIOD: LOSS OF ELIGIBILITY FOR OTHER COVERAGE

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

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

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

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

The Employee or Dependent must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The Effective Date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the special enrollment event.

SPECIAL ENROLLMENT PERIOD: DEPENDENT ACQUISITION

An Employee who is currently covered or not covered under the Plan, but who acquires a new Dependent may request a special enrollment period for himself, if applicable, his newly acquired Dependent and his Spouse/Domestic Partner, if not already covered under the Plan and otherwise eligible for coverage. For the purposes of this provision, the acquisition of a new Dependent includes:

1. Marriage or domestic partnership;
2. Birth of a Dependent child;
3. Adoption or placement for adoption of a Dependent child;
4. Obtaining Legal Guardianship or power of attorney of a Dependent child; or
5. A foster child being placed with an Employee.

The Employee must request the special enrollment within thirty (30) days of the acquisition of the Dependent.

The Effective Date of coverage as the result of a special enrollment shall be:

1. In the case of marriage or domestic partnership, the first day of the calendar month following the marriage or domestic partnership.
2. In the case of a Dependent's birth, the date of such birth.
3. In the case of adoption or placement for adoption, the first of the month following the date of such adoption or placement for adoption.
4. In the case of a court order mandating coverage under the Plan, the earlier of the first of the month following receipt of the court order, or the date specified in the court order.
5. In the case of a foster child being placed with the Employee, on the date on which such child is placed with the Employee by an authorized placement agency or by judgement, decree or other order of a court competent jurisdiction.

SPECIAL ENROLLMENT PERIOD: MEDICAID AND CHIP ELIGIBILITY

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

1. Termination of Medicaid or CHIP Coverage: If the Employee or Dependent is covered under a State Medicaid plan under Title XIX of the Social Security Act, or under a State Child Health Plan under Title XXI of the Social Security Act, and coverage of the Employee or Dependent under such coverage is terminated as a result of loss of eligibility for such coverage

2. Eligibility for Premium Assistance Under Medicaid or CHIP: If the Employee or Dependent becomes eligibility for premium assistance, with respect to coverage under the Plan, under a Medicaid plan or State Child Health Plan.

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

OPEN ENROLLMENT

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

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

LATE ENROLLMENT

With the exception of the provisions identified in Special Enrollment above, applications for Employee or Dependent coverage which are not filed with the Plan Administrator within thirty (30) days of meeting the eligibility requirements of the Plan shall be subject to this late enrollment provision.

Late enrollment applicants shall be eligible to enroll for coverage during the Plan's annual open enrollment period. Coverage shall be effective January 1 provided a properly completed application for enrollment has been received by the Plan Administrator. This late enrollment provision shall not apply to an Alternate Recipient.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

Eligible Employees, as described in Eligibility, are effective under the Plan the first of the month coincident with or following forty-five (45) days of continuous Full-Time employment; provided a properly completed enrollment form was submitted to the Plan Administrator. Temporary Employees and Interns are effective under the Plan on the ninety-first (91st) day of employment.

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

If the Employee does not enroll for coverage within thirty (30) days of meeting the Plan's eligibility requirements, the Effective Date of coverage will be delayed. Refer to Enrollment.

DEPENDENT EFFECTIVE DATE

Eligible Dependents, as described in Eligibility, will become covered under the Plan on the later of the dates listed below, provided the Employee has enrolled them in the Plan within thirty (30) days of meeting the Plan's eligibility requirements. If the Employee does not enroll eligible Dependents within thirty (30) days of meeting the Plan's eligibility requirements, the Dependents' Effective Date of coverage will be delayed. Refer to Enrollment.

1. The date the Employee's coverage becomes effective.
2. The date the Dependent is acquired, provided any required contributions are made and the Employee has applied for Dependent coverage within thirty (30) days of the date acquired.
3. Newborn children shall be covered as of the date of birth.
4. Coverage for a newly adopted child shall be effective on the date the child is Placed for Adoption.

TERMINATION OF COVERAGE

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

EMPLOYEE TERMINATION DATE

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

DEPENDENT TERMINATION DATE

1. The date the Plan is terminated.
2. The date the Employee's coverage terminates.
3. The date such person ceases to meet the eligibility requirements of the Plan.
4. Midnight on the first day after the date any required contribution is due but not paid, unless the Member has received confirmation in writing from a representative of the Plan that coverage will not be terminated.
5. The date the Dependent becomes a full-time, active member of the armed forces of any country.
6. The date the Plan discontinues Dependent coverage for any and all dependents.
7. The last day of the month in which the Dependent becomes eligible as an Employee.
8. The last day of the month in which the Plan Administrator receives a cancellation of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).
9. At any time, coverage may be rescinded, or retroactively terminated, effective the date the Employee commits or has committed an intentional act of fraud or material misrepresentation with respect to the Plan, with 30 days' written notice from the Plan.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, but not to exceed eighteen (18) months, contingent upon payment of any required contributions for Employees and/or Dependents, when the Employee is on an authorized Leave of Absence from the Employer. For additional information on Amy's Kitchen, Inc.'s leave policy contact the HR Department.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

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

Contributions

During this leave, the Employer will continue to pay the same portion of the Employee's contribution for the Plan. The Employee shall be responsible to continue payment for eligible Dependent's coverage and any remaining Employee contributions. For further information regarding continued contributions while on leave contact the Plan Administrator.

