PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

SALAD COLLECTIVE, LLC
HEALTH AND WELFARE BENEFITS PLAN

EFFECTIVE: JANUARY 1, 2025

Claims Administrator
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ARTICLE I - INTRODUCTION

This document is a description of Salad Collective Health and Welfare Benefits Plan (the Plan). The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. No oral interpretations can change this Plan. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Expenses Incurred before termination, amendment or elimination.

Where a court order, administrative order, judgement, new or changed law or regulation applies to the provisions of this Plan, the Plan will be deemed to have been automatically amended (without further action on the part of the Plan Administrator), to ensure that the Plan conforms to such change to the extent applicable. For the avoidance of doubt, it is the intent of the Plan Administrator that the Plan conform at all times to the requirements of any and all controlling law, including by way of example and not exclusion, the Employee Retirement Income Security Act ("ERISA") of 1974, as amended. In the event of a conflict between this Plan Document and applicable law, applicable law will prevail but only to the extent to satisfy compliance.

Failure to follow the eligibility or enrollment requirements of this Plan may result in suspension of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, Exclusions, timeliness of COBRA elections, eligibility, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses Incurred while this coverage is in force. No benefits are payable for expenses Incurred before coverage began or after coverage terminated. An expense for a service or supply is Incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the Claims Review Procedures have been exhausted. Specifically, before filing a lawsuit the Covered Person must exhaust all available administrative remedies as described in the Claims Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

This Plan is an employee welfare benefit plan within the meaning of ERISA. This Plan is a self-funded medical plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Code so that the portion of the cost of coverage paid by the Employer, and any benefits received by a Covered Person through this Plan, are not taxable income to the Covered Person. The specific tax treatment of any Covered Person will depend on the individual's personal circumstances; the Plan does not guarantee any particular tax treatment. Covered Persons are solely responsible for any and all federal, state, and local taxes attributable to their participation in this Plan, and the Plan expressly disclaims any liability for such taxes. This Plan is "self-funded," which means benefits are paid from the Employer's general assets and are not guaranteed by an insurance company.

The Plan is administered by the Plan Administrator, within the purview of ERISA and in accordance with these provisions. The Plan Administrator may delegate certain responsibilities for the operation and administration of the Plan. The Plan Administrator shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service Providers, adjust their compensation (if any), and exercise general administrative authority over them. The Plan Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder, unless otherwise delegated herein.

This document serves as both the written Plan Document and the Summary Plan Description ("SPD") required under ERISA.

Certain federal laws apply to most group health programs. The following is an overview of the laws and their impact. Should there be any conflict between the law and Plan provisions, the law will prevail.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Health Insurance Portability and Accountability Act (HIPAA) amended ERISA and was enacted, among other things, to improve portability and continuity of health care coverage. HIPAA also requires that Covered Persons and beneficiaries receive a summary of any change that is a "Material Reduction in Covered Services or benefits under a group health plan" within sixty (60) days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of ninety (90) days or less.

Pregnancy Discrimination Act of 1978 ("PDA"). Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent spouse of an Employee.

Family and Medical Leave Act of 1993 ("FMLA"). So long as the Employer and the applicable Employer division is subject to FMLA, if a covered Employee ceases active employment due to an Employer-approved Family Medical Leave in accordance with the requirements of Public Law 103, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in active employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

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

Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA"). The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans 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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours). All applicable benefit provisions still apply, including Copayments and/or Coinsurance.

The Women's Health and Cancer Rights Act of 1998 ("WHCRA"). The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. For health plans that cover a Mastectomy or Lumpectomy, if an Employee or Dependent receives benefits under the Plan in connection with a Mastectomy or Lumpectomy and they elect breast reconstruction (in a manner determined in consultation with the attending Physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which the Mastectomy or Lumpectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or
- Prostheses and treatment of physical complications at all stages of the Mastectomy and Lumpectomy, including lymphedemas.

Covered Expenses will be subject to the same annual Deductible, Copayment or Coinsurance provisions that currently apply to Mastectomy and Lumpectomy coverage and will be provided in consultation with the attending Physician.

Genetic Information Nondiscrimination Act of 2008 ("GINA"). GINA prohibits the Plan from:

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

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

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

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

Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The Mental Health Parity and Addiction Equity Act requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, benefits for such conditions must be provided in the same manner as benefits for any Illness. Also, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

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

Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"). Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within sixty (60) days from the date of the following loss of coverage or gain in eligibility:

- The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or

- The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Dependent special enrollment period is a period of sixty (60) days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this sixty (60) day period. *The effective date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

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

No Surprises Act ("NSA"). The No Surprises Act, part of Title I of the Consolidated Appropriations Act of 2021, prohibits Physicians, Providers, health care facilities and air ambulance companies from balance billing Covered Persons or otherwise holding Covered Persons liable for any more than the applicable cost sharing amounts they would have owed for network care. Specifically, these balance billing protections apply when a Covered Person receives Emergency Services from a Non-Network Provider or facility, when a Covered Person receives non-Emergency Services from a Non-Network Provider at a Network Facility, and when a Covered Person receives non-network air ambulance services.

However, these protections against balance billing do not apply if the Covered Person consents to treatment by a Non-Network Provider (this consent exception generally does not apply in emergency situations).

In addition, this Plan generally will cover Emergency Services without Pre-certification; cover Emergency Services by Non-Network Providers; base cost sharing amounts on network benefits; and count any cost sharing amounts for Emergency Services or non-network services toward a Covered Person's out-of-pocket limit.

If a Covered Person believes they have received a balance bill that is protected under the No Surprises Act, please contact Personify Health Solutions, LLC for additional information.

Please visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for additional information regarding the No Surprises Act.

In the event of an inconsistency between this Summary Plan Description/Plan Document and the law relative to the No Surprises Act, the law prevails only to the extent required to satisfy compliance.

The Civilian Reservist Emergency Workforce Act of 2021 ("CREW"). Beginning September 29, 2022, the CREW Act provides Eligible Employees, who are called to service by the Federal Emergency Management Agency ("FEMA") to respond to and perform services responding to natural disasters and emergencies, rights under the Uniformed Employment and Reemployment Rights Act ("USERRA"). *See USERRA section for additional information regarding benefits and coverage during such leave.*

ARTICLE II -
DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accident means a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury means an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

Active Employee means an Employee who on any day performs in the customary manner all of the regular duties of employment. An Employee will be deemed active on each day of a regular paid vacation or on a regular non-working day on which the covered Employee is not Totally Disabled, provided the covered Employee was working on the last preceding regular workday. An Employee shall be deemed active if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan's leave of absence provisions. An Employee will not be considered under any circumstances active if they have effectively terminated employment.

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a claim that is based on any: (a) determination of an individual's eligibility to participate in a Plan or health insurance coverage; (b) determination that a claimed benefit is not a Covered Service; (c) imposition of a source-of-injury Exclusion, or other limitation on otherwise Covered Services; (d) determination that a claimed benefit is Experimental and/or Investigational, or not Medically Necessary or appropriate; (e) invalid charges; or (f) improper balance, of (g) as otherwise defined in the Plan.

Affordable Care Act (ACA) means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

Allowable Expense(s) means any Medically Necessary item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Coordination of Benefits, this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore, whether or not it is actually made.

Alternate Recipient means any Child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Covered Person.

Ambulatory Surgical Center means any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Physician services and registered professional nursing service whenever a Covered Person is in the facility, and which does not provide service or other accommodations for Covered Persons to stay overnight.

Approved Clinical Trial means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an

investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an Approved Clinical Trial, the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an Approved Clinical Trial and either the individual's Physician has concluded that participation is appropriate, or the Covered Person provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include: (a) the investigational item, device or service itself; (b) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Covered Person; (c) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis; (d) and/or items and/or services to be paid for and or provided at no cost from a third party (including but not limited to a manufacturer.)

Authorized Representative means a person designated by the Covered Person to act on their behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be made in writing, signed and dated by the Covered Person, and include all information required in the Authorized Representative form.

Calendar Year means the twelve (12) month period beginning on January 1st and ending the following December 31st.

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Child and/or Children means the Employee's natural child, any stepchild, legally adopted child, or any other Child for whom the Employee has been named Legal Guardian, or an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. For purposes of this definition, a legally adopted child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

Claimant means a Covered Person or an Authorized Representative of a Covered Person making a claim or for whom a claim is made.

Claims Administrator is Personify Health Solutions, LLC.

Clean Claim means one that can be processed in accordance with the terms of this Plan without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this Plan, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this Plan, and only as permitted by this Plan, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity, or fees under review for Maximum Allowable Charge or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this Plan.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other

information in addition to these standard forms (as noted elsewhere in this Plan and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this Plan. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

CMS means Centers for Medicare and Medicaid Services.

Coinsurance means a cost sharing feature of many plans. It requires a Covered Person to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Covered Person must pay out-of-pocket is based upon their health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for Covered Services.

Copayment or Copay means the specified dollar amount that a Covered Person must pay each time certain medical care is provided, as specified in the Medical Benefits Schedule.

Covered Expense(s)/Covered Service(s) are Provider charges for Covered Services. Covered Expenses are billed charges minus non-Covered Expenses and invalid charges. Covered Expenses also means a reasonable fee for an appropriate, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is specified in this Plan as a Covered Expense. Covered Expenses will be determined based upon all other Plan provisions.

All treatment is subject to benefit payment maximums shown in the Medical Benefits Schedule and as determined elsewhere in this Plan.

Covered Person means an Employee, a Dependent, a COBRA Qualified Beneficiary, a COBRA Qualified Beneficiary's Dependent or other person meeting the eligibility requirements for coverage as specified in the Plan, and who is properly enrolled in the Plan.

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

Deductible means an amount of money that is paid once a Calendar Year per Covered Person and Family Unit. Typically, there is one Deductible amount per Plan, and it must be paid before any money is paid by the Plan for any medical care.

Dentist means a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

Dependent(s) means the covered Employee's eligible family members as outlined in this Plan.

Diagnosis means the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of Covered Person history, examination, and review of laboratory data.

Diagnostic Service means an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a Disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

Disease means any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any worker's compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime

doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness or Disease.

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

Emergency Services means a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the Diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

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

Employer is Salad Collective, LLC and any entity under common control as elected by the Plan Administrator to participate in the Plan.

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

Errors mean any billing mistakes or improprieties including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or medical care not actually rendered or performed, or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard.

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

Exclusion means conditions or services that this Plan does not cover.

