Dillon Family Medicine, PA

Dillon Family Medicine, PA
603 N 6th Avenue
Dillon, SC 29536

Dillon Family Medicine, PA Wrap Plan

Plan Document

Amended and Restated January 01, 2019

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INTRODUCTION

Dillon Family Medicine, PA ("Company"), a C Corporation, hereby amends and restates, effective as of January 01, 2019, an "employee welfare benefit plan," as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), known as the Dillon Family Medicine, PA Wrap Plan (hereinafter the "Plan"), originally established January 01, 2018, the terms of which are set forth in this Plan document and the Welfare Program documents. Effective as of January 01, the Dillon Family Medicine, PA Wrap Plan, Plan number 501, became administered as a single program or arrangement. The Plan provides for the payment or reimbursement of certain benefits for Eligible Employees (and certain eligible dependents of such Employees) , as well as such other trades or businesses designated by a proper officer of the Employer that include, but are not limited to: Medical, Basic Life & AD&D, Accident, Cancer, and Critical Illness, Dental, Long Term Disability - Class 1 only - excludes Physicians, Short Term Disability, Group Basic Life and AD&D, Medical Enhanced Plan - HDHP and Vision benefits.

The purpose of this Plan document is to set forth the essential terms and provisions of the Plan and to consolidate and combine into a single Plan document certain Welfare Programs maintained by the Employer, and to provide Participants and their beneficiaries with the benefits described herein and in the Welfare Programs which are incorporated into this Plan. Notwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as, a single benefit plan to the extent permitted under ERISA. The Plan is intended to meet all applicable requirements of ERISA, as well as rulings and regulations issued thereunder. Terms that are capitalized are defined in the Article titled: "Definitions".

Contributions are made by the Employer and Eligible Employees. These contributions are based on the amount of insurance premiums and costs necessary to provide the coverage under the Plan. The level of Employee contributions is established by the Employer annually. All group benefits underwritten by an Insurance Company are paid solely from the general assets of the Insurance Company.

The payment of all benefits under the Plan is expressly subject to all the provisions, including amendments, of this Plan document, as well as the terms and conditions of the Welfare Programs, including amendments/riders to said Welfare Programs (the terms of which are incorporated herein by reference).

In the event that the provisions of any Welfare Program conflict with the provisions of this Plan document or any other Welfare Program, the Plan Administrator shall, in its discretion, interpret the terms and purpose of the Plan so as to resolve any conflict. However, the terms of this Plan document may not increase the rights of a Participant or a Participant's beneficiary to benefits available under any Welfare Program.

I. ARTICLE - DEFINITIONS

01. "**Claims Administrator**" shall mean the person responsible for benefits administration under a Welfare Program. In the case of an insured Welfare Program, the Claims Administrator shall mean the insurance Company.

02. "**Eligible Employee**" shall mean an Employee who satisfies the eligibility provisions of the Article titled "Benefits", Section 01, including the eligibility provisions of the applicable component benefit program.

03. "**Dependent**" shall include:

    - any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract or under the Affordable Care Act,
    - any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only, or
    - any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609, shall be considered a Dependent under this Plan.

04. "**Employee**", except as otherwise defined in a Welfare Program, shall mean any individual who is employed by the Employer as a common-law employee as shown on applicable payroll records

    In addition, the term "Employee" shall not include any individual who, in good faith, is classified as an independent contractor by the Employer, even if such individual is later determined by any governmental agency or court to have been a common law employee of the Employer. Employees of Dillon Family Medicine, PA, and such other trades or businesses designated by a proper officer of the Employer are specifically included or excluded as Employees hereunder as such officer shall reasonably determine in good faith.

05. "**Employer**" shall mean Dillon Family Medicine, PA, a C Corporation and its successors and assigns.

06. "**Entry Date**" means the date on which an Eligible Employee has satisfied the enrollment requirements of this Plan or such Welfare Program, as specified by the Plan Administrator, and becomes a Participant in this Plan or such Welfare Program.

07. "**ERISA**" shall mean the Employee Retirement Income Security Act of 1974, as amended.

08. "**Grandfathered Health Plan Status**" as permitted by the PPACA regulations, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. The PPACA allows health plans that existed on March 23, 2010, to be grandfathered, and thus, be exempt from some of the new law's provisions, for as long as it maintains the "grandfathered" status under the applicable regulations.

    Example: Grandfathered Plan - is not required to include preventive

health services without any cost sharing. But the plan must comply with certain other protections in the Affordable Care Act, ie, the elimination of lifetime limits on essential health benefits.

09. "**Insurance Company**" or "**Insurance Companies**" means any Insurance Company licensed to do business in the State of the Employer and/or such other States in which the Employer does business, with which the Employer has entered into a contract for the purposes of providing benefits under the Plan.

10. "**Participant**" means an Eligible Employee who has satisfied the enrollment requirements of this Plan or a Welfare Program, as specified by the Plan Administrator, and is eligible to receive the benefits of this Plan or such Welfare Program.

11. "**Plan**" shall refer to the Dillon Family Medicine, PA Wrap Plan, as amended.

12. "**Plan Administrator**" shall refer to the Employer, unless the Employer has designated another person, committee or entity to act in its place, as provided in the Section titled: "Named Fiduciaries".

13. **"Plan Year**" means the 12-month period beginning January 01 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's entry date and ending on the last day of such Plan Year.

14. "**Policy**" or "**Policies**" shall mean the insurance contracts, as such contract or contracts may be amended or replaced with other insurance contracts, issued to the Employer by an Insurance Company or Companies (or such other contracts between the Employer and a benefit provider) for the purpose of providing benefits under the Plan. All such Policies (or contracts), the terms of which are incorporated herein by reference, shall be considered a part of this Plan.

15. "**PPACA**" means the Patient Protection and Affordable Care Act, as amended.

16. "**Rule of Parity**" Employer option to treat an employee who has a break of service (no credited hours of service for a minimum of 4 weeks) that was longer than the employees period of service immediately preceding the break, as a new hire upon return to active service. I.E., if the employee only worked credited hours for 4 weeks, then had a break in service for 6 weeks, the employee is treated as a new hire.

17. "**Special Unpaid Leave**" shall mean unpaid leave subject to FMLA, USERRA or on account of jury duty, as applicable to the look-back measurement method under ACA rules.

18. "**Spouse**" means a person legally married to a Participant under state law, including common law spouses, unless legally separated by court decree; provided, however, that the Plan Administrator may require the Participant to provide evidence of marriage, which may include a marriage certificate or other official documentation satisfactory to the Plan Administrator. The Plan Administrator has the sole and absolute authority to determine an individual's status as a spouse of a Participant

for the purposes of the Plan, and any such determination shall be final, binding and conclusive on all parties ever claiming an interest in the Plan. Spouse shall also mean "domestic partner" if designated by the Plan Administrator; provided, however, that the Plan Administrator may require the Participant to provide evidence of the domestic partnership, which may include an affidavit or other official documentation satisfactory to the Plan Administrator.

19. "**Summary Plan Description**" shall mean the document that describes the specific benefits under the Plan. The Summary Plan Description, as amended or as restated from time to time, shall be considered a part of the Plan, and is incorporated herein by reference.

20. "**Welfare Program**" shall mean each item identified in Appendix A, as it may be updated from time to time. The terms of each Welfare Program, as they may be set out in the Policies, contracts, or other documents with respect to the Welfare Program, shall form a part of this Plan in the same manner as if all the terms and provisions thereof were included in this Plan document.

    Any Welfare Programs and the corresponding Appendix A will also include any and all amendments, or replacement plans or documents, and summaries, policies, and contracts, if any, for such period(s) during which the document is in effect. Any amendment or replacement of any of the documents comprising the Welfare Programs and of Appendix A, may be certified by a duly authorized officer of the Company, and may be updated as required, without any need to amend this document.

II. ARTICLE - BENEFITS

01. **Eligibility and Participation.** The eligibility and participation requirements for each Welfare Program are stated in the applicable Policy or Welfare Program document.

    An Eligible Employee with respect to the Plan is any Employee who is eligible to participate in one or more of the component Welfare Programs in accordance with the terms and conditions of the Plan (including the terms of the applicable component Welfare Program).

    Where the eligibility and / or participation requirements are not stated in the Policy or Welfare Program document, the following eligibility and / or participation requirements shall apply.

    Every Employee who is regularly scheduled to work a minimum of 30 hours per week or 130 hours per month is an Eligible Employee.

    An Eligible Employee may become a Participant in a Welfare Program by satisfying the enrollment requirements specified by the Plan Administrator, which shall include a waiting period, based on the applicable classification of:

1st of the month following date requirements	30 Days

    An Eligible Employee shall become a participant on the first day of the month following any applicable waiting period, determined by benefit or classification.

    Other individuals, such as an Eligible Employee’s spouse, children, or other designated member, may be eligible to participate in and receive benefits under one or more of the Welfare Programs due to their relationship to an Eligible Employee. Information about such eligibility and coverage is found in the applicable Policy or Welfare Program Documents.

    With respect to any waiting period for initial enrollment under any Welfare Program, the Plan Administrator may provide for the crediting of prior service for Employees of participating employers involved in an acquisition, merger or similar transaction with the Employer .

02. **Termination of Participation.** Participation under the Plan shall cease when the Participant ceases to participate in all Welfare Programs. An individual's coverage under the Plan may be terminated by the Plan Administrator for cause. "Cause" shall be determined by the Plan Administrator in its sole discretion, and includes but is not limited to submission of a fraudulent claim under any Welfare Program.

    Subject to the terms and conditions of any applicable Welfare Plan, if an Eligible Employee stops working, and is rehired or resumes providing services to the Employer, he or she may enter (or reenter) the Plan when he or she once again meets the eligibility requirements set forth within this Plan. This period during which the individual either is not an

Employee or provides no services to the Employer is called a "break-in-service," as determined by the Plan Administrator consistent with the PPACA, and the regulations issued thereunder. The provisions below of the subsection titled: "Break-in-Service of 13 Weeks or More" and the subsection titled: "Break-in-Service of Less Than 13 Weeks" shall apply only to the extent PPACA applies to the benefits provided by the applicable Welfare Programs or as otherwise determined by the Plan Administrator.