Reinstatement

If coverage under the Plan was terminated during an approved FMLA leave, and the Employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the Employee returns to active work as if coverage had not terminated, provided the Employee makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

Repayment Requirement

The Employer may require Employees who fail to return from a leave under FMLA to repay any contributions paid by the Employer on the Employee's behalf during an unpaid leave. Contact the Plan Administrator for further information.

EMPLOYEE REINSTATEMENT

Employees and eligible Dependents that lost coverage due to an approved Leave of Absence, Layoff, or termination of employment with the Employer are eligible for reinstatement of coverage as follows:

1. Reinstatement of coverage is available to Employees and Dependents that were previously covered under the Plan.
2. Rehire or return to work must occur within six (6) months of last day worked.
3. The Employee must submit the completed application for enrollment to the Plan Administrator within thirty (30) days of rehire or return to work.
4. Coverage shall be effective from the first of the month coincident with or following the date of rehire or return to work. Prior benefits and limitations, such as Deductible and Maximum Benefit Amount shall be applied with no break in coverage if the Employee returns within the same Benefit Year.

If the provisions of (1) through (3) above are not met, the Plan's provisions for eligibility and application for enrollment shall apply.

An Employee who returns to work after six (6) months of an approved Leave of Absence, Layoff, or separation of employment will be considered a new Employee for purposes of eligibility and will be subject to all eligibility requirements.

CONTINUATION OF COVERAGE

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

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

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

QUALIFYING EVENTS

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

1. Death of the Employee.
2. The Employee's termination of employment or reduction in work hours to less than the minimum required for coverage under the Plan.
3. Divorce or legal separation from the Employee.
4. The Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family Medical Leave Act of 1993.
7. The call-up of an Employee reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered Employee, or a child's loss of Dependent status, the Employee or Dependent must notify the Plan Administrator of that event within sixty (60) days of the event. The Employee or Dependent must advise the date and nature of the qualifying event and the name, address and Social Security number of the affected individual. Failure to provide such notice to the Plan Administrator will result in the person forfeiting their rights to continuation of coverage under this provision.

2. The Plan Administrator has thirty (30) days to notify the Claims Administrator of the qualifying event. Within fourteen (14) days of receiving notice of the qualifying event, the COBRA administrator will notify the Employee or Dependent of his right to continuation of coverage, and what process is required to elect continuation of coverage.

3. After receiving notice, the Employee or Dependent has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the Plan prior to the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. The COBRA Administrator must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:

    a. The date coverage under the Plan would otherwise end; or
    b. The date the person receives the notice from the Plan Administrator of his or her rights to continuation of coverage.

4. Within forty-five (45) days after the date the person notifies the COBRA Administrator that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.

5. The Employee or Dependent must make payments for the continued coverage.

COST OF COVERAGE

1. The Plan Administrator requires that Members pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the COBRA Administrator, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.
2. For purposes of determining monthly costs for continued coverage, a person originally covered as an Employee or as a spouse will pay the rate applicable to an Employee if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an Employee.

WHEN CONTINUATION COVERAGE BEGINS

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

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

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

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

SUBSEQUENT QUALIFYING EVENTS

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

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

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

Only a person covered prior to the original qualifying event or a child born to or Placed for Adoption with a covered Employee during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other Dependent acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

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

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

EXTENSION FOR DISABLED INDIVIDUALS

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

MILITARY MOBILIZATION

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

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

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

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

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

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

The Employee or the Employee's Dependent coverage will be reinstated without exclusions or a waiting period.

CLAIM FILING PROCEDURE

FILING A CLEAN CLAIM

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

- Current version of CMS–1500 and UB-04

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

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

FOREIGN CLAIMS

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

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

TIME LIMIT FOR FILING ALL CLAIMS

A claim for benefits should be submitted to the Claims Administrator within 365 days after the occurrence or commencement of any services covered by the Plan, or as soon thereafter as reasonably possible.

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

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

TYPES OF CLAIMS

There are four types of Claims:

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

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

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

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

PAYMENT OF BENEFITS

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

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

1. Pre-service Urgent Care Claims:

    a. If the Member has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Member has not provided all of the information needed to process the claim, then the Member will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Member will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        i. The end of the period afforded the Member to provide the information.
        ii. The Plan's receipt of the specified information.
    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Member. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Member by telephone, facsimile, or other similarly expeditious method. Alternatively, the Member may request an expedited review under the external review process.