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

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

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

b. If the drug, device, medical treatment or procedure, or the Covered Person informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's

Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval; or

c. *Except as provided under the Approved Clinical Trial benefit in the Medical Benefits within the Covered Expenses section*, if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or Diagnosis; or

d. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or Approved Clinical Trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or Diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

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

FDA means the Food and Drug Administration.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

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

Hospital means an Institution that meets all of the following requirements:

a. It provides medical and surgical facilities for the treatment and care of injured or sick persons on an Inpatient basis;
b. It is under the supervision of a staff of Physicians;
c. It provides twenty-four (24) hours a day nursing service by registered nurses (R.N.);
d. It is duly licensed as a Hospital, except that this requirement will not apply in the case of a state tax supported Institution;
e. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training type Institution, or an Institution which is supported in whole or in part by a federal government fund;
f. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA;
g. The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA; and
h. In addition to those facilities that meet all of the requirements above, the definition of "Hospital" for purposes of this document, unless otherwise specifically stated, shall also include any facility that solely

provides medical care on an Outpatient basis whether affiliated with a Hospital as defined above or not ("independent facilities"), including but not limited to an Ambulatory Surgical Center.

Illness means a bodily disorder, Disease, physical Illness or Mental or Nervous Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Incurred means that a Covered Expense is Incurred on the date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Freestanding Emergency Department means a health care Facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include urgent care centers or clinics.

Injury means an Accidental Injury to the body caused by unexpected external means.

Inpatient means a Covered Person who receives medical care at a Hospital and is admitted as a registered overnight bed patient.

Institution means a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Use Disorder treatment center, alternative birthing center, or any other such facility that the Plan approves.

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

Lumpectomy means the surgical removal of a small tumor, which may be benign or cancerous.

Mastectomy means the surgical removal of all or part of a breast.

Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan and has the ultimate discretionary authority to determine the Maximum Allowable Charge. The Maximum Allowable Charge may be any one of the following, as determined by the Plan Administrator:

1. The charge made by the Provider that furnished the care, service, or supply;
2. The negotiated rate established by a negotiated arrangement; or
3. An amount determined by the Plan Administrator, using normative data and submitted information such as, but not limited to, any one or more of the following, in the Plan Administrator's discretion:
    a. Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services (CMS);
    b. Prices established by CMS utilizing standard Medicare payment methods and/or based upon supplemental Medicare pricing data for items Medicare doesn't cover based on data from CMS;
    c. Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care;
    d. Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings;
    e. Medicare cost data as reflected in the applicable individual provider's cost report(s);

f. The fee(s) which the Provider most frequently charges the majority of patients for the service or supply;
g. Amounts the Provider specifically agrees to accept as payment in full either through direct negotiation or through a preferred provider organization (PPO) network;
h. Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP);
i. Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply;
j. The allowable charge otherwise specified within the terms of this Plan;
k. The prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by Providers of similar training and experience for the service or supply;
l. With respect to non-network Emergency Services, the Plan allowance is the greater of:
    - The negotiated amount for Network Providers (the median amount if more than one amount to Network Providers).
    - One hundred percent (100%) of the Plan's Maximum Allowable Charge payment formula (reduced for cost-sharing).
    - The amount that Medicare Parts A or B would pay (reduced for cost-sharing); or
m. For claims subject to the No Surprises Act, if an initial payment under the Plan is challenged and no negotiation and/or settlement occurs resulting in a negotiated rate, the Maximum Allowable Charge will be the amount deemed payable by a certified independent dispute resolution entity as outlined in applicable law.

The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The national medical associations, societies, and organizations; and (b) The Food and Drug Administration (FDA). To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan and has the ultimate discretionary authority to determine the Maximum Allowable Charge. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Child Support Order means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that meets one of the following requirements:

a. Provides for child support with respect to a Covered Person's Child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
b. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Medically Necessary or Medical Necessity refers to medical care ordered by a Physician exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, Diagnosis or treatment of that Covered Person's Illness or Injury. For such medical care to be considered Medically Necessary, it must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Covered Person's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Person's medical symptoms and conditions, cannot be provided in a less intensive medical setting. For such medical care to be considered Medically Necessary it must be no more costly than alternative interventions and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Covered Person's Illness or Injury without adversely affecting the Covered Person's medical condition. In order for a service to be considered Medically Necessary: (a) it must not be maintenance therapy or maintenance treatment; (b) its purpose must be to restore health; (c) it must not be primarily custodial in nature.

For Hospital stays, Medically Necessary means that acute care as an Inpatient is necessary due to the kind of medical care the Covered Person is receiving, or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that medical care is recommended, ordered, prescribed, approved or furnished by a Physician or Dentist does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. The determination of whether medical care, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors or medical advisors to the Claims Administrator. The Plan Administrator has the ultimate discretionary authority to determine whether care or treatment is or was Medically Necessary.

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

a. The drug is approved by the Food and Drug Administration (FDA).
b. The prescribed drug use is supported by one of the following standard reference sources:
    i. Micromedex® DRUGDEX®.
    ii. The American Hospital Formulary Service Drug Information.
    iii. Medicare approved compendia.
    iv. Scientific evidence is supported in well-designed Approved Clinical Trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.
c. The drug is otherwise Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

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

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

National Medical Support Notice (NMSN) means a notice that contains all of the following information:

a. The name of an issuing State child support enforcement agency.
b. The name and mailing address (if any) of the Employee who is a Covered Person under the Plan or eligible for enrollment.

c. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Covered Person) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
d. Identity of an underlying child support order.

Network Provider or Network Facility means a healthcare institution or healthcare provider who has by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a health care Facility and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Non-Network Provider or Non-Network Facility means a healthcare institution or healthcare provider who does not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

Outpatient means a Covered Person who receives medical care at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than twenty-four (24) hours.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician means a person permitted to perform services provided by this Plan who is legally entitled to perform certain medical services according to applicable and current licensure, certification or registration ("License" or "Licensed" or "Licensure") in the state or jurisdiction where the services are rendered. The person must be acting within the scope of their Licensure and must hold one of the following Licenses, degrees and/or titles: Medical Doctor or Surgeon (M.D.); Doctor of Osteopathy (D.O.); Doctor of Optometry (O.D.); Doctor of Podiatric Medicine (D.P.M.); Doctor of Dental Surgery (D.D.S.); Doctor of Dental Medicine (D.M.D.); or Doctor of Chiropractic (D.C.).

Plan means Salad Collective Health and Welfare Benefits Plan which is a benefits plan for covered Employees, and Dependents of Salad Collective, LLC.

Plan Administrator or Plan Sponsor means Salad Collective, LLC.

Pre-certification means a decision by the Plan that a health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary. Sometimes called prior authorization, prior approval or preauthorization. The Plan may require Pre-certification for certain services before the Covered Person receive them, except in an emergency.

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

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

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

Residential Treatment Center and Wilderness Camps Programs means a facility and/or program that provides treatment twenty-four (24) hours a day and can usually serve more than twelve (12) people at a time. Treatment may include individual, group and family therapy, behavior therapy, special education, recreation therapy, or medical services. Residential treatment is usually more long-term than Inpatient Hospitalization. Residential treatment is for (1) severe and persistent Mental or Nervous Disorder that results in the person being unable to maintain independent

functioning without support and continued treatment for an indefinite period of time; or (2) Substance Use Disorder in which the patient is at a high risk for relapse.

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

a. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore Covered Persons to self-care in essential daily living activities must be provided.
b. Its services are provided for compensation and under the full-time supervision of a Physician.
c. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
d. It maintains a complete medical record on each Covered Person.
e. It has an effective Utilization Review plan.
f. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, custodial or educational care or care of Mental or Nervous Disorders.
g. It is approved and licensed by Medicare.

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

Substance Use Disorder means any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-V definition is applied as follows:

a. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:
    i. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
    ii. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    iii. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
    iv. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).
b. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Total Disability (Totally Disabled) means, in the case of a Dependent, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. To prove Total Disability, the covered Employee must prove that they have claimed the Dependent on their tax returns.

Waiting Period means the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE III -
OVERVIEW OF BENEFITS

MEDICAL BENEFITS

All benefits described in the Medical Benefits Schedule are subject to the Exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are limited to the Maximum Allowable Charge as defined; and services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are outlined under Defined Terms of this Plan.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all Covered Expenses and/or exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments, or procedures.

This Plan pays Covered Expenses pursuant to the Maximum Allowable Charge, which is defined in this Plan. **Covered Persons are responsible for any amounts determined to be in excess of the Maximum Allowable Charge.**

It is highly recommended that prior to seeking health care treatment and/or services, Covered Persons contact Personify Health Solutions, LLC. They can help Covered Persons determine which Providers and/or facilities have appropriate billing practices.

Pre-certification of certain services is required by the Plan. Pre-certification provides information regarding Medical Necessity and medical appropriateness *before* the Covered Person receives treatment, services or supplies. *A Pre-certification of services is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations and Exclusions of the Plan at the time services are provided.*

If Pre-certification is not obtained and the services are determined medically necessary via retro-certification, services are paid in full and no penalty applies. If Pre-certification is not obtained and the services are determined NOT medically necessary via retro-certification, no benefits paid under plan – member is 100% responsible for charges.

Pre-certification. The following services require Pre-certification:

- All Inpatient services;
- Advanced imaging (MRI, MRA, PET CT and nuclear medicine);
- Home health care;
- Renal dialysis;
- Skilled Nursing Facility stays;
- Sleep studies provided overnight in-lab; and
- Transplant services.

All services requiring Pre-certification are to be authorized in advance, except for emergencies, by contacting Aetna at the number on the Plan ID card. The Covered Person or their Authorized Representative is required to call for Pre-certification for the services specified above prior to the services being rendered. The Covered Person or their Authorized Representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Pre-certification determinations and service prepricing.

PROVIDER INFORMATION

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Covered

Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which provider to use.

To access a list of Network Providers, please refer to the preferred provider organization (PPO) website and/or toll-free number listed on the **Salad Collective Health and Welfare Benefits Plan** identification card. Prior to receiving medical care services, the Covered Person should confirm with the provider and the PPO that the provider is a participant in this organization.

Covered Services will be reimbursed at the Network Provider benefit level based on the Maximum Allowable Charge. The Covered Person may be balanced billed by the Non-Network Provider for any amount over the Maximum Allowable Charge.