Notwithstanding the foregoing, Participation under the Plan shall cease upon the latest of the following two dates: (a) the last day of FMLA leave as required by law, or (b) the day the participant no longer qualifies as an Eligible Employee and have exhausted all approved personal leave, sick leave, vacation leave or short term disability leave as determined by the Employer, but in no event later than the date on which long term disability benefits commence.

a. **Break-in-Service of 13 Weeks or More**

   If an Eligible Employee terminates employment OR he or she otherwise provides no services to the Employer during any thirteen (13) week (or longer) period, such individual will be treated as new Employee for purposes of eligibility for the Plan (and any corresponding Welfare Program) upon any subsequent resumption of services with the Employer (as determined by the Plan Administrator consistent with PPACA, "resumption of services"), and the provisions of the Section titled: "Eligible Employee" will apply.

b. **Break-in-Service of Less Than 13 Weeks**

   1. **Did NOT Reach an Entry Date Prior to the Break-in-Service**

      Subject to the eligibility provisions of the Section titled: "Eligible Employee", if an Eligible Employee ceases to provide services to the Employer prior to reaching any Entry Date and then returns to work after a break-in-service of less than 13 weeks, such individual will be considered eligible to enter the Plan upon the later of the date (a) of the resumption of services (in which case the provisions of the subsection titled: "Reach an Entry Date Prior to the Break-in-Service" below will apply), or (b) the Eligible Employee has completed the requirements to become an Eligible Employee, determined by disregarding any break-in-service (in which case the provisions of the Section titled: "Eligible Employee" will apply).

   2. **Reach an Entry Date Prior to the Break-in-Service**

      Subject to the eligibility provisions of the Section titled: "Eligible Employee", but regardless of any prior election/waiver of coverage during such Plan Year, anyone who was an Eligible Employee prior to a break-in-service of less than 13 weeks will be considered eligible to enter (or reenter) the Plan upon resumption of services. Such individual will be offered coverage under the Plan as soon as administratively practicable, but in no event later than the first day of the calendar month following his or her resumption

of services as an Eligible Employee; provided however, that anyone subject to this Section who returns to work must elect to participate and re-enroll in the Plan as soon as administratively practicable, but in no event later than 30 days following his or her resumption of services as an Eligible Employee. Notwithstanding the foregoing, if anyone returns during a stability period in which he or she was treated as an Eligible Employee and the Employer previously made the individual an offer of coverage with respect to the entire stability period which was declined, the Employer shall not be required to make a new offer of coverage for the remainder of the ongoing stability period due to an Eligible Employee's resumption of services.

The Employer or Plan Administrator may establish such other procedures, rules and guidelines to administer (or otherwise interpret) the eligibility or rehire provisions of this Plan, including, but not limited to, rules with respect to special unpaid leave or Rule of Parity, which procedures, rules or guidelines are incorporated into this Plan by reference.

03. **Benefits.** Participants shall receive benefits under the Welfare Programs. Benefits shall be determined exclusively by the terms of the Welfare Programs, including eligibility for coverage, levels and amounts of coverage, the terms and conditions of coverage and when coverage begins and terminates. Benefits will be paid solely in the form and in the amount set forth under the Welfare Programs.

    All of the benefits under the Plan are described in more detail in the Policies and Welfare Programs, the terms of which are incorporated herein and made a part hereof by reference. In the case of any conflict between the terms of the Plan document and the terms of the Policies or Welfare Programs, the terms of the Policies or Welfare Programs (as applicable) shall control.

04. **Funding.** The terms of each Welfare Program shall govern the amount and timing of any Participant contribution required to be made by the Employee. Nothing herein requires an Employer to contribute to or under any Welfare Program, or to maintain any fund or segregate any amount for the benefit of any Participant or his or her beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant or beneficiary shall have any right to, or interest in the assets of the Employer.

III. ARTICLE - ADMINISTRATION OF THE PLAN

01. **Named Fiduciaries.**
The following persons or entities are named fiduciaries under the Plan:

Dillon Family Medicine, PA
603 N 6th Avenue
Dillon, SC 29536

The following shall be the Plan Administrator:

Dillon Family Medicine, PA
603 N 6th Avenue
Dillon, SC 29536

The Plan Administrator shall be solely responsible for the administration of the Plan, unless this function is explicitly delegated to another named fiduciary under this article. The Employer may, from time to time, duly appoint another person, committee, or entity to be the Plan Administrator. In the absence of such appointment, the Employer shall serve as the Plan Administrator.

The Employer may enter into an agreement with an insurance company for the purpose of insuring all or part of the benefits under the Plan and for administering certain benefits provided by the Plan. However, the Insurance Company shall only be a fiduciary with respect to the Plan to the extent that the Insurance Company exercises any discretionary authority or control with respect to the management of the Plan, or exercises any authority or control with respect to management or disposition of assets, renders investment advice for a fee or other compensation, direct or indirect, with respect to any monies or other property of the Plan, or has any authority or responsibility to do so, has any discretionary authority or responsibility in the administration of the Plan, or otherwise agrees to be a fiduciary with respect to the Plan.

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan. Any named fiduciary hereunder may, pursuant to such other formal procedures as it shall establish, designate persons (including third party administrators) other than the named fiduciaries to carry out its fiduciary responsibilities under the Plan.

02. **Complete and Separate Allocation of Fiduciary Responsibilities.**
It is intended that this Plan shall allocate to each named fiduciary individual responsibility for the prudent execution of the functions assigned to each. The performance of such responsibilities shall be deemed a several assignment and not a joint assignment. No responsibility is intended to be shared by two (2) or more of such fiduciaries, unless such sharing shall be provided by a specific provision of the Plan. Whenever one named fiduciary is required by the Plan to follow the directions of another named fiduciary, the two shall not be deemed to have been assigned a shared responsibility. The fiduciary giving the direction shall be deemed to have that action as its sole responsibility, and the responsibility of the fiduciary receiving such direction shall be to follow the direction insofar as such direction is on its face proper under the Plan and applicable law.

03. **Plan Administrator.** The administration of the Plan is under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them. The Plan Administrator has full power to administer and interpret the Plan in all of its details, subject to applicable requirements of law. For this purpose, except to the extent otherwise provided under the terms of any Welfare Program, the Plan Administrator's powers include, but are not limited to, the following authority, in addition to all other powers provided by this Plan:

a. The authority to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of claims procedures;

b. The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, including but not limited to determinations regarding eligibility for participation in and coverage under the Plan and the types and amounts of benefits payable under the Plan, and to make all necessary findings of fact. The Plan Administrator's interpretations in good faith shall be final and conclusive on all persons claiming benefits under the Plan. Decisions by the Plan Administrator may not be overturned unless found by a court to be arbitrary and capricious and to have no reasonable foundation;

c. The authority to appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan;

d. The authority to allocate and delegate its responsibilities under the Plan, and to designate other persons to carry out any of its responsibilities under the Plan; and

e. The authority to enter into any and all contracts and agreements for carrying out the terms of this Plan and for the administration of the Plan, and to do all acts as the Plan Administrator, in its sole discretion, may deem necessary or advisable. Such contracts and agreements shall be binding and conclusive on the parties hereto and anyone claiming benefits hereunder.

Notwithstanding the foregoing, to the extent the benefits under any Welfare Program are provided under a fully insured arrangement, the Insurance Company for such program shall have the responsibility for determining entitlement to benefits under the program and prescribing the claims procedures to be followed by Participants and beneficiaries thereunder. The Insurance Company will act as a named fiduciary with respect to the Plan and will have the full power to interpret and apply the terms of any insured Welfare Program as they relate to benefits provided thereunder.

Benefits under the Plan will be paid only if the Plan Administrator decides, in its sole and absolute discretion, that payment is merited pursuant to the terms of the Plan. Notwithstanding the foregoing, any claim which arises under a Policy is not subject to review under this Plan, and the Plan Administrator's authority does not extend to any matter as to which any other person or entity is empowered to make determinations under the Policy or documents evidencing such

arrangement.

04. **Disclaimer of Liability.** Except as otherwise provided under Sections 404 through 409 of ERISA, neither the Employer, nor any person designated to carry out fiduciary responsibilities pursuant to this Section of the Plan, shall be liable for any act, or failure to act, that is made in good faith pursuant to the provisions of the Plan.

    All Plan fiduciaries who are also employees or officers of the Plan Administrator or any Employer shall be fully indemnified by the Employer against all liabilities, costs, and expenses (including but not limited to reasonable attorneys' fees and costs) imposed upon them in connection with any action, suit, or proceeding to which he or she may be a party by reason of being a Plan fiduciary and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

    Unless liability is otherwise provided under Section 405 of ERISA, a fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

05. **Reliance on Tables, Etc.** In administering the Plan, the Plan Administrator is entitled, to the extent permitted by law, to rely on all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Plan Administrator.

06. **Expenses.** The proper expenses of the Plan Administrator, including the compensation of its agents, will be paid by the Plan if not paid by the Employer.

IV. ARTICLE - AMENDMENT AND TERMINATION

01. **Modification and Amendment.** The Plan may be modified or amended at any time by the Employer. Such modification or amendment shall be effective as of the date of the requisite Employer approval, or at such other date as the Employer shall designate.

    The Welfare Programs may be modified or amended at any time by a proper officer of the Employer, provided that any Policy may only be modified or amended with the agreement of the issuing Insurance Company. Such modification or amendment shall be effective as of the date of the requisite approval, or at such other date as the Employer and, if applicable, Insurance Company shall designate.

02. **Termination.** The Plan may be terminated at any time by the Employer. Such termination shall be binding on all Plan Participants.

03. **Conflict.** Any conflict arising between the terms of this Plan document and the terms of the Summary Plan Description with respect to the provisions of this Article shall be resolved in favor of this Plan document.

V. ARTICLE - CLAIMS PROCEDURES FOR PPACA EXEMPT PLANS

01. **General.** For purposes of determination of the amount of, and entitlement to, benefits of an insured Welfare Program provided under a Policy provided by an Insurance Company, the Insurance Company is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the Policy.

    To obtain benefits from an insured Welfare Program, the Participant must follow the claims procedures prescribed under the applicable Welfare Program. ***In the event that (i) the Welfare Program does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or (ii) the Plan Administrator determines that the claims procedures described in the Welfare Program shall not apply, and (iii) the Welfare Program is not subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this Article shall apply with respect to such Welfare Program.*** If the Welfare Program is subject to PPACA, the claims procedure applicable to such Welfare Program is described in the Article titled: "Claims Procedures for Plans Subject to PPACA".

02. **Non-Group Health Claims; Disability Claims.**

    a. **Time for Decision on a Claim.** A claim shall be filed in writing with the Plan Administrator and decided within 45 days by the Plan Administrator. If special circumstances require an extension of time to review the claim, a maximum of two 30- day extensions will be permitted. A claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from a claimant, such claimant will have 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

    b. **Notification of Adverse Determination.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

        i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse benefit determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and a description of any limitation period within which the suit must be filed including the exact date the limitation period ends; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, provide a statement that such rules, guidelines, protocols,

standards or other similar criteria of the Plan do not exist; and (8) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

In the case of a claim for disability benefits filed under this Plan after April 1, 2018, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

c. **Right to Review.** A claimant may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 180 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the claimant’s right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Plan Administrator to consider.

d. **Review Procedures.** During the review process, the Plan Administrator will provide: (i) claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on any new or additional evidence, such evidence will be provided to the claimant sufficiently in advance of the date on which the notice of adverse benefit determination on review is to be provided, so as to give the claimant reasonable opportunity to respond to the new evidence prior to that date; (vi) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (vii) for the identification of

medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (viii) that the health care professional engaged for purposes of a consultation shall be an individual 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;

e. **Time for Decision on Review.** Written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for review. If an extension is necessary due to special circumstances, the claimant will be given a written notice of the required extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension may be for up to 45 additional days.

f. **Notification of Determination on Review.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA ; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) 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."

ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan.

g. **Legal Remedies.**

i. A suit under Section 502(a) of ERISA may be filed only after these review procedures have been exhausted and only if filed within the earlier of 90 days or a limitation period listed in the plan, after the final decision is provided.

ii. If the Plan fails to strictly adhere to these claims review

procedure requirements with respect to a claim for disability benefits filed under this Plan after April 1, 2018, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except as provided in the paragraph below. Accordingly, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

iii. Except as provided in the paragraph above, the administrative remedies available under the Plan with respect to a claim for disability benefits filed under this Plan after April 1, 2018, will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

03. **Group Health Claims.**

a. **Pre-Service Claim Determinations.** When a covered person requests a medical necessity determination prior to receiving care, the Claims Administrator will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Administrator's control, the Claims Administrator will notify the individual of this fact within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the covered person's request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice, or 45 days after the covered person's receipt of the notice, whichever

is sooner.

If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person's health condition, would cause severe pain that cannot be managed without the requested services, the Claims Administrator will make the pre-service determination on an expedited basis. The Claims Administrator will notify the covered person of the expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Administrator will notify the individual of that fact within 24 hours after receiving the request, specifying what additional information is needed. The covered person must provide the specified information to the Claims Administrator within a reasonable amount of time, not to exceed 48 hours. The Claims Administrator will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

b. **Concurrent Claim Determinations.** When an ongoing course of treatment, to be provided over a period of time or a number of treatments, has been approved for a covered person and there is a subsequent reduction or termination of such period of time or number of treatments (other than by the amendment or termination of the Welfare Program), such reduction or termination is considered an adverse benefit determination. The Claims Administrator shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

   When an ongoing course of treatment has been approved for a covered person and the person requests an extension of the course of treatment, such a request is deemed to be a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. The Claims Administrator will notify the covered person of the determination within 24 hours after receiving the request.

c. **Post-Service Claim Determinations.** When a covered person requests a claim determination after services have been rendered, the Claims Administrator will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify the individual of this fact within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the covered person's request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the

determination period will resume on the date the individual responds to the notice, or 45 days after the covered person's receipt of the notice, whichever is sooner.

d. **Notice of Adverse Determination.** Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal; (5) a statement that upon request and free of charge, the following will be provided: a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

e. **Appeal of Denied Claim.**

1. **First Level of Appeal.** If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstances warrant an expedited appeals procedure, then the covered person should contact the Claims Administrator immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Administrator will issue a decision on review.

   Subject to the other provisions of this Article, the Claims Administrator's review will be processed in accordance with the following time frames: (a) 72 hours in the case of an urgent care claim; (b) 30 days in the case of a pre-service claim; (c) before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment; (d) 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or (e) 60 days in the case of a post-service Claim.

2. **Second Level of Appeal.** If, after exhausting the first level of appeal with the Claims Administrator, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer. Appeals will not be considered by the Employer unless and until the

claimant has first exhausted all claims procedures with the Claims Administrator. The appeal must be initiated in writing within 180 days after the Claims Administrator's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

In the normal case, the Employer will make a determination on the basis of the documents and written statements already submitted. However, the Employer may require or permit submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

The Employers decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth in this Section.

f. **Notice of Benefit Determination on Appeal.** Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1)the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (4) a statement describing any voluntary appeal procedures offered by the Plan and any claimant's right to bring an action under ERISA Section 502(a); (5) a statement that upon request and free of charge, the following will be provided: a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) a statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency. Any action under ERISA Section 502(a) may be filed only after the Plan's appeal procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided.

Relevant Information is any document, record, or other information that (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

g. **Review Procedures on Appeal.** In the conduct of any review, the following will apply:

1. No deference will be afforded to the initial adverse determination;

2. The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

3. In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

4. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

5. Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual; and

6. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

VI. ARTICLE - CLAIMS PROCEDURES FOR PLANS SUBJECT TO PPACA

01. **General.** For purposes of determination of the amount of, and entitlement to, benefits of an insured Welfare Program provided under a Policy provided by an Insurance Company Policy, the Insurance Company is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the Policy.

    To obtain benefits from an insured Welfare Program, the Participant must follow the claims procedures prescribed under the applicable Welfare Program. ***In the event that (i) the Welfare Program does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or (ii) the Plan Administrator determines that the claims procedures described in the Welfare Program shall not apply, and (iii)the Welfare Program is subject to PPACA, the claims procedure described in this Article shall apply with respect to such Welfare Program.*** If the Welfare Program is not subject to PPACA, the claims procedure applicable to such Welfare Program is described in the Article titled: "Claims Procedures for PPACA Exempt Plans".

02. **Non-Group Health Claims; Disability Claims.**

    a. **Time for Decision on a Claim.** A claim shall be filed in writing with the Plan Administrator and decided within 45 days by the Plan Administrator. If special circumstances require an extension of time to review the claim, a maximum of two 30- day extensions will be permitted. A claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from a claimant, such claimant will have 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

    b. **Notification of Adverse Determination.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

        i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an

explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse benefit determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and a description of any limitation period within which the suit must be filed including the exact date the limitation period ends; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively,

provide a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and (8) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

In the case of a claim for disability benefits filed under this Plan after April 1, 2018, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

c. **Right to Review.** A claimant may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 180 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the claimant’s right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Plan Administrator to consider.

d. **Review Procedures.** During the review process, the Plan Administrator will provide: (i) claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on any new or additional evidence, such evidence will be provided to the claimant sufficiently in advance of the date on which the notice of adverse benefit determination on review is to be provided, so as to give the claimant reasonable opportunity to respond to the new evidence prior to that date; (vi) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine

involved in the medical judgment; (vii) for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (viii) that the health care professional engaged for purposes of a consultation shall be an individual 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;

e. **Time for Decision on Review.** Written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for review. If an extension is necessary due to special circumstances, the claimant will be given a written notice of the required extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension may be for up to 45 additional days.

f. **Notification of Determination on Review.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) 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."

ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan.

g. **Legal Remedies.**

i. A suit under Section 502(a) of ERISA may be filed only after these review procedures have been exhausted and only if filed within the earlier of 90 days or a limitation period listed in the plan, after the final decision is provided.

ii. If the Plan fails to strictly adhere to these claims review

procedure requirements with respect to a claim for disability benefits filed under this Plan after April 1, 2018, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except as provided in the paragraph below. Accordingly, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

iii. Except as provided in the paragraph above, the administrative remedies available under the Plan with respect to a claim for disability benefits filed under this Plan after April 1, 2018, will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

03. **Group Health Claims.**

a. **Pre-Service Claim Determinations.** When a covered person requests a medical necessity determination prior to receiving care, the Claims Administrator will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Administrator's control, the Claims Administrator will notify the individual of this fact within 30 days after receiving the request. This notice will include the date a determination can be expected. lf more time is needed because necessary information is missing from the covered person's request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice, or 45 days after the covered person's receipt of the notice, whichever

is sooner.

If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person's health condition, would cause severe pain that cannot be managed without the requested services, the Claims Administrator will make the pre-service determination on an expedited basis. The Claims Administrator will notify the covered person of the expedited determination of that fact within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Administrator will notify the individual of that fact within 24 hours after receiving the request, specifying what additional information is needed. The covered person must provide the specified information to the Claims Administrator within a reasonable amount of time, not to exceed 48 hours. The Claims Administrator will notify the individual of the expedited benefit determination within 48 hours after receipt of the specified information. Expedited determinations may be provided orally, followed within 3 days by written or electronic confirmation.

b. **Concurrent Claim Determinations.** When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a subsequent reduction or termination of such period of time or number of treatments (other than by the amendment or termination of the Welfare Program), such reduction or termination is considered an adverse benefit determination. The Claims Administrator shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

   When an ongoing course of treatment has been approved for a covered person and the person requests to extend the course of treatment, such a request is deemed to be a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the currently approved period of time or number of treatments. When the covered person requests such a determination, the Claims Administrator will notify the covered person of the determination within 24 hours after receiving the request.

c. **Post-Service Claim Determinations.** When a covered person requests a claim determination after services have been rendered, the Claims Administrator will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify the individual of this fact within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the covered person's request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims

Administrator sends such a notice of missing information, and the determination period will resume on the date covered person responds to the notice, or 45 days after the covered person's receipt of the notice, whichever is sooner.

d. **Notice of Adverse Determination.** Every notice of an adverse benefit determination will be provided in writing or electronically in a culturally and linguistically appropriate manner calculated to be understood by the claimant, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) a description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of ERISA following a final appeal; (6) a statement that upon request and free of charge, the following will be provided: a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim; and (8) a statement as to the availability of and the contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

e. **Appeal of Denied Claim.**

1. **First Level of Appeal.** If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Administrator immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Administrator will issue a decision on review.

   Subject to the other provisions of this Article, the Claims Administrator's review will be processed in accordance with the following time frames: (a) 72 hours in the case of an urgent care claim; (b) 30 days in the case of a pre-service claim; (c) before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated

course of treatment; (d) 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or (e) 60 days in the case of a post-service claim.

2. **Second Level of Appeal.** If, after exhausting the first level appeal with the Claims Administrator, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer. Appeals will not be considered by the Employer unless and until the claimant has first exhausted all claims procedures with the Claims Administrator. The appeal must be initiated in writing within 180 days after the Claims Administrator's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

   In the normal case, the Employer will make a determination on the basis of the documents and written statements already submitted. However, the Employer may require or permit submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

   The Employers decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth in subsection 1 above.

   After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to adhere to the requirements set forth in this Article, a claimant will be deemed to have exhausted the Plan's internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law.A deemed exhaustion, however, does not occur if violations of the claims review process are de minimis violations that do not cause, and are not likely to cause prejudice or harm to the claimant so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between the claimant and the Plan Administrator, claims administrator or Named Fiduciary.

f. **Notice of Benefit Determination on Appeal.** Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant

Information as defined below; (5) a statement describing any voluntary appeal procedures offered by the Plan and any claimants right to bring an action under ERISA; (6) a statement that upon request and free of charge, the following will be provided: a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (7) a statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency. Any action under ERISA may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided.