2. Pre-service Non-Urgent Care Claims:
    a. If the Member has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
    b. If the Member has not provided all of the information needed to process the claim, then the Member will be notified as to what specific information is needed as soon as possible. The Member will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Claims Administrator and the Member (if additional information was requested during the extension period).

3. Concurrent Claims:
    a. Plan Notice of Reduction or Termination. If the Claims Administrator is notifying the Member of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Member will be notified sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
    b. Request by Member Involving Urgent Care. If the Claims Administrator receives a request from a Member to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Member makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Member submits the request with less than 24 hours prior to the expiration of the

prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

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

d. Request by Member Involving Rescission. With respect to rescissions, the following timetable applies:

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

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

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

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

NOTIFICATION OF ADVERSE BENEFIT DETERMINATION

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

1. Information sufficient to allow the Member to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Member to perfect the claim and an explanation of why such information is necessary.

5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
6. A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Member's claim for benefits.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Member, free of charge, upon request).
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that such explanation will be provided to the Member, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

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

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

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

EXPLANATION OF PAYMENT

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

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

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

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

ASSIGNMENT OF BENEFITS

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

If benefits are paid directly to the Member, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

By submitting a claim to the Plan and accepting payment by the Plan, the Provider is expressly agreeing to the foregoing conditions and limitations of an Assignment of Benefits provision as well as the terms of the Plan Document. The Provider further agrees that the payments received constitute an **"**accord and satisfaction**"** and consideration in full for the services, supplies and/or treatment rendered. The Provider agrees that the conditions and limitations of an Assignment of Benefits as set forth herein and will take precedence over any previous terms and/or agreements. The Provider agrees to the specific condition that the patient will not be balance billed for any amount beyond the patient responsibility (Deductible/Copayment/Coinsurance) that may be applicable, or charges for non-Covered Benefits; the Provider may bill the Member directly for these amounts.

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

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

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

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

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

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

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this Plan.

If a Provider refuses to accept an Assignment of Benefits as compensation in full for services rendered, the Assignment of Benefits will be revoked and returned to the Member such that benefits will be payable to the Member and not the Provider. If benefits are paid directly to the Member, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits.

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

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

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

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

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

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

PROVIDER RECONSIDERATION REQUEST

When a Provider receives a copy of an Adverse Benefit Determination related to a Claim, the Provider may request a reconsideration of the decision. The request must be in writing and must be sent to the Claims Administrator within 180 days after the date of the Adverse Benefit Determination. The request must include the claim number, the reason for the request (i.e., an explanation of why the provider thinks the claim was processed incorrectly), and supporting documentation that was not included with the initial claim submission. Provider reconsideration requests sent later than 180 days after the date of the determination will not be considered. A Provider does not have the same rights as a Member and Providers are not Authorized Representatives of Members unless specifically appointed in writing. However, Providers will be allowed to exhaust the internal claims procedures under the terms of this Plan on behalf of a Member without the appointment as the Member's Authorized Representative. The Provider shall not, under any circumstances have the right to sue the Plan.

APPEALING A CLAIM

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

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

TWO LEVELS OF APPEAL

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

Once a Member receives an Adverse Benefit Determination in response to an initial claim for benefits, the Member may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Member receives an Adverse Benefit Determination in response to that initial appeal, the Member may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Member receives an Adverse Benefit Determination in response to the Member's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

REQUIREMENTS FOR FIRST LEVEL APPEAL

The Member must file the appeal in writing (although oral appeals are permitted for pre service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination.

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

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

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

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

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

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

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than 30 days per internal appeal.

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

MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATION ON REVIEW

The Claims Administrator shall provide a Member with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Member to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
3. A reference to the specific portion(s) of the summary plan description on which the denial is based.
4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Member, free of charge, upon request.
7. A description of any additional information necessary for the Member to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Member, free of charge, upon request.
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Members with the internal claims and appeals and external review processes.
12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

REQUIREMENTS FOR SECOND LEVEL APPEAL

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

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

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

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

DEEMED EXHAUSTION OF INTERNAL CLAIMS PROCEDURES AND DE MINIMIS

Exception to the Deemed Exhaustion Rule

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

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

EXTERNAL REVIEW PROCESS

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

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

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer.
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

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

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

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

    a. The Member is or was covered under the Plan at the time the health care item or service was requested or, in the case of a Retrospective Review, was covered under the Plan at the time the health care item or service was provided.
    b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Member's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).

c. The Member has exhausted the Plan's internal appeal process unless the Member is not required to exhaust the internal appeals process under the final regulations.
d. The Member has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Member. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number (866) 444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Member to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

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

Expedited external review

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

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

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

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with

the requirements set forth above, as expeditiously as the Member's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Member and the Plan.