CHOICE OF PROVIDERS

The Plan is not intended to disturb the Physician-patient relationship. Each Covered Person has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Plan Administrator, Employer or Claims Administrator. The delivery of medical and other health care services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Covered Person, together with their Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

ARTICLE IV -
MEDICAL BENEFITS SCHEDULES

PPO PREFERRED PLAN

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Claims must be received by the Claims Administrator within ***365 days*** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.		
LIFETIME MAXIMUM BENEFIT	**UNLIMITED**	
CALENDAR YEAR BENEFIT AMOUNT	**UNLIMITED**	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$4,500	$15,000
Per Family Unit	$9,000	$30,000
The family Deductible maximum includes Covered Expenses which are used to satisfy the Deductible for all family members combined. No one person must satisfy more than the individual Deductible amount. The network and non-network Deductible amounts are separate.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$9,000	$30,000
Per Family Unit	$18,000	$60,000
The family maximum out-of-pocket amount includes Covered Expenses which are used to satisfy the maximum out-of-pocket amount for all family members combined. No one person must satisfy more than the individual maximum out-of-pocket amount. The network and non-network maximum out-of-pocket amounts are separate. The maximum out-of-pocket amount includes Deductible, Coinsurance and Copayments applied toward covered medical and prescription benefits as shown above. The following expenses may not count toward the maximum out-of-pocket amount and will not be paid at 100%, even when the maximum out-of-pocket amount has been met: • Charges in excess of benefit maximums; • Charges in excess of the Maximum Allowable Charge; • Utilization review penalties; and • Charges for non-covered services. **Amounts outlined in this schedule are the Covered Person's responsibility amounts.**		
Covered Expenses are limited to the Maximum Allowable Charge as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.		
DESCRIPTION	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
Acupuncture Services Limited to 20 visits per Calendar Year. The visit limit only applies to acupuncture services, not to the office visits or other related services. Provider must submit a letter of Medical Necessity and all applicable notes.		
Office	$25 Copay/visit, Deductible waived	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Ambulance (Air* and Ground)	30% Coinsurance after Deductible is met.	
*Non-emergent Air Ambulance services are excluded.		
Ambulatory Surgical or Outpatient Surgical Facility	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Applied Behavior Analysis (ABA) Therapy	Pays as any other Illness.	Pays as any other Illness.
Cardiac Rehabilitation – Phase I & II Only Limited to 40 visits per Calendar Year combined with speech and occupational therapy.		
Office	$50 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Chemotherapy and Radiation Therapy	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Chiropractic Care Limited to 20 visits per Calendar Year. Provider must submit a letter of Medical Necessity and all applicable notes.		
Office	$25 Copay/visit, Deductible waived	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Diabetic Self-Management Training	No cost to Covered Person, Deductible waived.	Not covered.
Diagnostic Testing		
Advanced Imaging – Any Location	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Lab & Radiology – Inpatient, Outpatient or Stand Alone Facility	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Lab & Radiology – Office Based Services *Services are covered under office visit Copay.*	No cost to Covered Person, Deductible waived.	50% Coinsurance after Deductible is met.
Durable Medical Equipment (DME) Replacement only allowed after 5 years. Prosthetics & orthotics will only be covered under this benefit. Foot orthotics are covered.	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
C-PAP Machine (Rental or Purchase) Rental is only available up to purchase price.	$150 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Emergency Room Services Copay is waived if admitted to the Hospital.	$1000 Copay/visit Deductible waived.	
Hearing Exam	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Home Health Care Limited to 60 visits per Calendar Year. Visit limits do not apply to dialysis in the home or services to treat mental health conditions.	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Hospice Care Subject to home health care maximum only if rendered Outpatient.	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Hospital Services		
Inpatient Services	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Outpatient Services	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Maternity Care		
Office Visits	Pays as any other Illness.	Pays as any other Illness.
Newborn Care – Routine Inpatient	No cost to Covered Person, Deductible waived.	50% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Mental or Nervous Disorders and Substance Use Disorder Treatment		
Inpatient Services	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Outpatient Services	Pays as any other Illness.	Pays as any other Illness.
Occupational Therapy Limited to 40 visits per Calendar Year combined with speech & cardiac rehab therapy. Provider must submit a letter of Medical Necessity and all applicable notes.		
Office	$50 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Physical Therapy Limited to 20 visits per Calendar Year. Provider must submit a letter of Medical Necessity and all applicable notes.		
Office	$50 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Physician Services		
Primary Care Office Visits – Includes In-Person & Virtual	$35 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Specialist Office Visit – Includes In-Person & Virtual	$70 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Lab & Radiology *Services are covered under office visit Copay.*	No cost to Covered Person, Deductible waived.	50% Coinsurance after Deductible is met.
All Other Physician Services	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Telemedicine (Teladoc) *Covered for medical and mental health visits.*	No cost to Covered Person, Deductible waived.	N/A
Preventive Care	No cost to Covered Person, Deductible waived.	Not covered.
Routine Well Care services will be subject to age, and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) or as otherwise required by law, *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website: www.HealthCare.gov/center/regulations/prevention.html **Routine Well Care services will include, but will not be limited to, the following routine services:** Office visits, routine physical exams, prostate screening (including a prostate-specific antigen (PSA) test), patient education and counseling for men, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well childcare examinations. **Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune- deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. Additional information can be located using the following website: https://www.healthcare.gov/preventive-care-women		
Private Duty Nursing Limited to 60 visits per Calendar Year only in conjunction with home health care. Inpatient services are not covered.	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Skilled Nursing Facility and Extended Care Limited to 60 days per Calendar Year.	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Sleep Studies		
In-Home	No cost to Covered Person, Deductible waived.	50% Coinsurance after Deductible is met.
In-Lab	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Speech Therapy Limited to 40 visits per Calendar Year combined with occupational & cardiac rehab therapy. Provider must submit a letter of Medical Necessity and all applicable notes.		
Office	$50 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Sterilization Services		
For Male Covered Persons	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
For Female Covered Persons	No cost to Covered Person, Deductible waived.	Not covered.
Transplant Services		
Recipient Services – Facility & Professional	Refer to applicable service for benefit	Refer to applicable service for benefit.
Donor Services – Facility & Professional *Covered Expenses include evaluation of the organ, removing the organ from the donor & transportation of the organ to where the transplant is performed.*	Refer to applicable service for benefit.	Refer to applicable service for benefit
Travel and Accommodations *Limited to $10,000 total per transplant.*	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Urgent Care Copay applies to all services provided in an urgent care.	$100 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Wigs After Chemotherapy Limited to $800 every 2 Calendar Years.	30% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
All services requiring Pre-certification are to be authorized in advance, except for emergencies, by contacting Aetna at the number on the Plan ID card. The Covered Person or their Authorized Representative is required to call for Pre-certification for the services specified prior to the services being rendered. The Covered Person or their Authorized Representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Pre-certification determinations and service prepricing. Additional information is available in the Medical Management Services section of this Plan.		

PPO PREMIER PLAN

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Claims must be received by the Claims Administrator within ***365 days*** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.		
LIFETIME MAXIMUM BENEFIT	**UNLIMITED**	
CALENDAR YEAR BENEFIT AMOUNT	**UNLIMITED**	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$1,000	$3,000
Per Family Unit	$2,000	$6,000
The family Deductible maximum includes Covered Expenses which are used to satisfy the Deductible for all family members combined. No one person must satisfy more than the individual Deductible amount. The network and non-network Deductible amounts are separate.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$4,000	$12,000
Per Family Unit	$8,000	$24,000
The family maximum out-of-pocket amount includes Covered Expenses which are used to satisfy the maximum out-of-pocket amount for all family members combined. No one person must satisfy more than the individual maximum out-of-pocket amount. The network and non-network maximum out-of-pocket amounts are separate. The maximum out-of-pocket amount includes Deductible, Coinsurance and Copayments applied toward covered medical and prescription benefits as shown above. The following expenses may not count toward the maximum out-of-pocket amount and will not be paid at 100%, even when the maximum out-of-pocket amount has been met: • Charges in excess of benefit maximums; • Charges in excess of the Maximum Allowable Charge; • Utilization review penalties; and • Charges for non-covered services. **Amounts outlined in this schedule are the Covered Person's responsibility amounts.**		
Covered Expenses are limited to the Maximum Allowable Charge as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.		
DESCRIPTION	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
Acupuncture Services Limited to 20 visits per Calendar Year. The visit limit only applies to acupuncture services, not to the office visits or other related services. Provider must submit a letter of Medical Necessity and all applicable notes.		
Office	$25 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met
Inpatient & All Other Outpatient Settings	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met
Ambulance (Air* and Ground)	20% Coinsurance after Deductible is met.	
*Non-emergent Air Ambulance services are excluded.		
Ambulatory Surgical or Outpatient Surgical Facility	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Applied Behavior Analysis (ABA) Therapy	Pays as any other Illness.	Pays as any other Illness.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Cardiac Rehabilitation – Phase I & II Only Limited to 40 visits per Calendar Year combined with speech and occupational therapy.		
Office	$50 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Chemotherapy and Radiation Therapy	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Chiropractic Care Limited to 20 visits per Calendar Year. Provider must submit a letter of Medical Necessity and all applicable notes.		
Office	$25 Copay/visit, Deductible waived	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Diabetic Self-Management Training	No cost to Covered Person, Deductible waived.	Not covered.
Diagnostic Testing		
Advanced Imaging – Any Location	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Lab & Radiology – Inpatient, Outpatient or Stand Alone Facility	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Lab & Radiology – Office Based Services *Services are covered under office visit Copay.*	No cost to Covered Person, Deductible waived.	50% Coinsurance after Deductible is met.
Durable Medical Equipment (DME) Replacement only allowed after 5 years. Prosthetics & orthotics will only be covered under this benefit. Foot orthotics are covered.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
C-PAP Machine (Rental or Purchase) Rental is only available up to purchase price.	$150 Copay/visit, Deductible waived	50% Coinsurance after Deductible is met.
Emergency Room Services Copay is waived if admitted to the Hospital.	$500 Copay/visit Deductible waived.	
Hearing Exam	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Home Health Care Limited to 60 visits per Calendar Year. Visit limits do not apply to dialysis in the home or services to treat mental health conditions.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Hospice Care Subject to home health care maximum only if rendered Outpatient.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Hospital Services		
Inpatient Services	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Outpatient Services	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Maternity Care		
Office Visits	Pays as any other Illness.	Pays as any other Illness.
Newborn Care – Routine Inpatient	No cost to Covered Person, Deductible waived.	50% Coinsurance after Deductible is met.
Mental or Nervous Disorders and Substance Use Disorder Treatment		
Inpatient Services	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Outpatient Services	Pays as any other Illness.	Pays as any other Illness.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Occupational Therapy Limited to 40 visits per Calendar Year combined with speech & cardiac rehab therapy. Provider must submit a letter of Medical Necessity and all applicable notes.		
Office	$50 Copay/visit, Deductible waived	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Physical Therapy Limited to 20 visits per Calendar Year. Provider must submit a letter of Medical Necessity and all applicable notes.		
Office	$50 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Physician Services		
Primary Care Office Visits – Includes In-Person & Virtual	$35 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Specialist Office Visit – Includes In-Person & Virtual	$70 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Lab & Radiology – Office Based Services *Services are covered under office visit Copay.*	No cost to Covered Person, Deductible waived.	50% Coinsurance after Deductible is met.
All Other Physician Services	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Telemedicine (Teladoc)	No cost to Covered Person, Deductible waived.	N/A
Preventive Care	No cost to Covered Person, Deductible waived.	Not covered.
Routine Well Care services will be subject to age, and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) or as otherwise required by law, *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website: www.HealthCare.gov/center/regulations/prevention.html **Routine Well Care services will include, but will not be limited to, the following routine services:** Office visits, routine physical exams, prostate screening (including a prostate-specific antigen (PSA) test), patient education and counseling for men, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well childcare examinations. **Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune- deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. Additional information can be located using the following website: https://www.healthcare.gov/preventive-care-women		
Private Duty Nursing Limited to 60 visits per Calendar Year only in conjunction with home health care. Inpatient services are not covered.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Skilled Nursing Facility and Extended Care Limited to 60 days per Calendar Year.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Sleep Studies		
In-Home	No cost to Covered Person, Deductible waived	50% Coinsurance after Deductible is met.
In-Lab	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Speech Therapy Limited to 40 visits per Calendar Year combined with occupational & cardiac rehab therapy. Provider must submit a letter of Medical Necessity and all applicable notes.		
Office	$50 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Inpatient & All Other Outpatient Settings	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Sterilization Services		
For Male Covered Persons	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
For Female Covered Persons	No cost to Covered Person, Deductible waived.	Not covered.
Transplant Services		
Recipient Services – Facility & Professional	Refer to applicable service for benefit	Refer to applicable service for benefit
Donor Services – Facility & Professional *Covered Expenses include evaluation of the organ, removing the organ from the donor & transportation of the organ to where the transplant is performed.*	Refer to applicable service for benefit	Refer to applicable service for benefit.
Travel and Accommodations *Limited to $10,000 total per transplant.*	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Urgent Care Copay applies to all services provide in an urgent care.	$75 Copay/visit, Deductible waived.	50% Coinsurance after Deductible is met.
Wigs After Chemotherapy Limited to $800 every 2 Calendar Years.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.