"Relevant Information" is any document, record, or other information that (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

g. **Review Procedures on Appeal.** In the conduct of any review, the following will apply:

   1. No deference will be afforded to the initial adverse determination;

   2. The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

   3. In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

   4. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

   5. Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual; and

   6. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a

request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

7. The claimant will be provided with any 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 denial. The claimant will have a reasonable opportunity to respond to such new evidence or rationale.

VII. ARTICLE - QUALIFIED MEDICAL CHILD SUPPORT ORDERS

01. **Purposes.** The provisions of this Article shall apply with respect to any Welfare Program that does not contain provisions pertaining to QMCSOs (as defined below). The Plan Administrator, pursuant to Section 609(a) of ERISA, adopts the following procedures for determining whether medical child support orders are "qualified" in accordance with ERISA's requirements. The Plan Administrator also adopts these procedures to administer payments and other provisions under Qualified Medical Child Support Orders ("QMCSOs"), and to enforce these procedures as legally required. The Plan Administrator may alter, amend or terminate these procedures and substitute alternative procedures in its sole discretion.

02. **Definitions.** For purposes of the QMCSO requirements, the following terms have these meanings:

    a. **"Medical Child Support Order"** means any judgment, decree or order (including approval of a settlement agreement) which:

        i. Provides for child support for a child of a Participant under a group health plan, or provides for health coverage to such a child;

        ii. is made pursuant to state domestic relations law (including a community property law); and

        iii. Relates to benefits under such group health plan.

    b. **" Alternate Recipient"** means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under a group health plan with respect to such Participant.

    c. Any term used in this Article that is defined elsewhere in this Plan shall have the meaning assigned to such term under such other definition.

03. **Qualified Medical Child Support Order.**

    a. "Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order which creates or recognizes an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or beneficiary is eligible under the group health portion of this Plan, and which the Plan Administrator has determined meets the requirements of this Section.

    b. To be "qualified" as a QMCSO, a Medical Child Support Order must clearly:

        i. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order;

        ii. Include a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;

iii. Specify the period to which such order applies;

iv. Specify the Plan to which such order applies; and

v. Provide that the alternate recipient or parent of the alternate recipient will pay the applicable premium for family coverage under the Plan.

c. In addition, a QMCSO must not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993).

d. The alternate recipient's right to enroll in the Plan is dependent on the Participant's eligibility status in the Plan.

04. **Procedures.** Upon receipt of a Medical Child Support Order, the Plan Administrator shall:

a. Promptly notify in writing the Participant, each alternate recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and the Plan's procedures for determining whether such order is a QMCSO.

b. Permit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the Medical Child Support Order.

c. Within a reasonable period after receiving a Medical Child Support Order, determine whether it is a Qualified Medical Child Support Order and notify the parties indicated in this Section of such determination.

d. Ensure the alternate recipient is treated by the Plan as a beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the alternate recipient (and/or his or her representative) a copy of the summary plan description and any subsequent summaries of material modification generated by a Plan amendment.

VIII. ARTICLE - GENERAL PROVISIONS

01. **COBRA Rights.** With respect to each Welfare Program which is a group health plan within the meaning of Section 601 of ERISA, each Participant and his or her family members may have the right to purchase continuous coverage for a temporary period of time if coverage under the group health plan terminates due to certain COBRA qualifying events (such as termination of employment, reduction in work hours, divorce, death, or a child ceasing to meet the definition of dependent under the terms of the group health plan). In general, a Participant or family member must elect COBRA continuation coverage within 60 days following the date of the qualifying event, or if later, the date notice of the qualifying event is provided to the individual. If continuation coverage is elected, the individual will be responsible for paying the full cost of continuation coverage plus an administrative fee.

02. **Newborns' and Mothers' Health Protection Act.** With respect to each Welfare Program that is a group health plan providing maternity benefits, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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 newborn earlier than the above periods. In any case, such group health plan will not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

03. **Women's Health and Cancer Rights Act** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-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 upon which the mastectomy was performed;
    2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
    3. Prostheses; and
    4. Treatment of physical complications during all stages of mastectomy, including lymphedemas.

    These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits under this Plan.

04. **FMLA.** The Employer will maintain benefits under each Welfare Program that is a group health plan for an Employee on FMLA leave on the same terms and conditions as if the Employee had continued to work. lf an Employee returns from FMLA leave and chooses not to retain group health plan coverage during the leave, the Employer will reinstate the Employee in such group health plan coverage on the same terms as prior to the leave.

05. **USERRA.** Except to the extent greater benefits are provided under a

Welfare Program, a Participant who is performing service in the uniformed services and is covered under the Plan is entitled to continue coverage for himself and dependents if applicable, provided the Participant elects to continue coverage for the lesser of the following periods:

a. The 24-month period beginning on the date the Participant's absence for the purpose of performing service begins; or

b. The period beginning on the date the Participant's absence for the purpose of performing service begins, and ending on the date which the Participant fails to return from service or apply for a position of employment as provided in USERRA or the regulations thereunder.

COBRA continuation coverage provided under the Sections titled: "COBRA Rights" and "USERRA" under this Article are concurrent.

06. **Governing Law.** This Plan shall be governed and construed in accordance with the internal laws of the State of South Carolina without giving effect to any choice of law or conflict of law provision or rule (whether the State of South Carolina or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State of South Carolina. Notwithstanding the foregoing, in the event that the laws of the State of South Carolina are superseded by the Internal Revenue Code of 1986, as amended (the "Code") and/or ERISA, the Code and/or ERISA shall control.

07. **Construction of Plan Document.** The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

08. **Severability Clause.** In case any provision of this Plan shall be held unlawful or invalid for any reason, such unlawfulness or invalidity shall not affect the remaining parts of this Plan, and this Plan shall be construed and enforced as if such unlawful or invalid provisions had never been inserted herein.

09. **Plan in Effect at Termination of Employment Controls.** Unless expressly indicated otherwise, no provision of this Plan shall apply to any Employee who terminated employment prior to the effective date of such provision. In addition, unless expressly indicated otherwise, any amendment to this Plan shall not apply to any Eligible Employee who terminates employment prior to the effective date of such amendment.

10. **No Guarantee of Employment.** This Plan shall not be deemed to constitute a contract between the Employer and any Eligible Employee or Participant, or to be consideration or an inducement for the employment of any Participant or Eligible Employee. Nothing contained in this Plan shall be deemed to give any Participant or Eligible Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Eligible Employee at any time, regardless of the effect which such discharge shall have upon such Eligible Employee as a Participant in the Plan.

11. **Non-Alienation of Benefits.** No benefit, right or interest of any Participant or beneficiary under the Plan shall be subject to anticipation, alienation, sale, assignment, transfer, process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, and no such attempted or purported anticipation, etc., will be recognized by the Plan, except as otherwise required by law.

12. **Limitation of Rights.** Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed so as to give any person any legal or equitable right against the Employer, except as expressly provided herein or required by law.

13. **Cooperation.** Circumstances may arise in which the Employer or the Plan Administrator may require a Participant or beneficiary to furnish information or pay an amount that directly or indirectly relates to participation in, or benefits paid or payable from a Welfare Program. Each Participant or beneficiary, in consideration of the coverage provided by such Welfare Program, must fully cooperate and provide any and all information requested, execute any and all documents that will enable the Employer or the Plan Administrator to access such information, and pay any amount due pursuant to the Welfare Program. In the event a Participant or beneficiary fails to comply with this cooperation provision within the time period set by the Plan Sponsor in its sole and absolute discretion or provides false information in response to such request, payment of all benefits under the Welfare Program (whether or not such benefits relate to the requested information or failure to pay) may be suspended and/or coverage may be terminated either retroactively or prospectively in the Employers sole discretion. In addition, the Employer or the Plan Administrator may pursue any other remedy available to it, including obtaining an injunction to require cooperation, or recovering from the covered person or beneficiary damages for any loss incurred by it as a result of the failure to cooperate or make payment, or the provision of false information.

14. **Mental Health Parity and Addiction Equity Act.** Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712 (where applicable).

15. **Genetic Information Nondiscrimination Act (GINA).** Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

16. **Children's Health Insurance Program Reauthorization Act of 2009.** The Plan will comply with the "group health plan" requirements relating to CHIP under the Children's Health Insurance Program Reauthorization Act of 2009.

IX. ARTICLE - PLAN PRIVACY RULES

01. **Introduction.** The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") mandates strict privacy and security standards to protect Protected Health Information as defined below. In addition, the Plan will ensure that PHI that is Electronic Protected Health Information ("ePHI") pertaining to covered persons remains confidential. This Article sets forth the guidelines the Plan Sponsor must follow when using and disclosing PHI.

02. **Definitions.**

    a. "**Individually Identifiable Health information**" means health information that either actually identifies an individual, or creates a reasonable basis to believe that the information would identify the individual.

    b. "**Protected Health Information**" or "**PHI**" means health information that:

        i. Is created or received by health care providers, health plans, or health care clearinghouses;

        ii. Relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and

        iii. identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

    c. "**Electronic Protected Health Information**" or "**ePHI**" is PHI that is transmitted by or maintained in electronic media, as defined in 45 C.F.R. § 160.103.

    d. "**Plan Sponsor**" means the Employer.

03. **Permitted Uses and Disclosures.** The Plan Sponsor can use or disclose PHI without prior Participant authorization or consent in the following situations:

    a. When the PHI is used or disclosed to the Participant who is the subject of the PHI;

    b. When the PHI is used or disclosed for treatment, payment, or health care operations;

    c. When the PHI is used or disclosed incident to a use or disclosure otherwise permitted or required under the privacy rules set forth in this Article, and such disclosure occurs despite reasonable Plan safeguards which are in place;

    d. When the PHI is used or disclosed pursuant to and in compliance with a valid authorization; and

    e. When the PHI is used or disclosed pursuant to an agreement with

the Participant in situations where the Participant is given the choice to agree to or object to such use or disclosure.

04. **Required Uses and Disclosures.** The Plan Sponsor must disclose PHI in the following situations:

    a. When Participants request access to their own PHI, or request an accounting of the Plan's disclosures of their own PHI; and

    b. When required by the U.S. Department of Health and Human Services to determine the Plan's compliance with the privacy rules set forth in this Article.

05. **Certifications.** The Plan Sponsor certifies and agrees to:

    a. Not use or further disclose PHI other than as permitted or required by the Plan or applicable law;

    b. Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

    c. Not use or disclose PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan;

    d. Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by the Plan and of which the Plan Sponsor becomes aware;

    e. Make a Participant's PHI available to such Participant;

    f. Allow a Participant to amend his or her PHI;

    g. Make an accounting of disclosures of PHI available to a Participant;

    h. Make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance;

    i. If feasible, return or destroy all PHI received from the Plan that it still maintains and that is no longer needed for the purpose for which the disclosure was made; if destruction is not possible, limit further uses and disclosures; and

    j. Ensure adequate separation between the Plan and the Plan Sponsor.