COORDINATION OF BENEFITS

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

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

DEFINITIONS APPLICABLE TO THIS PROVISION

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

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

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

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

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

   The plan which covers the claimant as a Member (or named insured) pays as though no Other Plan existed. Remaining Covered Benefits are paid under a plan which covers the claimant as a Dependent.
3. Dependent Children of Parents Not Separated or Divorced

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

   When parents are separated or divorced, the birthday rule does not apply, instead:
   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent pays fourth.
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody pays fourth.
5. Active/Inactive

   The plan covering a person as an active (not laid off or retired) Employee, or as that person's Dependent pays first. The plan covering that person as a laid off or retired Employee, or as that person's Dependent pays second.
6. Limited Continuation of Coverage

   If a person is covered under another group health plan, but is also covered under this Plan for continuation of coverage due to the Other Plan's limitation for pre-existing conditions or exclusions, the Other Plan shall be primary for all Covered Benefits which are not related to the pre-existing condition or exclusions. This Plan shall be primary for the pre-existing condition only.
7. Longer/Shorter Length of Coverage
   If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

COORDINATION WITH MEDICARE

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

1. When an Employee becomes entitled to Medicare coverage and is still actively at work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
2. When a Dependent becomes entitled to Medicare coverage and the Employee is still actively at work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. If the Employee and/or Dependent is also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
4. If the Employee and/or Dependent elect to discontinue health coverage under this Plan and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.
5. A Member that is an active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan at open enrollment or some other specified special enrollment period. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

6. To the extent required by Federal regulations, this Plan will pay Covered Expenses at the "Reasonable and Allowed Amount" before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Member will be assumed to have full Medicare coverage (that is, both Parts A & B) whether or not the Member has enrolled for the full coverage. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.
7. If any Member is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

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

LIMITATIONS ON PAYMENTS

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF BENEFIT PAYMENT

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

THIRD PARTY RECOVERY, SUBROGATION, AND REIMBURSEMENT

PAYMENT CONDITION

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

Member(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 one hundred percent (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. By accepting benefits, the Member(s) agrees the Plan shall have an equitable lien on any funds received by the Member(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan fully expects to be reimbursed any amounts paid on behalf of the Member(s) for medical care from the amount(s) received in settlement from the third party and expects such award amounts to remain segregated until such time that the Plan has been repaid. The Member(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Member(s) settles, recovers, or is reimbursed by any Coverage, the Member(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Member(s). If the Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Member(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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 Member(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 Member(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 Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Member(s) may have against any Coverage and/or party causing the Injury, Illness, or Disease to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Member(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 Member(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Then the Member(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Member(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The

Member(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 one hundred percent (100%) of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Member(s) is fully compensated by his/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. If the Member(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Member(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 Member(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 Injury, Illness, or Disease or Disability.

MEMBER IS A TRUSTEE OVER PLAN ASSETS

Any Member 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 Member 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 Member is not represented by an attorney, instruct the insurance company or any third party from whom the Member 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 Member disputes this obligation to the Plan under this section, the Member 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 Member, 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 Member(s) (Incurred) prior to the liable party being released from liability. The Member's/Members' 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 Member 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.

REIMBURSEMENT DUE TO SURROGACY AGREEMENT

If a Member enters into a Surrogacy Arrangement, the Member must reimburse the Plan for Covered Expenses received related to conception, Pregnancy, delivery, or postpartum care in connection with that Surrogacy Arrangement. The reimbursed amount shall not exceed the payments or other compensation the Member or another person is entitled to receive under the Surrogacy Arrangement.

A "Surrogacy Arrangement" is one in which a Member agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the Member receives payment for being a surrogate.

A Surrogacy Arrangement does not affect a Member's obligation to pay any and all patient responsibility amounts for these services. These amounts will be taken into account at the time of the reimbursement.

After a Member surrenders a baby to the legal parents, the Plan is not obligated to pay for any services that the baby receives (the legal parents are financially responsible for any services that the baby receives).

As set forth above, as a condition precedent to the Member receiving benefits under the Plan, the Member automatically assigns to the Plan any right to receive payments that are payable to the Member or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow, trust, or other account that holds those payments) shall first be applied to satisfy the Plan's lien.

Within 30 days after entering into a Surrogacy Arrangement, a Member must send written notice of the arrangement to the Plan, including all of the following information:

1. Names, addresses, and telephone numbers of all parties to the arrangement;
2. Names, addresses, and telephone numbers of any escrow agent or trustee;
3. Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for the services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive;
4. A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and
5. Any other information the Plan requests in order to satisfy its rights.

You must send this information to:

Plan Administrator
c/o Hawaii Mainland Administrators, LLC (HMA)
P.O. Box 22009
Tempe, AZ 85285-2009

The Member must complete and send the Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for the Plan to determine the existence of any rights the Plan may have under this Surrogacy Arrangement and to satisfy those rights. The Member may not agree to waive, release, or reduce the Plan's rights without the Plan's prior, written consent.

If a Member's estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the Member had asserted the claim against the third party. The Plan may assign its rights to enforce its liens and/or other rights.

EXCESS INSURANCE

If at the time of Injury, Illness, or disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment of 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, whenever possible, any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Member(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Member(s), such that the death of the Member(s), or filing of bankruptcy by the Member(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 Member(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 Member(s) and all others that benefit from such payment.