All services requiring Pre-certification are to be authorized in advance, except for emergencies, by contacting Aetna at the number on the Plan ID card. The Covered Person or their Authorized Representative is required to call for Pre-certification for the services specified prior to the services being rendered. The Covered Person or their Authorized Representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Pre-certification determinations and service prepricing. Additional information is available in the Medical Management Services section of this Plan.

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	NETWORK PROVIDER	NON-NETWORK PROVIDER
Claims must be received by the Claims Administrator within ***365 days*** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.		
LIFETIME MAXIMUM BENEFIT	**UNLIMITED**	
CALENDAR YEAR BENEFIT AMOUNT	**UNLIMITED**	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$3,500	$10,500
Per Family Unit	$7,000	$21,000
The family Deductible maximum includes Covered Expenses which are used to satisfy the Deductible for all family members combined. No one person must satisfy more than the individual Deductible amount. The network and non-network Deductible amounts are separate.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$6,000	$18,000
Per Family Unit	$12,000	$36,000
The family maximum out-of-pocket amount includes Covered Expenses which are used to satisfy the maximum out-of-pocket amount for all family members combined. No one person must satisfy more than the individual maximum out-of-pocket amount. The network and non-network maximum out-of-pocket amounts are separate. The maximum out-of-pocket amount includes Deductible, Coinsurance and Copayments applied toward covered medical and prescription benefits as shown above. The following expenses may not count toward the maximum out-of-pocket amount and will not be paid at 100%, even when the maximum out-of-pocket amount has been met: • Charges in excess of benefit maximums; • Charges in excess of the Maximum Allowable Charge; • Utilization review penalties; and • Charges for non-covered services. **Amounts outlined in this schedule are the Covered Person's responsibility amounts.**		
Covered Expenses are limited to the Maximum Allowable Charge as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.		
DESCRIPTION	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
Acupuncture Services Limited to 20 visits per Calendar Year. The visit limit only applies to acupuncture services, not to the office visits or other related services. Provider must submit a letter of Medical Necessity and all applicable notes.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Ambulance (Air* and Ground)	20% Coinsurance after Deductible is met.	
*Non-emergent Air Ambulance services are excluded.		
Ambulatory Surgical or Outpatient Surgical Facility	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Applied Behavior Analysis (ABA) Therapy	Pays as any other Illness.	Pays as any other Illness.
Cardiac Rehabilitation – Phase I & II Only Limited to 40 visits per Calendar Year combined with speech and occupational therapy.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Chemotherapy and Radiation Therapy	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Chiropractic Care Limited to 20 visits per Calendar Year. Provider must submit a letter of Medical Necessity and all applicable notes.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Diabetic Self-Management Training	No cost to Covered Person, after Deductible is met.	Not covered.
Diagnostic Testing		
Advanced Imaging – Any Location	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Lab & Radiology – Any Location	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Durable Medical Equipment (DME) Replacement only allowed after 5 years. Prosthetics & orthotics will only be covered under this benefit. Foot orthotics are covered.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Emergency Room Services	20% Coinsurance after Deductible is met.	
Hearing Exam	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Home Health Care Limited to 60 visits per Calendar Year. Visit limits do not apply to dialysis in the home or services to treat mental health conditions.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Hospice Care Subject to home health care maximum only if rendered Outpatient.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Hospital Services		
Inpatient Services	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Outpatient Services	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Maternity Care		
Office Visits	Pays as any other Illness.	Pays as any other Illness.
Newborn Care – Routine Inpatient	No cost to Covered Person, after Deductible is met.	50% Coinsurance after Deductible is met.
Mental or Nervous Disorders and Substance Use Disorder Treatment		
Inpatient Services	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Outpatient Services	Pays as any other Illness.	Pays as any other Illness.
Occupational Therapy Limited to 40 visits per Calendar Year combined with speech & cardiac rehab therapy. Provider must submit a letter of Medical Necessity and all applicable notes.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Physical Therapy Limited to 20 visits per Calendar Year. Provider must submit a letter of Medical Necessity and all applicable notes.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Physician Services		
Primary Care Office Visits – Includes In-Person & Virtual	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Specialist Office Visit – Includes In-Person & Virtual	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
All Other Physician Services	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Telemedicine (Teladoc)	No cost to Covered Person, after Deductible is met.	N/A
Preventive Care	No cost to Covered Person, Deductible waived.	Not covered.
Routine Well Care services will be subject to age, and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) or as otherwise required by law, *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website: www.HealthCare.gov/center/regulations/prevention.html **Routine Well Care services will include, but will not be limited to, the following routine services:** Office visits, routine physical exams, prostate screening (including a prostate-specific antigen (PSA) test), patient education and counseling for men, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well childcare examinations. **Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune- deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. Additional information can be located using the following website: https://www.healthcare.gov/preventive-care-women		
Private Duty Nursing Limited to 60 visits per Calendar Year only in conjunction with home health care. Inpatient services are not covered.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Skilled Nursing Facility and Extended Care Limited to 60 days per Calendar Year.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Sleep Studies.		
In-Home	No cost to Covered Person, after Deductible is met.	50% Coinsurance after Deductible is met.
In-Lab	20% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met.
Speech Therapy Limited to 40 visits per Calendar Year combined with occupational & cardiac rehab therapy. Provider must submit a letter of Medical Necessity and all applicable notes.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Sterilization Services		
For Male Covered Persons	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
For Female Covered Persons	No cost to Covered Person, Deductible waived.	Not covered.
Transplant Services		
Recipient Services – Facility & Professional	Refer to applicable service for benefit.	Refer to applicable service for benefit.
Donor Services – Facility & Professional *Covered Expenses include evaluation of the organ, removing the organ from the donor & transportation of the organ to where the transplant is performed.*	Refer to applicable service for benefit	Refer to applicable service for benefit.
Travel and Accommodations *Limited to $10,000 total per transplant.*	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Urgent Care	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
Wigs After Chemotherapy Limited to $800 every 2 Calendar Years.	20% Coinsurance after Deductible is met.	50% Coinsurance after Deductible is met.
All services requiring Pre-certification are to be authorized in advance, except for emergencies, by contacting Aetna at the number on the Plan ID card. The Covered Person or their Authorized Representative is required to call for Pre-certification for the services specified prior to the services being rendered. The Covered Person or their Authorized Representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Pre-certification determinations and service prepricing. Additional information is available in the Medical Management Services section of this Plan.		

ARTICLE V -
PRESCRIPTION DRUG BENEFITS SCHEDULES

PPO PREFERRED & PPO PREMIER PLANS

Not all Prescription Drugs are covered.

PRESCRIPTION DRUG BENEFIT	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
Pharmacy Option - 30 Day Supply		
Prescribed Preventive Medications & Contraceptives	No cost to Covered Person, Deductible waived.	Not covered.
Generic Drugs	$5 Copay/drug, Deductible waived.	Not covered.
Preferred Brand Name Drugs	$35 Copay/drug, Deductible waived.	Not covered.
Non-Preferred Brand Name Drugs	$70 Copay/drug, Deductible waived.	Not covered.
Specialty Drugs*	Not covered	Not covered.
Pharmacy & Mail Order Option - 90 Day Supply		
Prescribed Preventive Medications & Contraceptives	No cost to Covered Person, Deductible waived.	Not covered.
Generic Drugs	$15 Copay/drug, Deductible waived.	Not covered.
Preferred Brand Name Drugs	$105 Copay/drug, Deductible waived.	Not covered.
Non-Preferred Brand Name Drugs	$210 Copay/drug, Deductible waived.	Not covered.
Specialty Drugs*	Not covered.	Not covered.
***Veracity has full authority to work with members to obtain patient assistance/manufacturer programs for specialty drugs since they are not covered under the plan. Members who call in for specialty drug coverage should be directed to (888) 388-8228 or help@veracity-rx.com for assistance with specialty drugs.**		
In addition to other coverages provided under the Plan, the Plan provides coverage for certain prescription drugs facilitated by the Plan's International Vendors. Additional mail-order options are available through VeracityRx via the voluntary International Mail Order program. This program provides up to a 90-day supply of brand name medications via pharmacies in Tier 1 countries (Canada, UK, Australia). The copay is $0 for covered members. The program does not include any experimental or investigational medications and does not replace the current PBM option for eligible members.		
Refer to the Prescription Drug Benefits for details on the Prescription Drug Program.		
For additional information regarding the Prescription Drug program contact ProCare RX at (855) 828-1484 or visit www.procarerx.com.		