06. **Obligations with Respect to ePHI Obtained From the Plan.** As a condition of receiving ePHI from the Plan for Plan administrative functions, the Plan Sponsor specifically agrees to:

    a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

    b. Ensure that the adequate separation, between the Plan Sponsor

and persons who have no legitimate need to access such PHI, as required by 45 CFR. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

c. Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect ePHI; and

d. Report to the Plan any security incident of which it becomes aware.

07. **Adequate Separation Between the Plan and the Plan Sponsor.**

a. **Access to PHI.** The following employees of the Plan Sponsor (and any successors to their current job titles/positions) may be given access to PHI because such access is essential for them to perform their Plan administration duties:

    - Full Time Employee

b. **Restricted Access.** The employees listed in (a) above shall have access to PHI that is restricted to Plan administration functions necessary and essential for the ongoing functioning of the Plan.

c. **Procedures for Resolving Noncompliance.** The Plan's Privacy Officer has responsibility for facilitating and ensuring compliance with all privacy rules and procedures. All employees and contractors of the Plan Sponsor who handle PHI will be subject to enforcement sanctions administered in a manner that is consistent with the Plan Sponsor's human resources policies and procedures. Sanctions will be determined based on the nature of the violation, its severity, whether or not the violation was intentional, and whether or not the offending individual has engaged in previous violations. Sanctions may include verbal warnings, written warnings, probationary periods, suspension or termination. Sanctions will be consistently applied in a nondiscriminatory manner.

X. ARTICLE - PATIENT PROTECTION AND AFFORDABLE CARE ACT COMPLIANCE

01. **Pre-Existing Conditions.** Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any limitation or exclusion on coverage of pre-existing conditions for individuals.

02. **Lifetime/Annual Limits.** Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any lifetime or annual limits on the dollar value of essential benefits for any individual under the group health plan. "Essential benefits" shall be those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.

03. **Cost Sharing Requirements for Preventive Care Expenses.** With regard to non-grandfathered benefits under the Plan, there shall be no participant cost sharing requirements for any in-network preventive care expenses, as set forth in PPACA and the regulations and guidance issued thereunder.

04. **Dependent Definition.** The term "Dependent" shall include any child of a participant who is covered under an insurance contract, as defined in the contract, as defined in the plan, subject to PPACA and the regulations and guidance issued thereunder.

05. **No Rescission of Coverage.** The Plan shall not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.

06. **Selection of Providers.** If a non-grandfathered group health plan or a health insurance issuer offering group or individual health insurance coverage under the Plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. The plan or issuer must also permit the Participant to designate an in-network pediatrician who is available to accept the participant, beneficiary, or enrollee, and the plan may not require referral or authorization for any in-network obstetrician or gynecologist who is available to accept the participant, beneficiary, or enrollee.

07. **Emergency Services.** With respect to non-grandfathered benefits under the Plan, a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services.

08. **Cost Sharing Limits.** With respect to non-grandfathered benefits under the Plan, this Plan does not impose cost sharing amounts (i.e., copayments, coinsurance, and deductibles, but not premiums) that are more than the maximum allowed for high deductible health plans. In

2018, these limits will be 7,350 for an individual and 14,700 for family coverage. After 2018, these amounts will be adjusted for health insurance premium inflation. For these purposes, if the Plan utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums, the Plan will combine the annual limitation on out-of-pocket maximums for each other type of plan coverage (e.g., prescription drug coverage) on an aggregate basis.

09. **Clinical Trials.** With respect to non-grandfathered benefits under the Plan, this Plan shall not deny any "qualified individual," as set forth in Public Health Service Act §2709, participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. This Plan also shall not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. Finally, this Plan shall not discriminate against the individual on the basis of the individual's participation in such trial.

10. **Provider Discrimination.** With respect to non-grandfathered benefits under the Plan, this Plan shall not discriminate with respect to participation under the Plan against any health care provider that is acting within the scope of that provider's license or certification under applicable state law, as required by Public Health Service Act §2706(a).

11. **Applicability.** This Article shall apply to Welfare Programs under the Plan only if the Welfare Programs are subject to PPACA and if the Welfare Programs do not contain provisions compliant with PPACA.

APPENDIX A

Welfare Program	Benefit Administrator	Policy or Contract Number	PPACA Applicability
Health Plan (Fully-Insured) Blue Cross Blue Shield of SC Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	15-85029-00 Base PPO	Applicable
Group-Term Life for Employees Companion Life Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	385-15-73247-000	Applicable
Accident, Cancer, and Critical Illness Colonial Life Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	E4923157	Applicable
Dental Guardian Life Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	00336041	Applicable
Long-Term Disability (Fully-Insured) Guardian Life Effective Date: 01/01/2018	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	00336041	Applicable
Short-Term Disability (Fully-Insured) Guardian Life Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	00336041	Applicable
Group-Term Life for Employees Guardian Life Effective Date: 07/25/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	00336041	Applicable
Health Plan (Fully-Insured) Blue Cross Blue Shield of SC Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	15-85029-01	Applicable
Vision Physicians Eyecare Plan	Dillon Family Medicine, PA 603 N 6th Avenue	00309	Applicable

Effective Date: 01/01/2019	Dillon , SC 29536		

Execution Agreement

IN WITNESS WHEREOF, Dillon Family Medicine, PA has caused its authorized officer to execute this amended and restated Plan document as of _____, the same to be effective **January 01, 2019**, unless otherwise indicated herein.

Dillon Family Medicine, PA

By: _____

Name: _____

Title: _____

CERTIFICATE OF RESOLUTION

The undersigned authorized representative of **Dillon Family Medicine, PA** (the Employer) hereby certifies that the following resolutions were duly adopted by the governing body of the Employer on _____, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of amended and restated Welfare Benefit Plan, effective January 01, 2019, presented to this meeting (and a copy of which is attached hereto) is hereby approved and adopted, and that the proper agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of said Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that the Administrator deems necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures for the provision of benefits under the Plan.

RESOLVED, that the proper agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Plan and to deliver to each employee a copy of the Summary Plan Description of the Plan, which Summary Plan Description is attached hereto and is hereby approved.

The undersigned further certifies that attached hereto as Exhibits, are true copies of Dillon Family Medicine, PA's Benefit Plan Document and Summary Plan Description approved and adopted at this meeting.

Dillon Family Medicine, PA

By: _____

Name: _____

Title: _____

Dillon Family Medicine, PA

Dillon Family Medicine, PA
603 N 6th Avenue
Dillon, SC 29536

Dillon Family Medicine, PA Wrap Plan

Summary Plan Description

Amended and Restated January 01, 2019

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I. SUMMARY PLAN DESCRIPTION SUPPLEMENT

This document and the certificates issued with respect to the Welfare Programs described herein (the “Certificates”) together comprise the Summary Plan Description (SPD) for the Dillon Family Medicine, PA Wrap Plan (the “Plan”). If the terms of this document conflict with the terms of the Certificates, then the terms of the Certificates will control, unless otherwise required by law.

The SPD summarizes your rights and obligations as a participant (or beneficiary) in the Plan. It is intended to comply with the minimum federal legal requirements for SPDs. To the extent any greater legal rights are afforded to you by the Plan or any applicable state law not pre-empted by ERISA, those legal rights supersede the rights set forth in the SPD.

GENERAL INFORMATION

NAME OF PLAN:

Dillon Family Medicine, PA Wrap Plan

PLAN SPONSOR:

Dillon Family Medicine, PA
603 N 6th Avenue
Dillon, SC 29536

The Plan Sponsor is sometimes referred to as the “***Company***.”

EMPLOYER IDENTIFICATION NUMBER:

57-0534420

PLAN NUMBER:

501

PLAN ADMINISTRATOR:

Dillon Family Medicine, PA
603 N 6th Avenue
Dillon, SC 29536

TYPE OF PLAN:

Dillon Family Medicine, PA Wrap Plan including Medical, Basic Life & AD&D, Accident, Cancer, and Critical Illness, Dental, Long Term Disability - Class 1 only - excludes Physicians, Short Term Disability, Group Basic Life and AD&D, Medical Enhanced Plan - HDHP and Vision benefits.

PLAN YEAR:

Other than any applicable short plan year, the Plan’s records are maintained

on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 01 and ends on December 31.

CLAIMS ADMINISTRATION:

Claims for benefits are administered by the respective companies set forth at Appendix A that include but are not limited to: Medical, Basic Life & AD&D, Accident, Cancer, and Critical Illness, Dental, Long Term Disability - Class 1 only - excludes Physicians, Short Term Disability, Group Basic Life and AD&D, Medical Enhanced Plan - HDHP and Vision.

AGENT FOR SERVICE OF LEGAL PROCESS:

Dillon Family Medicine, PA
603 N 6th Avenue
Dillon, SC 29536

You may also serve legal process on the Plan Administrator or any successor in title or office of the current registered agent of the company.

TYPE OF ADMINISTRATION:

Benefits under the Plan are fully insured and are paid pursuant to the terms of insurance policies issued by insurance companies.

ELIGIBILITY:

The eligibility and participation requirements for each Welfare Program are stated in the applicable Policy or Welfare Program document. Where the eligibility and/or participation requirements are not stated in the Policy or Welfare Program document, the eligibility and/or participation requirements stated in this SPD and the Plan Document shall control, as otherwise set forth below:

You will be eligible to participate in the Plan if you are a full-time employee regularly scheduled to work at least 30 hours per week ("full-time Employee").

Other individuals, such as an Eligible Employee’s spouse, children, or other designated member, may be eligible to participate in and receive benefits under one or more of the Welfare Programs due to their relationship to an Eligible Employee. Information about such eligibility and coverage is found in the applicable Policy or Welfare Program Documents.

You will enter the plan on the first day of the month, following the waiting period based on the applicable classification below.

1st of the month following date requirements	30 Days

A reemployed former Participant shall again be eligible to become a Participant in the Plan when the Participant again satisfies the requirements set forth in the Section titled: "Eligibility and Participation".

AMENDMENT AND TERMINATION:

The Dillon Family Medicine, PA Wrap Plan (the "Plan Document") contains all the terms of the Plan and may be amended from time to time at its sole discretion by your Employer. Any changes made shall be binding on each Covered Participant and any other Covered Persons referred to in the Plan Document.

The Booklet will disclose any Plan provisions governing your benefits, rights and obligations upon plan termination or the amendment or elimination of benefits under the Plan.

NO CONTRACT OF EMPLOYMENT:

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the companies listed below to the effect that you will be employed for any specific period of time.

BENEFITS AND ADMINISTRATION:

The Plan provides benefits for eligible employees and covered dependents as administered under policies of insurance as listed in Appendix A that include but are not limited to: Medical, Basic Life & AD&D, Accident, Cancer, and Critical Illness, Dental, Long Term Disability - Class 1 only - excludes Physicians, Short Term Disability, Group Basic Life and AD&D, Medical Enhanced Plan - HDHP and Vision. These Welfare Programs are insured or administered by the companies also listed in Appendix A and are generally described in the Plan Document. The administrative functions include paying claims and determining medical necessity.