OBLIGATIONS

It is the Member(s)' 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 Injury, Illness, disease or disability, including accident reports, settlement information and any other requested additional information;
3. To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights;
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
6. To notify the Plan or its Authorized Representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement;
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Member 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 Member is not represented by an attorney, instruct the insurance company or any third party from whom the Member obtains a settlement to include the Plan or its Authorized Representative as a payee on the settlement draft; and
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Member over settlement funds is resolved.

If the Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or 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, Illness, or disease or condition, out of any proceeds, judgment or settlement received, the Member(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 Member(s).

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

OFFSET

If timely repayment is not made, or the Member 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 Member'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 Member(s) in an amount equivalent to any outstanding amounts owed by the Member to the Plan. This provision applies even if the Member has disbursed settlement funds.

MINOR STATUS

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

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

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights 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.

HIPAA PRIVACY AND SECURITY

HIPAA PRIVACY STATEMENT-USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

The Plan Administrator agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards*;*
4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Make PHI available in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524)*;*
6. Make PHI available for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
8. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
9. If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

SEPARATION BETWEEN PLAN ADMINISTRATOR AND PLAN

In order to ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)) is established as follows:

1. The following Employees or classes of Employees, or other persons under the control of the Plan Administrator, may be given access to the PHI to be disclosed:
    - Administration
    - Human Resource/Financial Administration Support
2. The access to and use of PHI by the individuals described in section (1) above shall be restricted to the Plan Administrator functions that the Plan Sponsor performs for the Plan.
3. In the event any of the individuals described in section (1) above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation. The Plan Administrator will promptly report any violation of this provision to the Plan and will cooperate with the Plan to remedy or mitigate the effect of such violation.

CONTACT INFORMATION

Privacy Officer and Contact Information:

Senior Director, HR Shared Services
Amy's Kitchen, Inc.
1650 Corporate Circle, Suite 100
Petaluma, CA 94954
(707) 781-7625

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by Reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement Reasonable and appropriate security measures to protect the Electronic PHI; and
4. Report to the Plan any security incident of which it becomes aware.

CERTAIN MEMBER(S) RIGHTS UNDER ERISA

As a Member in Amy's Kitchen, Inc. Medical Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Members shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

CONTINUE GROUP HEALTH PLAN COVERAGE

If your Employer is eligible for COBRA coverage, you, your spouse and/or Dependents may continue receiving health care benefits 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.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/agencies/ebsa/. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL PROVISIONS

PLAN ADMINISTRATOR AND FIDUCIARY

Amy's Kitchen, Inc. shall be the Plan Administrator and named Fiduciary of this Plan and as such, has the authority to control and manage the operation and administration of the Plan. The Plan Administrator intends to continue the Plan indefinitely, but reserves the right to terminate or amend the Plan in any way. No consent of any Member or any other person referred to in the Plan will be required to terminate, modify, amend or change the Plan. The Plan Administrator may amend any provision, condition, limitation or exclusion of the Plan. Notice will be given to all covered Employees in compliance with applicable law. No agent is authorized to modify the Plan.

ASSIGNMENT

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

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

BENEFITS NOT TRANSFERABLE

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

CLERICAL ERROR

No clerical Error on the part of the Plan Administrator or Claims Administrator shall operate to defeat any of the rights, privileges, services, or benefits of any Employee or any Dependent(s) hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the Error or delay is discovered. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

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

EFFECTIVE DATE OF THE PLAN

The Effective Date of the Plan January 1, 2021.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

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

INCAPACITY

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

INCONTESTABILITY

All statements made by the Plan Administrator or by the Employee covered under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the Plan Administrator or by the Member, as the

case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of one (1) year from the exhaustion of the administrative process.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the Plan Administrator shall not be liable for any obligation of the Member Incurred in excess thereof. The Plan Administrator shall not be liable for the negligence, wrongful act, or omission of any Physician, Professional Provider, Hospital, or other institution, or their employees, or any other person. The liability of the Plan shall be limited to the reasonable cost of Covered Benefits and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

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

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

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

MISREPRESENTATION

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

PLAN IS NOT A CONTRACT

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

PLAN MODIFICATION AND AMENDMENT

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

An amendment to the Plan may be retroactively effective, but shall not adversely affect the rights of Members under this Plan for Covered Benefits provided after the Effective Date of the amendment but before the amendment is adopted.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the Plan Administrator, or a written copy thereof shall be deposited with such master copy of the Plan.

PLAN TERMINATION

The Plan Administrator reserves the right to terminate the Plan at any time. Upon termination, the rights of the Members to benefits are limited to claims Incurred up to the date of termination. Any termination of the Plan will be communicated to the Members.

Upon termination of this Plan, all claims Incurred prior to termination, but not submitted to either the Plan Administrator or Claims Administrator within three (3) months of the Effective Date of termination of this Plan, will be excluded from any benefit consideration.