HSA SAVER PLAN

Not all Prescription Drugs are covered.

PRESCRIPTION DRUG BENEFIT	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
Pharmacy Option - 30 Day Supply		
Prescribed Preventive Medications & Contraceptives	No cost to Covered Person, Deductible waived.	Not covered.
Generic Drugs	$5 Copay/drug, after Deductible is met.	Not covered.
Preferred Brand Name Drugs	$35 Copay/drug, after Deductible is met.	Not covered.
Non-Preferred Brand Name Drugs	$60 Copay/drug, after Deductible is met.	Not covered.
Specialty Drugs*	Not covered.	Not covered.
Pharmacy & Mail Order Option - 90 Day Supply		
Prescribed Preventive Medications & Contraceptives	No cost to Covered Person, Deductible waived.	Not covered.
Generic Drugs	$15 Copay/drug, after Deductible is met.	Not covered.
Preferred Brand Name Drugs	$105 Copay/drug, after Deductible is met.	Not covered.
Non-Preferred Brand Name Drugs	$180 Copay/drug, after Deductible is met.	Not covered.
Specialty Drugs*	Not covered.	Not covered.
***Veracity has full authority to work with members to obtain patient assistance/manufacturer programs for specialty drugs since they are not covered under the plan. Members who call in for specialty drug coverage should be directed to (888) 388-8228 or help@veracity-rx.com for assistance with specialty drugs.**		
In addition to other coverages provided under the Plan, the Plan provides coverage for certain prescription drugs facilitated by the Plan's International Vendors. Additional mail-order options are available through VeracityRx via the voluntary International Mail Order program. This program provides up to a 90-day supply of brand name medications via pharmacies in Tier 1 countries (Canada, UK, Australia). The copay is $0 for covered members. The program does not include any experimental or investigational medications and does not replace the current PBM option for eligible members.		
Refer to the Prescription Drug Benefits for details on the Prescription Drug Program.		
For additional information regarding the Prescription Drug program contact ProCare RX at (855) 828-1484 or visit www.procarerx.com.		

ARTICLE VI -
ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Eligible Classes of Employees

- All Active Employees of the Employer.

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

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day of the month coincident with or after they:

1. Are a full-time, Active Employee of the Employer. An Employee is considered to be full-time if they normally work at least thirty (30) hours per week and is on the regular payroll of the Employer for that work (i.e. non-variable hour Employee); or is a variable hour Employee who has averaged at least thirty (30) hours per week for a complete measurement period and is currently in a stability period as determined by the Plan Administrator.

   For Employees of a Large Employer:

   An Applicable Large Employer is an Employer with fifty (50) full-time equivalents or more (combination of full-time and part-time Employees) in the prior Calendar Year.

   An Applicable Large Employer may use a look-back measurement method or a monthly measurement method to determine the full-time status. For more information on the measurement method elected by the Employer, contact the Employer's Human Resources staff;

2. Are in a class eligible for coverage; and

3. Complete the employment Waiting Period of thirty (30) days as an Active Employee.

A **Waiting Period** is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

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

1. A covered **Employee's legal spouse and Children** from birth until the limiting age of twenty-six (26) years. When the Child reaches the limiting age, coverage will end on the last day of the Child's birthday month.

   The term **"spouse"** means a person recognized as the covered Employee's husband or wife by the laws of the state or country in which the marriage was formalized. "Married" means a legal union between two individuals and will not include a common law spouse. The Plan Administrator may require documentation proving a legal marital relationship.

   The term **"Children"** means natural children, adopted children, foster children, Children placed with a covered Employee in anticipation of adoption and stepchildren.

   The phrase **"Child placed with a covered Employee in anticipation of adoption"** refers to a Child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption

and retention by such Employee of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

Any Child of a Covered Person who is an Alternate Recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A Covered Person of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax free benefits. (i.e., non-IRC Section 152 Dependent). There may be tax implications for the Employee if they enroll certain eligible Dependent(s). The Employee should consult their tax advisor with any questions on the tax consequences of benefits for their eligible Dependent(s).

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

2. A covered Dependent Child who reaches the **limiting age** and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

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

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

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

- If both parents are Employees, their Children will be covered as Dependents of one of the parents, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a spouse or a Dependent Child qualifies or continues to qualify as a Dependent as defined by this Plan.

EFFECTIVE DATE

Effective Date of Employee Coverage. Coverage will begin the first day of the calendar month following with the completion of all eligibility and enrollment requirements as stated under this Plan.

Effective Date of Dependent Coverage. Coverage will begin on the day that the eligibility requirements are met; the Employee is covered under the Plan; and all enrollment requirements are met.

ENROLLMENT

TIMELY, LATE OR OPEN ENROLLMENT

1. **Timely Enrollment.** The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty (30) days after the person becomes eligible for the coverage either initially or under a special enrollment period.

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

2. **Late Enrollment.** An enrollment is "late" if it is not made on a "timely basis" or during a special enrollment period. Late enrollees and their Dependents who are not eligible to join the Plan during a special enrollment period may join only during open enrollment.

   If an individual loses eligibility for coverage as a result of terminating employment, a reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a late enrollee.

   The time between the date a late enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins as specified in this Plan.

3. **Open Enrollment.** Each year there is an annual open enrollment period designated by the Plan Administrator during which Covered Persons may change their benefit elections under the Plan, and Employees and their Dependents, who are late enrollees, will be able to enroll in the Plan.

   Benefit choices for late enrollees made during the open enrollment period will become effective as of the start of the new plan year. Covered Persons will receive detailed information regarding open enrollment from the Plan Administrator.

   Benefit choices made during the open enrollment period will remain in effect until the next open enrollment period unless there is a special enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

   If an Employee drops spousal coverage during open enrollment in anticipation of divorce, the covered Employee should notify the Plan Administrator.

NOTE: Enrollment Requirements for Newborn Children. A newborn child of a covered Employee who is currently enrolled will be automatically enrolled from the date of birth for the first thirty-one (31) days.

The Employee will be required to enroll the newborn child on a timely basis, as defined in the section "Timely, Late or Open Enrollment" above, or there will be no further payment from the Plan and the parents will be responsible for all costs.

SPECIAL ENROLLMENT RIGHTS

Federal law provides special enrollment provisions under some circumstances. If an Employee is declining enrollment for themself or their Dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the Employer stops contributing towards the other coverage).

In addition, if an Employee or their Dependents (including their spouse) is losing coverage due to a loss of a government sponsored subsidy (due to ineligibility for coverage or cost of coverage) there may be a right to enroll in this Plan.

However, a request for enrollment must be made within thirty (30) days after the coverage ends (or after the Employer stops contributing towards the other coverage).

In addition, in the case of a birth, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within thirty (30) days of the date of birth, adoption or placement for adoption or of the date of marriage.

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a special enrollment period is the first date of coverage. The events described below may create a right to enroll in the Plan under a special enrollment period.

1. **Losing other coverage may create a special enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

    a. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
    b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
    c. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because Employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date of loss.
    d. The Employee or Dependent requests enrollment in this Plan not later than thirty (30) days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date of loss.

    For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

    a. The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time Employees).
    b. The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
    c. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
    d. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a special enrollment right.

2. Acquiring a newly eligible Dependent may create a special enrollment right. If:

- **a.** The Employee is a Covered Person under this Plan (or has met the Waiting Period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- **b.** A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a Child, the spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this special enrollment period in order for his eligible Dependents to enroll.

The Dependent special enrollment period is a period of thirty (30) days and begins on the date of birth, adoption or placement for adoption, or on the date of the marriage. To be eligible for this special enrollment, the Dependent and/or Employee must request enrollment during this time period as stated above.

The coverage of the Dependent and/or Employee enrolled in the special enrollment period will be effective:

- **a.** In the case of marriage, as of the first of the month following enrollment;
- **b.** In the case of a Dependent's birth, as of the date of birth;
- **c.** In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption; or
- **d.** In the case of loss of coverage, the first of the month following enrollment.

TERMINATION OF COVERAGE

The Plan Administrator has the right to rescind any coverage of the Employee and/or Dependents for cause, including but not limited to making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or benefits under the Plan. The Plan Administrator may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

1. The date the Plan is terminated.

2. The last day of the month in which the covered Employee ceases to be in one of the eligible classes. This includes death or termination of active employment of the covered Employee. This also includes failure to satisfy the eligibility requirements of the Plan due to periods of leave unless the plan specifically provides for continuation during these periods.

3. If an Employee fails to make the required premium payment, commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the

Plan, or fails to notify the Plan Administrator that they have become ineligible for coverage, then the Employer or Plan will void coverage for the Employee and covered Dependents for the period of time coverage was in effect.

4. As otherwise specified in this Plan.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the COBRA Continuation Coverage section in this Plan.

Continuation During Periods of Employer-Approved Leave(s) of Absence. A person may remain eligible under the terms of this Plan during an Employer-approved leave of absence. While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the covered Employee. The Employer has sole discretion to determine the length of the Employer-approved leave of absence.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations.

This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and their covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA Leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired by within thirteen (13) consecutive weeks from the date of termination will be credited for time towards the satisfaction of any applicable employment Waiting Period prior to the initial date of termination.

Coverage will begin the first day of the calendar month following the date of rehire or the first day of the calendar month following the satisfaction of any applicable employment Waiting Period, whichever comes first.

A terminated Employee who is rehired after thirteen (13) weeks from the date of termination will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

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

1. The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

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

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

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

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

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

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

2. The last day of the month in which an Employee's coverage under the Plan terminates for any reason including death.

3. The last day of the month in which a covered spouse loses coverage due to loss of eligibility status.

4. The last day of the month in which the Dependent Child ceases to meet the applicable eligibility requirements.

5. If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that they have become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such action; or

6. As otherwise specified in this Plan.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the COBRA Continuation Coverage section in this Plan.

ARTICLE VII -
MEDICAL BENEFITS

Medical benefits apply when Covered Expenses are Incurred by a Covered Person for care of an Injury or Illness and while the person is covered for these benefits under the Plan.

PAYMENT OF BENEFITS

All benefits under this Plan are payable, in U.S. Dollars, to the Covered Person whose Illness or Injury is the basis of a claim, unless the Covered Person, in accordance with the terms of this Plan, compensates Hospital or Physician of medical care with an assignment of benefits. Payment of benefits from the Plan to a health care Hospital or Physician pursuant to written direction of the Covered Person is subject to the approval of the Plan Administrator, and shall be made as consideration in full for services rendered. In the event of the death or incapacity of a Covered Person and in the absence of written evidence to this Plan of the qualification of a guardian for their estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Covered Person.