Replacements for lost or misplaced copies of the Plan Document may be obtained by writing to the Plan Administrator. Notification will be given of changes in benefits that may occur from time to time.

II. SUMMARY OF PLAN BENEFITS

The Plan provides you and your eligible dependents with the coverages summarized in Appendix A. A summary of the benefits provided under the Plan is set forth in the certificates issued by the insurance companies.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT:

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 insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

WOMEN'S HEALTH CANCER RIGHTS ACT:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-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 upon which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. Prostheses; and

4. Treatment of physical complications during all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits under this Plan.

LOSS OF BENEFITS:

The provisions regarding termination of coverage and limitations and exclusions of benefits that may result in reduction or loss of benefits are explained in the Welfare Benefit Booklet.

CONTRIBUTIONS:

Contributions to the Plan are provided by the Employer and Employees. Employee contributions are made via automatic payroll deductions. The Plan Administrator will provide a schedule of the applicable premiums during open enrollment periods and upon request.

HOW TO RECEIVE YOUR BENEFITS:

This information is explained in the article entitled “CLAIMS PROCEDURE FOR PPACA EXEMPT PLANS” or “CLAIMS PROCEDURE FOR PLANS SUBJECT TO PPACA” as the case may be.

BENEFIT-SPECIFIC INFORMATION:

Please refer to the appropriate insurance policies and/or summaries of coverage for the following information:

- A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which you or a beneficiary will be responsible;
- Any annual or lifetime caps or other limits on benefits under the Plan;
- The extent to which preventative services are covered under the Plan;
- Whether, and under what circumstances, existing and new drugs are covered under the Plan;
- Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers;
- The composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services;
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care; and
- Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

III. CLAIMS PROCEDURE FOR PPACA EXEMPT PLANS

A claim for benefits under a Welfare Program must be submitted in accordance with the claims procedure prescribed for the applicable Welfare Program. ***To the extent that a claims procedure is not prescribed for a Welfare Program, and the Welfare Program is not subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this section shall apply with respect to such Welfare Program.*** If the Welfare Program is subject to PPACA, the claims procedure applicable to such Welfare Program is described in the section entitled "Claims Procedure for Plans Subject to PPACA."

A "claim" is defined as any request for a plan benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. "Days" means calendar days, not business days.

There are different types of claims (including Disability, Pre-Service, Concurrent and Post-Service), and each one has specific timetables for approval, payment, request for further information, and denial of the claim.

NON-GROUP HEALTH & DISABILITY CLAIMS PROCEDURES:

1. **Time for Decision on a Claim.** A claim shall be filed in writing with the Plan Administrator and decided within 45 days by the Plan Administrator. If special circumstances require an extension of time to review the claim, a maximum of two 30- day extensions will be permitted. A claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from a claimant, such claimant will have 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

2. **Notification of Adverse Determination.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse

benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse benefit determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and a description of any limitation period within which the suit must be filed including the exact date the limitation period ends; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, provide a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and (8) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

In the case of a claim for disability benefits filed under this Plan after April 1, 2018, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a

participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

3. **Right to Review.** A claimant may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 180 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the claimant’s right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Plan Administrator to consider.

4. **Review Procedures.** During the review process, the Plan Administrator will provide: (i) claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on any new or additional evidence, such evidence will be provided to the claimant sufficiently in advance of the date on which the notice of adverse benefit determination on review is to be provided, so as to give the claimant reasonable opportunity to respond to the new evidence prior to that date; (vi) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (vii) for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (viii) that the health care professional engaged for purposes of a consultation shall be an individual 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;

5. **Time for Decision on Review.** Written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for review. If an extension is necessary due to special circumstances, the claimant will be given a written notice of the required

extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension may be for up to 45 additional days.

6. **Notification of Determination on Review.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

   i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) 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."

   ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan of health care professionals treating the

claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan.

7. **Legal Remedies.**

i. A suit under Section 502(a) of ERISA may be filed only after these review procedures have been exhausted and only if filed within the earlier of 90 days or a limitation period listed in the plan, after the final decision is provided.

ii. If the Plan fails to strictly adhere to these claims review procedure requirements with respect to a claim for disability benefits filed under this Plan after April 1, 2018, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except as provided in the paragraph below. Accordingly, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

iii. Except as provided in the paragraph above, the administrative remedies available under the Plan with respect to a claim for disability benefits filed under this Plan after April 1, 2018, will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good

faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

GROUP HEALTH CLAIMS PROCEDURES:

1. **Pre-Service Claim Determinations.** When a covered person requests a medical necessity determination prior to receiving care, the Claims Administrator (as defined in the Plan) will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Administrator's control, the Claims Administrator will notify the individual of this fact within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice or 45 days after the covered person's receipt of the notice, whichever is sooner.

   If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person's health condition, would cause severe pain which cannot be managed without the requested services, the Claims Administrator will make the pre-service determination on an expedited basis. The Claims Administrator will notify the covered person of the expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Supervisor will notify the individual within 24 hours after receiving the request, specifying what information is needed. The covered person must provide the specified information to the Claims Supervisor within a reasonable amount of time, not to exceed 48 hours. The Claims Supervisor will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

   If the covered person fails to follow the Claims Supervisor's procedures for requesting a pre-service medical necessity determination, the Claims Administrator will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person requests written notification.

2. **Concurrent Claim Determinations.** When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a reduction or termination of such course of treatment (other than by the amendment or termination of the Welfare Program) such reduction or termination constitutes an adverse benefit determination. The Claims Administrator shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

   When an ongoing course of treatment to be provided over a period of time or number of treatments has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Administrator will notify the covered person of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

3. **Post-Service Claim Determinations.** When a covered person requests a claim determination after services have been rendered, the Claims Administrator will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Supervisor will notify the individual of that fact within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice or 45 days after the covered person's receipt of the notice, whichever is sooner.

4. **Notice of Adverse Determination.** Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) in the case of a claim involving urgent care, a description of

the expedited review process applicable to such claim.

5. **Appeal of Denied Claim.**

    1. **First Level of Appeal.** If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Administrator immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Administrator will issue a decision on review.

        The Claims Administrator's review will be processed in accordance with the following time frames:

        1. 72 hours in the case of an urgent care claim;

        2. 30 days in the case of a pre-service claim;

        3. before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment;

        4. 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or

        5. 60 days in the case of a post-service claim.

    2. **Second Level Of Appeal.** If, after exhausting the first level appeal with the Claims Administrator, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer. Appeals will not be considered by the Employer unless and until the claimant has first exhausted the claims procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Administrator's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

        The Employer may require submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

        The Employer's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth above.

        After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to strictly adhere to the requirements set forth in this Article, a claimant will be deemed to have exhausted the Plan's internal

claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law. A deemed exhaustion, however, does not occur if violations of the claims review process are de minimis, violations that do not cause, and are not likely to cause prejudice or harm to the claimant so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between the claimant and the Plan Administrator, claims administrator or Named Fiduciary.

6. **Notice of Benefit Determination on Appeal.** Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information (as defined below); (4) a statement describing any voluntary appeal procedures offered by the Plan and any claimant's right to bring an actionunder ERISA Section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) a statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency.

   Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided.

   Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

7. **Review Procedures on Appeal.** In the conduct of any review, the following will apply:

   1. No deference will be afforded to the initial adverse determination;

   2. The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

   3. In deciding an appeal that is based in whole or in part on a medical

judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

4. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

5. Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual; and

6. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan’s determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

IV. CLAIMS PROCEDURE FOR PLANS SUBJECT TO PPACA

A claim for benefits under a Welfare Program must be submitted in accordance with the claims procedure prescribed for the applicable Welfare Program. ***To the extent that a claims procedure is not prescribed for a Welfare Program, and the Welfare Program is subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this section shall apply with respect to such Welfare Program.*** If the Welfare Program is not subject to PPACA, the claims procedure applicable to such Welfare Program is described in the section entitled "Claims Procedure for PPACA Exempt Plans."

A "claim" is defined as any request for a plan benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. "Days" means calendar days, not business days.

There are different types of claims (including Disability, Pre-Service, Concurrent and Post-Service), and each one has specific timetables for approval, payment, request for further information, and denial of the claim.

NON-GROUP HEALTH & DISABILITY CLAIMS PROCEDURES:

1. **Time for Decision on a Claim.** A claim shall be filed in writing with the Plan Administrator and decided within 45 days by the Plan Administrator. If special circumstances require an extension of time to review the claim, a maximum of two 30- day extensions will be permitted. A claimant will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 45-day period. A claimant will receive notice of any second extension prior to the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from a claimant, such claimant will have 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

2. **Notification of Adverse Determination.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

    i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse

benefit determination on review; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse benefit determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and a description of any limitation period within which the suit must be filed including the exact date the limitation period ends; (5) a discussion of the decision, which will include an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or provide a statement that such explanation will be provided free of charge upon request; (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, provide a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and (8) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

In the case of a claim for disability benefits filed under this Plan after April 1, 2018, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a

participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

3. **Right to Review.** A claimant may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 180 days after receipt by the claimant of written notice of the decision. A failure to file a request for review within 180 days will constitute a waiver of the claimant’s right to request a review of the denial of the claim. Such written request for review shall contain all additional information that the claimant wishes the Plan Administrator to consider.

4. **Review Procedures.** During the review process, the Plan Administrator will provide: (i) claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (iii) for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination; (iv) for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; (v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on any new or additional evidence, such evidence will be provided to the claimant sufficiently in advance of the date on which the notice of adverse benefit determination on review is to be provided, so as to give the claimant reasonable opportunity to respond to the new evidence prior to that date; (vi) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (vii) for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (viii) that the health care professional engaged for purposes of a consultation shall be an individual 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;

5. **Time for Decision on Review.** Written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for review. If an extension is necessary due to special circumstances, the claimant will be given a written notice of the required

extension prior to the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension may be for up to 45 additional days.

6. **Notification of Determination on Review.** Written notice of the decision on such claim shall be furnished promptly to the claimant.

   i. For claims for disability benefits filed under this Plan on or before April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (7) 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."

   ii. For claims for disability benefits filed under this Plan after April 1, 2018, every notice of an adverse benefit determination will be provided in writing or electronically, in a culturally and linguistically appropriate manner, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the benefit determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits; (4) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA; (5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan of health care professionals treating the

claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request; and (7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If ten percent or more of the population residing in the county (in which a claims notice is sent) is literate only in the same non-English language, as determined in guidance published by the Secretary, the Employer must: (i) provide assistance with filing claims and appeals in that non-English language, (ii) upon request, provide a notice in that non-English language to the claimant; and (iii) include a non-English statement in the English version of the notice on how to access the non-English language services provided by the Plan.