PRONOUNS

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

RECOVERY FOR OVERPAYMENT

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

SECONDARY COVERAGE

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

STATUS CHANGE

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

STATUTE OF LIMITATIONS

Before filing a lawsuit, a Claimant must exhaust all available levels of review as described in this Plan, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year from the exhaustion of the administrative process.

TIME EFFECTIVE

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

WORKERS' COMPENSATION NOT AFFECTED

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

DEFINITIONS

Some of the terms used in this Plan begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

Adverse Benefit Determination

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

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

Alternate Recipient

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

Ambulatory Surgical Facility

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

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

Approved Clinical Trial

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

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

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

"Routine patient costs" include all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include: 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member; 3) a service that is clearly

inconsistent with the widely accepted and established standards of care for a particular Diagnosis; 4) and/or items and/or services to be paid for and or provided at no cost from a third party (including but not limited to a manufacturer.)

Assignment of Benefits

Assignment of Benefits shall mean an arrangement whereby the Member assigns their right to seek and receive payment of eligible Covered Expenses, in strict accordance with the terms of this Plan, to the Provider. If the Provider accepts the Assignment of Benefits, the Provider's right to receive payment for Covered Expenses are equal to those of the Member, and are limited by the terms of this Plan. The Plan will only consider an Assignment of Benefits valid under the condition that the Provider accepts the payment received from the Plan as consideration in full for the services, supplies and/or treatment rendered. By virtue of a valid Assignment of Benefits, the Provider will also have the right to appeal an Adverse Benefit Determination under the terms of the Plan. The Assignment of Benefits does not grant the Provider any other rights other than those specifically set forth in this Plan provision.

Benefit Year

The twelve-month period beginning January 1 through December 31 for which all Plan benefits shall be calculated. Any applicable Deductible, Out-of-Pocket maximum expense limit, or Maximum Benefit Amount shall accrue on a benefit (calendar) year basis.

Birthing Center

A Facility that meets professionally recognized standards and all of the following tests:

1. It mainly provides an Outpatient setting for childbirth following a normal, uncomplicated Pregnancy, in a home-like atmosphere.
2. It has: (a) at least two (2) delivery rooms; (b) all the medical equipment needed to support the services furnished by the Facility; (c) laboratory diagnostic facilities; and (d) emergency equipment, trays, and supplies for use in life threatening situations.
3. It has a medical staff that: (a) is supervised full-time by a Physician; and (b) includes a Registered Nurse at all times when Members are at the Facility.
4. If it is not part of a Hospital, it has written agreement(s) with a local Hospital(s) and a local ambulance company for the immediate transfer of Members who develop complications or who require either pre or post-natal care.
5. It admits only Members who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.
6. It schedules Confinements of not more than twenty-four (24) hours for a birth.
7. It maintains medical records for each Member.
8. It complies with all licensing and other legal requirements that apply.
9. It is not the office or clinic of one or more Physicians or a specialized Facility other than a Birthing Center.

Case Management

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under the Plan provisions in lieu of Inpatient Hospital treatment.

Center of Excellence

Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Chemical Dependency

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-5 (diagnostic and statistical manual of mental disorders) criteria.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Administrator

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

Clean Claim

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

Close Relative

The Employee's spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the Employee's spouse.

Coinsurance

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

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from Pregnancy, but is adversely affected by or caused by Pregnancy. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic pregnancy.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. 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.

Concurrent Review

A review by the Utilization Review Department which occurs during the Member's Hospital Confinement to determine if continued Inpatient care is Medically Necessary.

Confinement

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.

Copayment

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

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward or resulting in improvement or preservation of physical appearance, rather than to restore the anatomy and/or function of the body which are lost or impaired due to an Illness or Injury.

Covered Benefits

Medically Necessary services, supplies or treatments, and payments for the same, that are recommended or provided by a Physician, Professional Provider or covered Facility for the treatment of an Illness or Injury and:

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

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

Covered Expense

Those Medically Necessary services, supplies and/or treatment that are covered under this Plan. Covered Expense does not necessarily mean the actual charge made nor the specific service or supply furnished to a Member by a Provider. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider's medical Error are not considered Covered Expenses. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not "Reasonable and Allowed".

Custodial Care

Care provided primarily for maintenance of the Member or which is designed essentially to assist the Member in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an Illness or Injury. Custodial Care includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered Custodial Care without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and Board and skilled nursing services are not, however, considered Custodial Care (1) if provided during Confinement in an institution for which coverage is available under this Plan, and (2) if combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the Member's medical condition.

Deductible

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

Dentist

A licensed doctor of dental medicine (D.M.D.) or a licensed doctor of dental surgery (D.D.S.), other than a Close Relative of the Member.

Dependents

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

Dialysis

Hemodialysis or peritoneal Dialysis and supplies.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an Illness or Injury;
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered Durable Medical Equipment. Durable Medical Equipment includes, but is not limited to: crutches, wheel chairs, hospital beds, etc.