COVERED EXPENSES

Charges for Covered Expenses are not to exceed the Maximum Allowable Charge that are Incurred for the following items of services and supplies when Medically Necessary to diagnose or treat a Covered Person. These charges are subject to all benefit limits, Exclusions, and other provisions of this Plan. Covered Expenses and Medically Necessary are defined terms; see the Defined Terms section in this Plan for definitions of capitalized terms.

1. **Acupuncture and Acupressure Treatment.** Charges for acupuncture and acupressure services up to the limits outlined in the Medical Benefits Schedule.

2. **Allergy Testing and Injections.** Covered Expenses will include testing, injections, serum and syringes.

3. **Ambulance.** Local Medically Necessary professional land and air ambulance service that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support or advanced life support.

   In a medical emergency, coverage will be provided to the nearest medical facility that can provide medical emergency care. Ambulance transfers between facilities must be approved in advance by the Plan Administrator as Medically Necessary.

   Non-emergent Air Ambulance services are excluded from coverage.

4. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care.

5. **Anesthesia Services.** Anesthesia services provided by a Physician (other than the attending Physician) or Nurse anesthetist including the administration of spinal anesthesia, the injection or inhalation of a drug or other anesthetic agent.

6. **Applied Behavior Analysis (ABA) Therapy.** Medically Necessary Applied Behavioral Analysis therapy services prescribed by a Physician or behavioral health practitioner.

7. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a Hospital as defined by this Plan.

8. **Cataracts.** Cataract surgery and one set of lenses (contacts or frame-type) following surgery.

9. **Chemotherapy**. Charges for chemotherapy, including materials and services of technicians are included.

10. **Chiropractic Care**. Charges for chiropractic treatment up to the limits outlined in the Medical Benefits Schedule. The Provider must submit a letter of Medical Necessity and all applicable notes.

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

    a. The clinical trial is registered on the National Institute of Health (NIH) maintained web site www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial for cancer treatment.
    b. The Covered Person meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
    c. The Covered Person has signed an informed consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed informed consent;
    d. The trial is approved by the Institutional Review Board of the Institution administering the treatment.
    e. Routine patient costs will not be considered Experimental and/or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Covered Person would receive whether or not they were participating in a clinical trial.

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

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

12. **Contraceptives.** All Food and Drug Administration approved contraceptive methods when prescribed by a Physician.

13. **Cosmetic/Reconstructive Surgery.** Cosmetic surgery or reconstructive surgery will be a Covered Expense provided: (a) a Covered Person receives an Injury as a result of an Accident and, as a result requires surgery; cosmetic surgery or reconstructive surgery and treatment must be for the purpose of restoring the Covered Person to his normal function immediately prior to the Accident; and (b) it is required to correct a congenital anomaly, for example, a birth defect. Additional benefits are available under Mastectomy coverage outlined below.

14. **Diabetes Education.** Services and supplies used in Outpatient diabetes self-management programs are covered under this Plan when they are provided by a Physician.

15. **Diagnostic Services and Supplies.** Covered Expenses include, but are not limited to, services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging, radiology and oncology, sleep studies, and x-ray.

16. **Dialysis treatment.** The plan will pay dialysis-related claims according to the Medical Benefits Schedules for the first 3 months after commencement of treatment. Thereafter, the Plan will pay for dialysis-related

services at 80% of 125% of the then current Medicare Allowable for those services in that region, after satisfaction of any Deductibles and Copayments. Dialysis treatment shall include hemodialysis or peritoneal dialysis and the supplies utilized to administer under the direction of a Physician in a Hospital, health care facility, Physician's office or at home. Laboratory testing and Physician visits will be payable pursuant to the normal Plan provisions. Dialysis charges are excluded from any Network Provider agreements and are treated as out-of-network claims; they are paid at a percentage of the Medicare allowable rate and may be subject to Medicare Rules. This provision applies to charges for dialysis treatment only. Any other applicable provisions, conditions, and Exclusions remain in effect, including restrictions on benefits under an Exclusive Provider Only (EPO) Plan, or any dollar maximums applied to non-network claims. A Plan Participant undergoing dialysis should promptly apply for Medicare coverage, regardless of age. Contact the Plan Administrator for information on how to be reimbursed for Medicare Part B premiums.

17. **Durable Medical Equipment (DME).** Rental or purchase, whichever is less costly, of necessary Durable Medical Equipment which is prescribed by a Physician and required for therapeutic use by the Covered Person will be a Covered Expense. Equipment ordered prior to the Covered Person's effective date of coverage is not covered, even if delivered after the effective date of coverage. Repair or replacement of purchased Durable Medical Equipment which is Medically Necessary due to normal use or physiological change in the patient's condition will be considered a Covered Expense as limited in the Medical Benefits Schedule. Prosthetics and orthotics are covered under this benefit. Foot orthotics will be covered.

18. **Emergency Services.** Coverage is provided for a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in: (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn Child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the Diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

19. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed Physician (excluding routine foot care).

20. **Hearing Benefit.** Services of a licensed audiologist to determine and measure hearing loss will be a Covered Expense. Hearing aids are not covered.

21. **Home Health Care.** Home health care is subject to Pre-certification. Failure to obtain Pre-certification will result in a denied benefit payment. Home health care enables the Covered Person to receive treatment in their home for an Illness or Injury instead of being confined in a Hospital or Skilled Nursing Facility. Covered Expenses shall include:

    a. Part-time or intermittent nursing care by a registered nurse, licensed practical nurse or a licensed vocational nurse;
    b. Physical therapy, respiratory therapy, occupational therapy, hearing therapy or speech therapy;
    c. Part-time or intermittent home health aide services for a Covered Person who is receiving covered nursing or therapy services;
    d. Medical social service consultations;
    e. Nutritional guidance by a registered dietician and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be medically necessary.

A visit by a member of a home health care team and four (4) hours of home health aide service will each be considered one (1) home health care visit.

Covered Expenses shall be subject to the maximum benefit specified on the Medical Benefits Schedule.

No home health care benefits will be provided for services provided by a close relative; or transportation services.

22. **Hospice Care.** Hospice care is a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in facility settings for a Covered Person suffering from a condition that has a terminal prognosis.

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

    a. The Covered Person is terminally ill; and
    b. The Covered Person has a life expectancy of six (6) months or less.

    Covered Expenses include:

    a. Confinement in a hospice facility to include ancillary charges and room and board;
    b. Services, supplies and treatment provided by a hospice agency to a Covered Person in a home setting;
    c. Physician services and/or nursing care by a registered nurse, licensed practical nurse. licensed vocational nurse, or a public health nurse;
    d. Physical therapy, respiratory therapy, occupational therapy, or speech therapy;
    e. Nutrition services to include nutritional advice by a registered dietician, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation;
    f. Counseling services provided through the hospice agency.

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

23. **Hospital Care.** The medical services and supplies furnished by a Hospital or similar Institution for Inpatient and Outpatient services. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

24. **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy or Lumpectomy. The Federal law requires group health plans that provide Mastectomy or Lumpectomy coverage to also cover breast reconstruction surgery and prostheses following a Mastectomy or Lumpectomy.

    As required by law, the Covered Person is being provided this notice to inform them about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy or Lumpectomy will also receive coverage for:

    a. Reconstruction of the breast on which the Mastectomy or Lumpectomy has been performed.
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
    c. Prostheses and physical complications from all stages of Mastectomy or Lumpectomy, including lymphedemas.

    The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the Covered Person.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy or Lumpectomy coverage, and will be provided in consultation with the Covered Person and their attending Physician.

25. **Maternity Care.** Charges for the care and treatment of Pregnancy are covered the same as any other Illness and will be payable as stated in the Medical Benefits Schedule.

    Charges related to Pregnancy for Dependent daughters are covered.

26. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy Diagnosis, and lancets and chemstrips for diabetics.

27. **Mental or Nervous Disorders and Substance Use Disorder Treatment.** Covered Expenses will be payable for care, supplies and treatment of Mental or Nervous Disorders and Substance Use Disorder.

28. **Mouth and Teeth Conditions.** Charges for mouth and teeth conditions will be covered as follows:

    a. Treatment or removal of malignant or benign tumors;
    b. Treatment of Accidental Injury to a sound, natural tooth, or for the setting of a jaw fracture or dislocation if the treatment begins within three (3) months of the Accident;
    c. Removal of impacted wisdom teeth; and
    d. Hospital services, supplies and anesthesia for oral surgical procedures for which a doctor (M.D., D.O. or D.D.S.) provides satisfactory certification to the Plan Administrator that hospitalization is Medically Necessary.

29. **Occupational Therapy.** Services provided by a licensed occupational therapist, payable up to the limits as stated in the Medical Benefits Schedule. The Provider must send in a letter of Medical Necessity and all applicable notes.

30. **Physical Therapy.** Services provided by a licensed physical therapist, payable up to the limits as stated in the Medical Benefits Schedule. The Provider must send in a letter of Medical Necessity and all applicable notes.

31. **Physician Care.** The professional services of a Physician for surgical or medical services.

32. **Prescription Medications.** Covered Expenses include drugs that are administered as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription Drug benefit.

33. **Preventive Care.** Covered Expenses under medical benefits are payable for routine preventive care as described in the Medical Benefits Schedule. Standard preventive care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force or as otherwise identified in applicable law. Examples of standard preventive care include:

    - Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
    - Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
    - Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
        - Breastfeeding support, supplies, and counseling.
        - Gestational diabetes screening.

Standard preventive care includes women's contraceptives sterilization procedures, and counseling.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Illness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Illness. Standard preventive care for Children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of standard preventive care include:

- Immunizations for Children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  - Diphtheria,
  - Pertussis,
  - Tetanus,
  - Polio,
  - Measles,
  - Mumps,
  - Rubella,
  - Hemophilus influenza b (Hib),
  - Hepatitis B,
  - Varicella.
- Preventive care and screenings for infants, Children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as standard preventive care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html

34. **Private Duty Nursing.** Services of a registered nurse for private duty nursing shall be a Covered Expense only in conjunction with home health care. Inpatient services are not covered.

35. **Radiation Therapy.** Charges for radiation therapy and treatment.

36. **Skilled Nursing Facility Care and Extended Care.** Skilled Nursing Facility confinement is subject to Pre-certification. Failure to obtain Pre-certification will result in a denied benefit payment. Covered Expenses include:

    a. Room and board (including regular daily services, supplies and treatments furnished by the Skilled Nursing Facility) limited to the facility's average semiprivate room rate;
    b. Other services, supplies and treatment ordered by a Physician and furnished by the Skilled Nursing Facility for Inpatient medical care; and
    c. Drugs, biological, solutions, dressings and casts furnished for use during the confinement, but no other supplies. Skilled Nursing Facility benefits are limited as shown on the Medical Benefits Schedule.