7. **Legal Remedies.**

i. A suit under Section 502(a) of ERISA may be filed only after these review procedures have been exhausted and only if filed within the earlier of 90 days or a limitation period listed in the plan, after the final decision is provided.

ii. If the Plan fails to strictly adhere to these claims review procedure requirements with respect to a claim for disability benefits filed under this Plan after April 1, 2018, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except as provided in the paragraph below. Accordingly, the claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

iii. Except as provided in the paragraph above, the administrative remedies available under the Plan with respect to a claim for disability benefits filed under this Plan after April 1, 2018, will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good

faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under the preceding paragraph on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

GROUP HEALTH CLAIMS PROCEDURES:

1. **Pre-Service Claim Determinations.** When a covered person requests a medical necessity determination prior to receiving care, the Claims Administrator will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Administrator’s control, the Claims Administrator will notify the individual of that fact within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice or 45 days after the covered person's receipt of the notice, whichever is sooner.

   If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person’s health condition, would cause severe pain which cannot be managed without the requested services, the Claims Administrator will make the pre-service determination on an expedited basis. The Claims Administrator will notify the covered person of the expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Administrator will notify the individual within 24 hours after receiving the request specifying what information is needed. The covered person must provide the specified information to the Claims Administrator within a reasonable amount of time not to exceed 48 hours. The Claims Administrator will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

   If the covered person fails to follow the Claims Supervisor’s procedures for requesting a pre-service medical necessity determination, the Claims Administrator will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person

requests written notification.

2. **Concurrent Claim Determinations.** When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a reduction or termination of such course of treatment (other than by the amendment or termination of the Welfare Program) such reduction or termination constitutes an adverse benefit determination. The Claims Administrator shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

   When an ongoing course of treatment to be provided over a period of time or number of treatments has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Administrator will notify the covered person of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

3. **Post-Service Claim Determinations.** When a covered person requests a claim determination after services have been rendered, the Claims Administrator will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Supervisor will notify the individual of that fact within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice or 45 days after the covered person's receipt of the notice.

4. **Notice of Adverse Determination.** Every notice of an adverse benefit determination will be provided in writing or electronically in a culturally and linguistically appropriate manner calculated to be understood by the claimant, as required by law, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) a description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of

ERISA following a final appeal; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim; and (8) The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

5. **Appeal of Denied Claim.**

    1. **First Level of Appeal.** If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Administrator immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Administrator will issue a decision on review.

        The Claims Administrator's review will be processed in accordance with the following time frames: (a) 72 hours in the case of an urgent care claim; (b) 30 days in the case of a pre-service claim; (c) before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment; (d) 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or (e) 60 days in the case of a post-service claim.

    2. **Second Level Of Appeal.** If, after exhausting the first level appeal with the Claims Administrator, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer. Appeals will not be considered by the Employer unless and until the claimant has first exhausted the appeal procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Administrator's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

        The Employer may require or permit submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

        The Employer's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth above.

        After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to

strictly adhere to the requirements set forth in this Article VII, a claimant will be deemed to have exhausted the Plan's internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law.

6. **Notice of Benefit Determination on Appeal.** Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (5) a statement describing any voluntary appeal procedures offered by the Plan; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (7) a statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office or state insurance regulatory agency.

   Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided.

   "Relevant Information" is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

7. **Review Procedures on Appeal.** In the conduct of any review, the following will apply:

   1. No deference will be afforded to the initial adverse determination;

   2. The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

   3. In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of

medicine involved in the medical judgment;

4. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

5. Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual;

6. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method; and

7. The claimant will be provided with any 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 denial. The claimant will have a reasonable opportunity to respond to such new evidence or rationale.

8. **External Claims Procedure.** After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the Plan a request for an external review, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the Plan is not eligible for the external review process. A claimant may request from the Plan Administrator additional information describing the Plan's external review procedure.

V. WHEN COVERAGE MAY BE CONTINUED

You and your covered dependents may continue your medical coverage under this Plan under certain circumstances, according to the terms of your employer's Leave of Absence Policy, the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment And Reemployment Rights Act (USERRA), and the Consolidated Omnibus Budget Reconciliation Act (COBRA). Medical coverage for yourself and your covered dependents may be continued if you cease active work because of an approved medical, family, personal, or military leave of absence or if your employment with the Company ends.

COBRA CONTINUATION OPTIONS:

To the extent a description of COBRA rights is not provided for a Welfare Program, the following applies:

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries). When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Are there other coverage options?

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (the "Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You may be eligible for Medicaid. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Please note that certain excepted benefits such as health flexible spending accounts, integrated health reimbursement arrangements, or standalone vision or dental plans will not be offered under the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a Covered Employee, the spouse of a Covered Employee, or a dependent child of a Covered

Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. Any child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "Covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility for these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a Covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding sentence, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

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

1. The death of a Covered Employee.

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

3. The divorce or legal separation of a Covered Employee from the Employee's spouse. If the Employee reduces or eliminates the Employee's spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.

4. A Covered Employee's enrollment in any part of the Medicare program.

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

If the Qualifying Event causes the Covered Employee, or the covered spouse or a dependent child of the Covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a Covered Employee, or the spouse, or a dependent child of the Covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

Premiums. This plan can charge up to 102% of the total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

Enrolling in another Group Health Plan. You should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

COBRA vs. Marketplace. Other factors to consider when weighing your coverage options include: premium costs, whether a change in coverage will affect your access to certain providers, service areas or drug formularies and whether the coverage change will affect your cost sharing (i.e., new deductibles, etc.). See the discussion above under “Are there other coverage options?” for more information on your options for Marketplace coverage.

What is the election period and how long must it last?

The Plan has conditioned the availability of COBRA continuation coverage

upon the timely election of such coverage. An election is timely if it is made during the election period.

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his or her right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a Covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for the Employee and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a Covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. death of the Employee,
3. commencement of a proceeding in bankruptcy with respect to the Employer, or
4. the Employee's entitlement to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (e.g., divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60 day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation

coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing*****.** Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Dillon Family Medicine, PA
603 N 6th Avenue
Dillon, SC 29536

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their dependent children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

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

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

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

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.
5. The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
    1. 29 months after the date of the Qualifying Event or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
    2. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

What are the maximum coverage periods for COBRA continuation coverage?

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

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

2. In the case of a Covered Employee's entitlement to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of:

    1. 36 months after the date the Covered Employee becomes entitled to Medicare; or

    2. 18 months (or 29 months, if there is a disability extension) after the date of the Covered Employee's termination of employment or reduction of hours of employment.

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

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

Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18 month or 29 month maximum coverage period is followed, within that 18 or 29 month period, by a second Qualifying Event that gives rise to a 36 months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension?

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

maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan at a later date is also considered Timely Payment if either (i) under the terms of the Plan, Covered Employees or Qualified Beneficiaries are allowed to make the payment until that later date, or (ii) under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed to pay for coverage of similarly situated non COBRA beneficiaries for the period in question until that later date.

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

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. You should be aware that if you do not pay a premium by the first day of a period of coverage, but pay the premium within the grace period for that period of coverage, the plan has the option to cancel your coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Failure to make payment in full before the end of a grace period could cause you to lose all COBRA rights.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a

conversion health plan if such an option is otherwise generally available to similarly situated non COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

For more information

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

FAMILY AND MEDICAL LEAVE ACT:

Except to the extent otherwise provided in the appropriate insurance policies and/or summaries of coverage, the provisions provided in this document with respect to the Family and Medical Leave Act of 1993 (FMLA) will apply. If you meet certain service requirements, you may be entitled to take a maximum of 12 weeks of unpaid leave each year for certain specified family and medical reasons under the FMLA. Upon your return to work after FMLA leave, you will be entitled to the position that you held when your FMLA leave began or an equivalent position with equivalent pay, benefits and other terms and conditions of employment.

Under certain circumstances, when restoration of employment would cause substantial and grievous economic injury to the Company's operations, certain highly paid "key" employees may not be reinstated after FMLA leave.

You must notify your Plan Administrator at least 30 days before the beginning of your leave if the leave is foreseeable. If the leave is not foreseeable, you must provide such notification as soon as possible. Please contact the Plan Administrator to determine whether you qualify for FMLA leave.

If you take leave under FMLA, you will be entitled during your leave to continue your benefits at the same coverage level in effect at the time of your leave. If you marry or have or adopt a child (or you otherwise acquire a new dependent) during your leave, your new spouse or dependent will also be eligible for coverage during your leave (if you continued your coverage under the Plan and such spouse or dependent meets the plan's eligibility requirements). You will be responsible for paying your portion of these benefits at active employee rates while you are on leave. You will be required to pay your contributions for your benefits on a monthly basis (with after-tax dollars) in the manner required by the Company. Please contact your Plan Administrator for more information.

You will be eligible for new benefits that are offered by the Company during your leave. Your coverage will also be affected by any changes that the Company makes to the benefit plans and programs during your leave. If the costs for providing new or changed benefits increase during your leave, your contributions may increase accordingly.

When you return from your FMLA leave, you will continue your benefits in

accordance with your coverage elections that were in effect immediately before your leave. You will be able to make coverage elections that differ from those that were in effect before your leave only if there is an annual open enrollment period at that time or you have a life change event.

FMLA and leave to care for a service member

If you need to care for a family member who was injured or became ill while on active military duty, you may be entitled to up to 26 weeks of FMLA leave. Additionally, unpaid active duty leave may also be available. Any leave related to military duty or military illness or injury will be administered in accordance with applicable federal requirements.

Caregiver leave

Caregiver leave, which is unpaid, will be granted to you in the event that you are needed to care for a family member who is an Armed Forces service member recovering from a serious illness or injury. If you are the spouse, son, daughter, parent, or nearest blood relative of a service member who is medically unfit to perform the duties of his or her office, grade, rank or rating, and the service member is undergoing medical treatment, recuperation, or therapy, is in an outpatient status, or is on the temporary disability retired list, you may take job-protected leave in order to care for the service member.

Caregiver leave will not be provided in addition to FMLA leave taken for other reasons, and the 26-week caregiver leave may only be taken in a single 12-month period.

Active Duty leave

If you are eligible for FMLA leave, active duty unpaid leave (when required by the government) will be granted if a family member has been called up to or engaged in active military duty. Under the active duty leave provision, the Company will grant up to 12 weeks of FMLA leave. This leave will be granted for events outlined in regulations, and the leave will be available if your spouse, son, daughter, or parent is on or is called into active duty against another military force. If you request this leave you must provide the Company with notice as soon as it is “reasonable and practicable” and you may be required to provide certification supporting the active duty of the affected family member.

If you have any questions regarding whether FMLA leave applies to you, you should contact your human resources office.