Effective Date

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

Emergency

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

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

Employee

A person directly involved in the regular business of and compensated for services by the Employer, who is regularly scheduled to work not less than twenty-four (24) hours per work week.

Employer

The Employer is Amy's Kitchen, Inc.

Errors

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

Excess Charges

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

Experimental/Investigational

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

The Plan Administrator must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. 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 Member 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 in 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 as compared with a standard means of treatment or diagnosis; or
4. If "reliable evidence" shows that 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, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean published reports and articles in the authoritative medical and scientific literature and any other materials the Plan Administrator deems reliable; the written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same drug, device, 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.

Extended Care Facility

An institution or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Illness or Injury, professional nursing services, and physical restoration services to assist Members to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.
2. Its services are provided for compensation from its Members and under the full-time supervision of a Physician or Registered Nurse.
3. It provides twenty-four (24) hour-a-day nursing services.
4. It maintains a complete medical record on each Member.
5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of Mental and Nervous Disorders.
6. It is approved and licensed by Medicare.

This term shall also apply to expenses Incurred in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements, such as a Hospital, ambulatory or outpatient surgery center, freestanding Dialysis facility, a lithotriptor center or an outpatient imaging center.

Full-Time

Employee's regularly scheduled to work not less than twenty-four (24) hours per work week in any forty-five (45) day period.

Generic Drug

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

Home Health Aide Services

Those services which may be provided by a person, other than a Registered Nurse, which are Medically Necessary for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one Physician and at least one Registered Nurse. It must provide for full-time supervision of such services by a Physician or Registered Nurse.
3. It maintains a complete medical record on each Member.
4. It has a full-time administrator.
5. It qualifies as a reimbursable service under Medicare.

Hospice

An agency that provides counseling and medical services and may provide Room and Board to a terminally ill Member and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.
3. It is under the direct supervision of a Physician.
4. It has a Nurse coordinator who is a Registered Nurse.
5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of Hospice services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the Member.
9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to Hospitals.
2. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the Member's expense.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or Injury; and such treatment is provided by or under the supervision of a Physician with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.
4. It qualifies as a Hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.
5. It must be approved by Medicare.

Under no circumstances will a Hospital be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a Facility designed exclusively for rehabilitative services where the Member received treatment as a result of an Illness or Injury.

The term Hospital, when used in conjunction with Inpatient Confinement for Mental and Nervous Disorders or Chemical Dependency, will be deemed to include an institution which is licensed as a mental hospital or Chemical Dependency rehabilitation and/or detoxification facility by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

A Hospital is considered a Facility for the purposes of this Plan.

Hospital Expenses

Charges by a Hospital for Room and Board (including private room accommodations) and/or for care in an Intensive Care Unit provided that such care is furnished at the direction of a Physician.

Illness

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

Incurred

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

Injury

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

Inpatient

A Confinement of a Member in a Hospital, Hospice, or Extended Care Facility as a registered bed patient, for eighteen (18) or more consecutive hours and for whom charges are made for Room and Board.

Intensive Care

A service which is reserved for critically and seriously ill Members requiring constant audio-visual surveillance which is prescribed by the attending Physician.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a Hospital solely for the provision of Intensive Care. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the Hospital;
2. Special lifesaving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and
4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room.

Invalid Charges

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

Late Enrollee

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

Layoff

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

Leave of Absence

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

Maximum Payable Amount Maximum Amount, or Maximum Allowable Charge

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

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

The Plan will reimburse the actual charge(s) if they are less than the "Reasonable and Allowed Amount"(s). The Plan has the discretionary authority to decide if a charge is "Reasonable and Allowed", as well as Medically Necessary.

In no event will the Maximum Payable Amount exceed benefits for the Maximum Benefit Amount. Certain services in the Schedule of Benefits are subject to specific limitations, and certain general limitations apply to benefits payable for all services. The Plan will take these limitations into account in calculating its Maximum Allowable Charge. The Maximum Payable will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary (Medical Necessity)

Service, supply or treatment which, as determined by the Plan Administrator, to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the Member's Illness or Injury and which could not have been omitted without adversely affecting the Member's condition or the quality of the care rendered;
2. In accordance with current standards of good medical practice within the organized medical community and is medically proven to be effective treatment of the Illness or Injury;
3. The most appropriate supply or level of service that can safely be provided to the Member. When applied to an Inpatient admission, this further means that the Member requires acute care as a bed patient due to the nature of the services rendered or the Member's Illness or Injury, and the Member cannot receive safe or adequate care as an Outpatient.

A service, supply, or treatment will not be considered Medically Necessary if:

1. It is provided only as a convenience to the Member or provider;
2. It is part of a plan of treatment that is Experimental, unproven, or related to research protocol.

The fact that a Physician may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment Medically Necessary. In making the determination of whether a service or supply was Medically Necessary, the Plan Administrator, or its designee, may request and rely upon the opinion of a Physician or Physicians. The Plan Administrator has the ultimate discretionary authority to determine whether care or treatment is or was Medically Necessary. The determination of the Plan Administrator shall be final and binding.