37. **Sleep Studies.** Covered Expenses shall include charges for Medically Necessary sleep studies and treatment of sleep apnea and other sleep disorders. The patient must exhibit a history of sleep disturbance which is having an adverse effect on the patient's health, could be potentially life-threatening or is aggravating a medical condition of the patient.

38. **Smoking Cessation**. Care and treatment for smoking cessation programs, including smoking deterrent patches, nicotine gum or other deterrents.

39. **Speech Therapy.** Services provided by a licensed speech therapist, payable up to the limits as stated in the Medical Benefits Schedule. The Provider must send in a letter of Medical Necessity and all applicable notes.

40. **Sterilization Procedures.** Charges for sterilization procedures.

41. **Telemedicine Services (Teladoc).** Telehealth services are a Covered Expense which include office visits, psychotherapy, and/or medical consultations via phone, or video conference technology.

42. **Temporomandibular Joint Disorder (TMJ).** Charges for the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment.

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

    a. The following transplant procedures are paid the same as any Illness and are not subject to the transplant provision of this Plan: corneal transplants; implantable prosthetic lenses in connection with cataracts; prosthetic by-pass or replacement vessels; artery or vein transplants; heart valve transplants; and prosthetic joint replacements.
    b. When the recipient is covered under this Plan, the Plan will pay the recipient's Covered Expenses related to the transplant.
    c. When the donor is covered under this Plan, the Plan will pay the donor's Covered Expenses related to evaluating the organ, removing the organ from the donor, transportation of the organ to the place where the transplant will be performed.
    d. Expenses Incurred by the donor who is not ordinarily covered under this Plan according to eligibility requirements will be Covered Expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan. The donor's expense shall be applied to the recipient's maximum benefit. In no event will benefits be payable in excess of the maximum benefit still available to the recipient.
    e. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a Covered Expense under this Plan. If a Covered Person's transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.
    f. Travel and accommodations will be covered up to the limits outlined in the Medical Benefits Schedule.

    There is no obligation to the Covered Person to use either a Network Provider or a Center of Excellence facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by a Network Provider or a Non-Network Provider and whether or not a Center of Excellence facility is utilized. A Center of Excellence is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access.

44. **Urgent Care.** Services and supplies provided by an urgent care facility.

45. **Well Newborn Nursery and Physician Care.** Covered is provided for the following:

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

This coverage is only provided if the newborn child, who is neither injured nor ill, is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls themself (as well as the newborn child if required) in accordance with the special enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to the Maximum Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the Child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn.

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

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

Charges for Routine Physician Care. The benefit is limited to the Maximum Allowable Charges made by a Physician for the newborn child while Hospital confined, including circumcision, as a result of the Child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn.

46. **Wigs After Chemotherapy.** Charges for wigs when generalized hair loss is due to chemotherapy or radiation therapy up the limits outlined in the Medical Benefits Schedule.

ARTICLE VIII -
MEDICAL MANAGEMENT SERVICES

Salad Collective Health and Welfare Benefits Plan has contracted with Aetna in order to assist the Covered Person in determining whether or not proposed services are appropriate for reimbursement under the Plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

UTILIZATION REVIEW

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

PRE-CERTIFICATION

Pre-certification is the process of performing a Medical Necessity review. This process is performed by Aetna. The following non-Emergency Services require Pre-certification:

- All Inpatient services;
- Advanced imaging (MRI, MRA, PET CT and nuclear medicine);
- Home health care;
- Renal dialysis;
- Skilled Nursing Facility stays;
- Sleep studies provided overnight in-lab; and
- Transplant services.

The purpose of the program is to determine Medical Necessity, medical appropriateness, health care setting, and level of care.

All services requiring Pre-certification are to be authorized in advance, except for emergencies, by contacting Aetna at the number on the Plan ID card. The Covered Person or their Authorized Representative is required to call for Pre-certification for the services specified above prior to the services being rendered. The Covered Person or their Authorized Representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Pre-certification determinations and service prepricing.

If Pre-certification is not obtained and the services are determined medically necessary via retro-certification, services are paid in full and no penalty applies. If Pre-certification is not obtained and the services are determined NOT medically necessary via retro-certification, no benefits paid under plan – member is 100% responsible for charges.

If a particular course of treatment or medical service is not Preauthorized as Medically Necessary before the Covered Person receives the care or treatment, it means that the charges for the care or treatment may be denied.

Any reduced reimbursement or denied claims, due to failure to follow Pre-certification procedures will not accrue toward the maximum out-of-pocket amount.

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

HOW THE UTILIZATION REVIEW PROGRAM WORKS

Before a Covered Person enters a Hospital on a non-emergency basis or receives other listed medical services, Aetna will, in conjunction with the attending Physician, certify the care as Medically Necessary. A non-emergency stay in a Hospital is one that can be scheduled in advance.

The Utilization Review program is set in motion by a telephone call from, or on behalf of, the Covered Person or the treating Provider. Contact Aetna at the numbers listed above before services are scheduled to be provided with the following information.

- The name of the Covered Person and relationship to the covered Employee
- The name, Employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an emergency admission to the Hospital, the Covered Person, Covered Person's family member, Hospital or attending Physician must contact Aetna **within forty-eight (48) hours** of the first business day after admission.

Aetna will review and make a determination on the Medical Necessity of the care, treatment or service.

Note: *Pre-certification does not guarantee payment of the claim(s) Incurred during the period of authorization. Whether an individual is a Covered Person, whether a charge is eligible for payment, and how much of a charge is paid are determined after the claim for the care, treatment or service is received by the Claims Administrator. All claims are subject to all Plan terms and conditions, limitations, and Exclusions at the time the charges are Incurred. Providers and Covered Persons are informed at the time the Hospital stay is authorized that authorization does not guarantee payment of claims for the same.*

Concurrent Review and Discharge Planning. Concurrent review of a course of treatment and discharge planning from a Hospital are parts of the Utilization Review. Aetna will monitor the Covered Person's Hospital stay or use of other medical services and coordinate with the attending Physician, Hospital and Covered Person either the scheduled discharge or extension of the Hospital stay or extension or cessation of other medical services.

If the attending Physician believes it Medically Necessary for a Covered Person to receive additional services or to stay in the Hospital for a greater length of time than has been Preauthorized, the attending Physician must request the additional services or days.

RETROSPECTIVE REVIEW

The Utilization Review Service will review and evaluate the medical records and other pertinent data of an individual whose Hospital stay, or a portion of his stay, was not authorized under the provisions of the Plan.

Requests for such review must be made, in writing, by the attending Physician or Hospital and must define the medical basis for the review.

Benefits will be limited to only those expenses Incurred during the period of hospitalization which **would have been** authorized. Benefits are not payable for expenses related to any period of Hospital confinement which is deemed not Medically Necessary.

CONTINUITY OF CARE

In the event a Covered Person is a continuing care patient receiving a course of treatment from a Network Provider or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have the following rights to continuation of care.

The Plan shall notify the Covered Person that the Provider's contractual relationship with the Plan has terminated, and that the Covered Person has rights to elect continued transitional care from the Provider. If the Covered Person elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions

as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending ninety (90) days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. Is undergoing a course of treatment for a serious and complex condition from a specific Provider,

2. Is undergoing a course of institutional or Inpatient care from a specific Provider,
3. Is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. Is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. Is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the Provider termination had not occurred, and the Covered Person is responsible for their network share of cost.

CASE MANAGEMENT AND ALTERNATIVE BENEFIT

If a Covered Person has an ongoing Illness or Injury, a Case Manager may be assigned to monitor the Covered Person, and to coordinate with the attending Physician and Covered Person to design a treatment plan and coordinate appropriate Medically Necessary care. The case manager will consult with the Covered Person, the family, and the attending Physician to assist in coordinating a plan of care approved by the Covered Person's attending Physician and the Covered Person.

Case management is a voluntary program of the Plan. If the Covered Person chooses not to participate in the case management program, there will be no reductions of benefits or penalties.

Each treatment plan is individualized to a specific Covered Person and is not appropriate or recommended for any other Covered Person, even one with the same Diagnosis. All treatment and care decisions will be the sole determination of the Covered Person and the attending Physician.

Alternative Benefit. The Plan may elect, in its sole discretion, to allow for alternative benefits that are otherwise excluded under the Plan. The Plan's decision to allow alternative benefits shall be determined on a case-by-case basis in conjunction with the treating Provider and the Covered Person. The Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan Administrator to strictly enforce the provisions of the Plan

The Alternative Benefit must be beneficial to both the Covered Person and the Plan. Alternative benefits, if approved by the Plan Administrator, are subject to all applicable Plan terms and conditions, limitations and Exclusions at the time the charges are Incurred. Once agreement has been reached, the Plan Administrator or its delegate will direct the Claims Administrator to reimburse for Medically Necessary expenses as stated in the alternative treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses Incurred in connections with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

ARTICLE IX -
MEDICAL PLAN EXCLUSIONS

Note: All Exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits section.

The following are not covered under this Plan:

1. **Abortion.** Elective abortions, unless the life of the mother is endangered by the continued Pregnancy, or the Pregnancy is the result of rape or incest. However, complications from abortions, whether elective or non-elective, are covered.

2. **Administrative Costs.** Charges for failure to keep scheduled appointments, completion of a claim form, obtaining medical records, late payments, telephone charges or information required to process a claim.

3. **Bariatric Surgery.** Charges for bariatric surgery (including, but not limited to, gastric bypass, intestinal bypass, lap band, Roux-en-Y gastroenterostomy, adjustable gastric restrictive procedure, sleeve gastrectomy, gastroplasty, liposuction, or similar surgeries, including pre- and post-op care).

4. **Blood.** Charges for blood.

5. **Cellular Therapy.** Charges for cellular therapy.

6. **Complications of Non-Covered Expenses.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. However, complications from abortions, whether elective or non-elective, are covered.

7. **Coordination of Benefits.** Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits or subrogation rules.

8. **Cosmetic.** Charges that are Incurred in connection with the care and/or treatment of surgical procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent outlined under Covered Expenses. A treatment will be considered cosmetic for either of the following reasons; (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality.

9. **Counseling.** Charges for marital counseling or family counseling without a mental health diagnosis.

10. **Custodial Care.** Charges for Custodial Care, domiciliary care or rest cures.

11. **Deductible.** Charges that Are not payable due to the application of any specified Deductible, Copay or Coinsurance provision of the Plan.

12. **Durable Medical Equipment.** Replacement of Durable Medical Equipment outside the time specified in the Medical Benefits Schedule unless approved by the Plan Administrator.