CONTINUATION OF COVERAGE UNDER USERRA:

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of health care coverage for employees called for active duty military service.

Except to the extent greater benefits are provided under the terms of the appropriate insurance policies and/or summaries of coverage, the maximum length of extended coverage under USERRA is the lesser of:

1. 24 months beginning on the date that the military leave begins; or

2. A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee.

If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a result of the military service.

COBRA continuation coverage and USERRA continuation coverage are concurrent.

VI. QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order (including approval of a settlement agreement) issued by a state court or through an administrative process under state law that creates or recognizes the right of a child to receive benefits under a group health plan. A QMCSO may apply to coverage under the Plan. Once the Plan Administrator determines that the order meets the requirements for a QMCSO, coverage will be provided in accordance with federal and applicable state law. If the Plan Administrator receives a QMCSO, you and the affected child will be notified by the Plan Administrator before benefits are assigned pursuant to the order.

VII. PPACA COMPLIANCE

Pre-Existing Conditions. Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any limitation or exclusion on coverage of pre-existing conditions for individuals.

Lifetime/Annual Limits. Notwithstanding anything contained in the Plan to the contrary, the Plan does not place any lifetime or annual limits on the dollar value of essential benefits for any individual under the group health plan. “Essential benefits” are those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.

Cost Sharing Requirements for Preventive Care Expenses. With regard to non-grandfathered benefits under the Plan, there will be no participant cost sharing requirements for any in-network preventive care expenses, as set forth in PPACA and the regulations and guidance issued thereunder.

Dependent Definition. The term “Dependent" includes any child of a participant who is covered under an insurance contract, as defined in the contract, as defined in the plan, to the extent allowed by PPACA and the regulations and guidance issued thereunder.

No Rescission of Coverage. The Plan will not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.

Selection of Providers. If a non-grandfathered group health plan or a health insurance issuer offering group or individual health insurance coverage under the Plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. The plan or issuer must also permit the Participant to designate an in-network pediatrician who is available to accept the participant, beneficiary, or enrollee, and the plan may not require referral or authorization for any in-network obstetrician or gynecologist who is available to accept the participant, beneficiary, or enrollee.

Emergency Services. With respect to non-grandfathered benefits under the Plan, a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services.

Cost Sharing Limits. With respect to non-grandfathered benefits under the Plan, this Plan does not impose cost sharing amounts (i.e., copayments, coinsurance, and deductibles, but not premiums) that are more than the maximum allowed for high deductible health plans. In 2018, these limits are 7,350 for an individual and 14,700 for family coverage. After 2018, these amounts will be adjusted for health insurance premium inflation. For these purposes, if the Plan utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums for Essential Health Benefits of a group health plan, the Plan will combine with the annual limitation on out-of-pocket maximums between each provider as

an aggregate benefit limit amount.

Clinical Trials. With respect to non-grandfathered benefits under the Plan, this Plan will not deny any “qualified individual,” as set forth in Public Health Service Act §2709, participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. This Plan also will not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. Finally, this Plan will not discriminate against the individual on the basis of the individual's participation in such trial.

Provider Discrimination. With respect to non-grandfathered benefits under the Plan, this Plan will not discriminate with respect to participation under the Plan against any health care provider that is acting within the scope of that provider's license or certification under applicable state law, as required by Public Health Service Act §2706(a).

Applicability. This section will apply to Welfare Programs under the Plan only if the Welfare Programs are subject to PPACA and if the Welfare Programs do not contain provisions compliant with PPACA.

VIII. ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants 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) if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, 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) if any, and updated plan document and summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if any is required by ERISA to be prepared, in which case, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants 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 plan participants 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 welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a 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 administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees- for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

APPENDIX A

SUMMARY OF BENEFIT OPTIONS AND PROVIDER CONTACTS

Welfare Program	Insurance Company or Third Party Administrator	Policy or Contract Number	PPACA Applicability
Health Plan (Fully-Insured) Blue Cross Blue Shield of SC Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	15-85029-00 Base PPO	Applicable
Group-Term Life for Employees Companion Life Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	385-15-73247-000	Applicable
Accident, Cancer, and Critical Illness Colonial Life Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	E4923157	Applicable
Dental Guardian Life Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	00336041	Applicable
Long-Term Disability (Fully-Insured) Guardian Life Effective Date: 01/01/2018	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	00336041	Applicable
Short-Term Disability (Fully-Insured) Guardian Life Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	00336041	Applicable
Group-Term Life for Employees Guardian Life Effective Date: 07/25/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	00336041	Applicable
Health Plan (Fully-Insured) Blue Cross Blue Shield of SC Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon, SC 29536	15-85029-01	Applicable

Vision Physicians Eyecare Plan Effective Date: 01/01/2019	Dillon Family Medicine, PA 603 N 6th Avenue Dillon , SC 29536	00309	Applicable

Important Notice from Dillon Family Medicine, PA About Your Prescription Drug Coverage and Medicare

Individual creditable coverage disclosure notice

Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with Dillon Family Medicine, PA (the "Company") in the Dillon Family Medicine, PA Wrap Plan (the "Plan") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Company has been informed that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered "Creditable Coverage". Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan coverage may be affected. If you opt to purchase a Medicare drug plan, the coverage under the drug Plan may no longer be available. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Plan coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact your plan administrator if you have further questions.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Plan and don't join a Medicare drug plan within 62 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage Contact the Company Office for further information at:

Rachel Huggins
Dillon Family Medicine, PA
603 N 6th Avenue
Dillon, SC 29536
843-774-7336
Rachel.Huggins@dillonfamilymedicine.com

NOTE: You will receive this notice annually. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender	Dillon Family Medicine, PA
Contact / Attention	Rachel Huggins
Address	603 N 6th Avenue
	Dillon, SC 29536
Phone Number	843-774-7336
Date	January 01, 2018

Employer Requirements for Medicare Modernization Act

1. Must identify who is Medicare Eligible Individual, including their dependents;
    - Active Medicare eligible Employees or their Medicare eligible dependents
    - Medicare eligible Cobra Participant, or their Medicare eligible dependents
    - Medicare eligible Disabled Individual covered under the RX Plan
    - Medicare eligible Retirees or their dependents who are covered under the RX Plan
2. Determine if Group Health Plan or RX benefit is "Creditable"
3. Provide the disclosure notices to Medicare Eligible individuals (as noted above), at minimum
    - prior to individuals initial enrollment period for Medicare RX drug benefit
    - prior to the effective date of enrolling in the sponsors plan & upon any change that affects whether coverage is creditable RX benefit
    - prior to the commencement of annual election period that begins on 10/15 of each year
    - and upon beneficiary request
4. Complete Online Questionnaire (link below) within 60 days of the beginning of the Plan year or within 30 days of a plan termination or change

    https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose

This notice is intended to inform you of the privacy practices followed by the Company's group health Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan sponsor we often need access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information

Healthcare Operations. We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as an merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you $0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within our records is incorrect or missing, you

have a right to request that we correct the incorrect or missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Information

The Company is required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our current notice at any time. For more information about our privacy practices, contact the person listed below:

Dillon Family Medicine, PA
603 N 6th Avenue
Dillon, SC 29536

If you have any questions or complaints, please contact the Plan Administrator listed under the Article titled: "General Information About Our Plan".

Filing a Complaint

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit *www.hhs.gov/ocr* for further information.

Employer Requirements for Distributing ERISA Documents

The Plan Administrator/Employer is responsible for preparing the Summary Plan Description ("SPD") and **AFFIRMATIVELY DELIVERING** it to certain persons:

- Covered Employees
- Terminated Cobra Participants
- Parents or guardians of children covered under a qualified medical support order
- Dependents of a deceased participant
- Guardians of an incapacitated person

An employer should be prepared to prove it furnished the SPD in a way "reasonably calculated to ensure actual receipt" using a method "likely to result in full distribution".

I.E., first class mail, hand-delivery, and electronically, if the employees have access to computers in the workplace and can print a copy easily.

Electronic Distribution of ERISA Documents

Employees with work-related computer access

The employee has the ability to access documents at any location where they perform employment duties. Access to Employer’s electronic information system must be an integral part of their normal duties.

- Electronic materials prepared and furnished in accordance with applicable requirements
- Notice is provided to each recipient when furnished, detailing the document
- Notice advises participant of their rights to access the document and how to request a paper copy
- Employer must take steps to ensure the electronic transmittal will result in actual receipt
- If disclosure includes PHI, steps are taken to safeguard the confidentiality of the information

Requirements for Employees with Non-work related computer access or non-employees

May include COBRA participants, dependents or disabled participants.

- Affirmative consent required; Pre-Consent must be obtained, which include details of types of document to be provided, right to withdraw consent, including procedures and updating of information (new email), right to request a paper version and if any cost, and the hardware and software requirements to access the electronic document.
- Pre-Consent statement can be sent electronically if have a reliable e-mail address
- If system hardware or software requirements change, a revised statement must be provided and consent from each individual must be obtained.
- If documents provided on Internet, Consent must be given in a manner that illustrates the individual’s ability to access the information along with a current email address.
- Employer must keep track of individual email addresses for delivery, the consents and actual receipt of emailed documents by recipients.
- These requirements along with the five steps outlined for Employees with work-related computer access above.

ERISA Required Documents for Participants

- SPD - Summary Plan Description
- Restatement of SPD due to Plan Modifications
- SBC - Summary of Benefits and Coverage
- SAR - Summary Annual Report
- Plan Documents

Document	Distribution Instructions
SPD	To Participants within 90 days of coverage on existing plan; within 120 days for new plan. Every 5 years if plan amended or every 10 years if no changes made.
Restatement of SPD	To Participants no later than 210 days after end of the plan year in which change is adopted.
SBC	To participants with enrollment materials, at renewal or reissue of coverage. Special enrollees no later than 90 days from enrollment. Otherwise, within 7 days of written request.
SAR	To participants within 9 months after plan year end if Employer is required to file Form 5500 for the benefit plan.
PLAN DOCUMENT	Copies must be furnished no later than 30 days after written request.

- Other Group Health Plan Notices

There are notices required under other provisions in ERISA (i.e., the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Newborns' and Mothers' Health Protection Act (Newborns' Act), and the Women's Health and Cancer Rights Act (WHCRA)). Some of these notices may be included in the SPD and others must be provided separately due to the timeframes for when they are required to be provided.

Please be sure to check for current laws and regulations on the reporting and disclosure provisions included in the publication on EBSA's Website at http://dol.gov/ebsa.

Participant Distribution Receipt

The Plan Administrator should provide a copy of the Summary Plan Description to each participant every year.

The Plan Administrator should have each participant sign a copy of this form and should keep the signed copy in the Plan Administrator’s records.

Plan Name	**Dillon Family Medicine, PA Wrap Plan**
Plan Year Start	**January 01**

Participant Signature _____

Participant Name _____

Date _____