Medicare

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

Member

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

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-IV (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Negotiated Rate

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

Non-Participating Pharmacy

Any pharmacy, including a Hospital pharmacy, Physician or other organization, licensed to dispense prescription drugs which do not fall within the definition of a Participating Pharmacy.

Non-Participating Provider

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

Nurse

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

Outpatient

A Member shall be considered to be an Outpatient if he is treated at:

1. A Hospital as other than an Inpatient;
2. A Physician's office, laboratory or x-ray facility; or
3. An Ambulatory Surgical Facility; and

The stay is less than eighteen (18) consecutive hours.

Partial Confinement

A period of less than twenty-four (24) hours of active treatment in a Facility licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.
2. Treatment of Mental and Nervous Disorders.
3. Alcoholism/Chemical Dependency treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

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

Physician

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

Placed for Adoption

The date the Employee assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

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

Plan Administrator

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

Plan Sponsor

The Plan Sponsor is the Employer.

PPACA

The Patient Protection and Affordable Care Act of 2010.

Participating Provider

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

Participating Provider Organization

An organization who selects and contracts with certain Hospitals, Physicians, and other health care providers to provide Members services, supplies and treatment at a Negotiated Rate.

Pregnancy

The physical state which results in childbirth or miscarriage.

Preventive Care Services

Preventive care services as recommended by the U.S. Preventive Task Force to include, but not limited to preventive screenings, immunizations, and pediatric care. For a complete listing, go to:

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

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered Professional Providers are:

1. Audiologist
2. Certified Addictions Counselor

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

Reasonable and Allowed

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

1. For Inpatient or Outpatient Facility claims, an amount equivalent to 150% of the Medicare equivalent allowable amount;
2. For Physician, professional and ancillary (such as laboratory and radiology), an amount equivalent to 125% of the Medicare equivalent allowable amount that is based on the current National Medicare fee schedule and the Clinical Laboratory fee schedule amount;
3. If no Medicare equivalent is available for a charge then the Plan will reimburse the 85th percentile of UCR (Usual, Customary, and Reasonable). For this purpose, UCR shall mean the amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar medical services;and
4. For specialty drugs, the lesser of the average wholesale price (AWP) minus 10% or the amount set by the Plan's prescription drug service vendor.

The reasonable and customary charge shall mean an amount equivalent to the lesser of a commercially available database or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan from time to time. If there is insufficient information submitted for a given procedure, the Plan will determine the "Reasonable and Allowed Amount" based upon charges made for similar services. Determination of the reasonable and customary charge will consider the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that Provider.

The term 'geographic area' shall be defined as a metropolitan area, county, zip code, state or such greater area as is necessary to obtain a representative cross-section of Providers, persons, or organizations rendering such treatment, service or supply for which a specific charge is made.

For Covered Expenses rendered by a Physician, Hospital or Ancillary Provider in a geographic area where applicable law dictates the Maximum Amount that can be billed by the rendering Provider, the "Reasonable and Allowed Amount" shall mean the amount established by applicable law for that Covered Expense.

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

The term “Reasonable and Allowed” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Member by a Provider. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider’s medical Error are not considered Covered Expenses or "Reasonable and Allowed". The Plan Administrator will determine whether a specific procedure, service or supply is "Reasonable and Allowed". A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Appropriate.

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Retrospective Review

A review by the Utilization Review Organization after the Member's discharge from Hospital Confinement to determine if, and to what extent, Inpatient care was Medically Necessary.

Room and Board

Room and linen service, dietary service, including meals, Medically Necessary special diets and nourishments, and general nursing service. Room and Board does not include personal items.

Semiprivate

The daily Room and Board charge which a Facility applies to the greatest number of beds in its Semiprivate rooms containing two (2) or more beds.

Total Disability or Totally Disabled

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

Treatment Center

1. An institution which does not qualify as a Hospital, but which does provide a program of effective medical and therapeutic treatment for Chemical Dependency, and
2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or
3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    b. It provides a program of treatment approved by the Physician.
    c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the Member.
    d. It provides at least the following basic services:
        i. Room and Board
        ii. Evaluation and diagnosis
        iii. Counseling
        iv. Referral and orientation to specialized community resources.

Utilization Review

A process of evaluating if services, supplies or treatment are Medically Necessary to help ensure cost-effective care.

Utilization Review Department

An entity designated by the Plan Administrator for the process of evaluating whether the service, supply, or treatment is Medically Necessary.

ADOPTION STATEMENT

Amy's Kitchen, Inc. has caused this Medical Plan to take effect as of January 1, 2021 at Petaluma, California 94954.

I have read the document herein and certify the document reflects the terms and conditions of the Employee Benefit Plan as established by Amy's Kitchen, Inc. .

Sign: Carme Lewis

Print: Carme Lewis

Date: January 1, 2021