13. **Educational or Vocational Testing.** Services for educational or vocational testing or training other than diabetes self-management training, including instruction in alternate life patterns, or training or bed and board from an institution that is primarily a school or other institution for training.

14. **Excess Charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Maximum Allowable Charge. For Network Providers, the part of an expense for care and treatment of an Injury or Illness that is in excess of the Maximum Allowable Charge is excluded.

15. **Experimental and/or Investigational or not Medically Necessary.** Care and treatment that is either Experimental and/or Investigational, is not Medically Necessary.

16. **Foot Care.** Except as Medically Necessary for the treatment of metabolic or peripheral-vascular illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet, subluxations of the foot, treatment of corns or calluses, non-surgical care of toenails.

17. **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical service. Emergency care is covered.

18. **Gene Therapy.** Charges associated with gene therapy.

19. **Genetic Testing.** Genetic testing or treatment unless the results are specifically required for a medical treatment decision on the member or as required by federal law or specifically covered by this Plan.

20. **Government Plan.** Services or supplies furnished by or on behalf of the United States government or any other government, unless, as to such other government, payment of the charge is legally required. Services or supplies are excluded to the extent benefits for them are provided by any law or governmental program under which the person is or could be covered, unless payment of the charge is legally required.

21. **Hair Loss.** Charges for wigs, artificial hair pieces, artificial hair transplants, or any Prescription Drug or over the counter medical to eliminate baldness except as outlined under Covered Expenses.

22. **Hearing Aids.** Hearing aids, including (but not limited to) semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. The Plan does; however, cover cochlear implants as described in the Medical Benefits Schedule.

23. **Hypnosis.** Charges for hypnosis or hypnotherapy.

24. **Immediate Family Member.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

25. **Impotence.** Diagnostic services, surgical or non-surgical procedures and Prescription Drugs used to treat impotence.

26. **Infertility.** Charges for services, supplies or treatment related to the diagnosis or treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT).

27. **Late Claims.** Claims not submitted within the Plan's filing limit deadlines.

28. **Medicare.** Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits with Medicare when Medicare is the primary payor. This limitation may apply to Members aged sixty-five (65) or older, and is subject to federal regulation.

29. **Mouth and Teeth Conditions.** Charges for normal dental care benefits, including any dental, gum treatments, or oral surgery, except as outlined under Covered Expenses.

30. **Non-Surgical Treatment of the Spine.** Charges for non-surgical treatment of the spine.

31. **No Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by

a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

32. **Not Legally Required to Pay.** Charges for any item for which the Covered Person is not legally required to pay, or for which a charge would not have been made if the Covered Person did not have this coverage.

33. **Not Listed.** Any items not outlined under Covered Expenses.

34. **Obesity.** Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment, special diets or diet supplements, appetite suppressants, Nutri System, Weight Watchers or similar programs and Hospital confinements for weight reduction programs except to the extent as required by the Affordable Care Act.

35. **Occupational Injury.** Charges in connection with any Illness or Injury arising out of or in the course of any employment intended for wage or profit, including self-employment, or the Illness or Injury is covered under the Worker's Compensation Law or any similar legislation.

36. **Oral Statements.** Charges which are Incurred based upon oral statements made by anyone involved in the administration of the Plan that are in conflict with the benefits described in this document.

37. **Personal Convenience Items.** Charges for equipment that does not meet the definition of Durable Medical Equipment, including but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, and first-aid supplies and non-hospital adjustable beds.

38. **Prison.** Charges for services received while confined in a prison, jail or other penal institution.

39. **Radioactive Contamination.** An Injury or Illness caused as a result of radioactive contamination.

40. **Room and Board.** Charges for room and board for any other room at the same time the patient is being charged for use of a special care unit.

41. **Sales Tax.** Charges for sales tax on Prescription Drugs or on any other covered items.

42. **Services Before or After Coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

43. **Sexual Dysfunctions.** Sexual dysfunctions, penile implants, sex transformations, gender dysphoria or inadequacies, and sex therapy.

44. **Sterilization Reversal.** Care and treatment for reversal of sterilization.

45. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit under this Plan.

46. **Utilities.** Electrical power, water supply, sanitary waste disposal systems, saunas, hot tubs or swimming pools or their installation, or any similar expense associated with a residence.

47. **Vax-D Therapy.** Charges associated with Vax-D therapy.

48. **Violation of Law.** The sale use, or administration of any supplies, services or treatment, which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.

49. **Vision Care.** Charges for Physicians' services in connection with eye refractions or any other examinations

to determine the need for, or the proper adjustment of, eyeglasses or contact lenses, unless for the initial examination following cataract surgery. Radial Keratotomy and any surgical procedures to improve refractive errors such as nearsightedness, etc., are also excluded. This Exclusion does not apply to any services otherwise covered under vision benefits, if any.

50. **Vitamins.** Charges for vitamins, (except prenatal vitamins prescribed by a Physician), minerals, nutritional food supplements, or any over the counter items, whether or not prescribed by a Physician, unless otherwise specifically covered under this Plan.

51. **War.** Services Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression.

52. **Weekend Admission.** Charges for a Covered Person admitted to the Hospital on a Friday, Saturday or Sunday, charges for these days will be excluded unless admitted due to an emergency or if surgery is performed within twenty-four (24) hours of admission.

ARTICLE X -
PRESCRIPTION DRUG BENEFITS

The purpose of the Salad Collective, LLC Prescription Drug Program is to provide eligible Employees and their Dependents with certain Prescription Drugs approved by the Food and Drug Administration (FDA) and dispensed at a retail or mail in Pharmacy.

The Plan has partnered with a ProCare RX, a Pharmacy Benefits Manager, to offer Covered Persons covered Prescription Drugs. For a list of covered Prescription Drugs as well as participating pharmacies that have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs, please contact the Plan Administrator. More information about the Plan's Prescription Drug Program can be found in the Prescription Drug Benefit Schedule.

The ProCare RX is always available to assist Covered Persons and can be contacted at (855) 828-1484.

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

Prescription Drug Copayments. A Prescription Drug Copayment is applied to each covered Pharmacy drug, specialty medication or mail order drug charge.

Mail Order Pharmacy. The mail order Pharmacy benefit is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

Any one mail order prescription is limited up to a 90-day supply.

Note: Some quantity limitations and/or prior authorization may apply.

PRIOR AUTHORIZATION (PA)

Prior authorization is required for all new drugs after-market availability for 12 months. There are additional medications that may require Pre-certification, check with the Pharmacy Benefits Manager for the most updated information.

LIMITATIONS TO THIS BENEFIT

1. Certain Prescription Drugs are subject to supply limits. The limit may restrict the amount dispensed for each prescription or refill and/or the amount dispensed for any month's supply (for example, medications used to treat sexual dysfunction), and this is to ensure certain medications are not utilized inappropriately or recommended maximum dosages are not exceeded.
2. Limitations and Exclusions may apply to certain classes of Prescription Drugs where lower cost clinical alternatives exist.
3. Specific rules, including increased supply limits, may apply. Contact the Pharmacy Benefit Manager for more information.

EXCLUSIONS

1. **Administration.** Any charge for the administration of a covered drug or medication.

2. **Anorexiants.** Charges for anorexiants or any drug or medication used as an appetite suppressant.

3. **Consumed on Site.** Charges for any drug or medication which is consumed or administered at the place where it is dispensed.

4. **Cosmetic Drugs.** Prescription Drugs used for cosmetic purposes, including, but not limited to, for hair growth stimulants, growth hormones and Retin-A for Covered Persons over age twenty-five (25).

5. **Devices.** Devices of any type, even though they may require a prescription order (including but not limited to therapeutic devices, artificial appliances, support garments and other similar devices, regardless of their intended use).

6. **Diagnostic Agents.** Charges for diagnostic agents.

7. **Excess Refills.** Refills beyond the number specified by a Physician or refills more than one (1) year from the date of the initial prescription order.

8. **Experimental & Non-FDA Approved Drugs.** Experimental drugs and medicines, even though a charge is made to the Covered Person and drugs not approved by the Food and Drug Administration (FDA).

9. **Immunizations.** Charges for immunization agents or biological sera except as required by applicable law.

10. **Impotence.** Medications for erectile dysfunction or organic impotence.

11. **Infertility.** Drugs and other related products used to treat infertility or assist with fertility.

12. **Injectables and Supplies.** A charge for hypodermic syringes and/or needles, injectable medications or any prescription directing administration by injection for any medication or treatment other than insulin, preventive immunizations and female contraceptives as required by applicable law, or as specifically covered by any specialty drug benefit or otherwise herein.

13. **Inpatient Medication.** Any drug or medication which is to be taken by or administered to the Covered Person, in whole or in part, while they are a patient in a Hospital, rest home, sanitarium, Skilled Nursing Facility or extended care facility, convalescent hospital, nursing home or similar Institution which operates on its premises, a facility for dispensing pharmaceuticals.

14. **Investigational Drugs.** A drug or medicine labeled: "Caution-limited by federal law to investigational use."

15. **Medical Exclusions.** Any drug or medication otherwise excluded by the medical benefits in this Plan.

16. **No Charge.** Any drug or medication that may be properly received without charge under a local, state, or federal program or for which the cost is recoverable under any workers' compensation or occupational disease law.

17. **Non-Prescription Drugs.** A drug or medicine that can be legally bought without a written prescription. This does not apply to injectable insulin.

18. **Vitamins.** Charges for vitamins except for prenatal vitamins and vitamins with fluoride that require a prescription.

For additional information regarding the Prescription Drug program contact ProCare RX at (855) 828-1484 or visit www.procarerx.com.

ARTICLE XI -
CLAIMS PROCEDURES

When services are received from a health care Provider, a Covered Person should show their **identification card** to the Provider.

If it is necessary for a Covered Person to submit a claim, they should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from their health care Provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill;
- Group name and number;
- Provider Billing Identification Number;
- Employee's name and Identification Number;
- Name of Covered Person;
- Name, address, telephone number of the Provider of care;
- Date of service(s);
- Place of service; and
- Amount billed.

Note: A Covered Person can obtain a claim form from the Claims Administrator. Claim forms are also available at:

login.personifyhealth.com

WHERE TO SUBMIT CLAIMS

Claims for expenses should be submitted to the address below:

Personify Health Solutions, LLC
P.O. Box 1590
Covington, LA 70434
(855) 613-4330

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.

The Covered Person must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Covered Person seek a second opinion. The Plan also encourages Covered Persons to obtain second opinions as outlined in the Covered Expenses section set forth above. **The Plan Administrator will only process Clean Claims as defined by this Plan Document.**

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

TYPES OF CLAIMS

A **claim** means a request for a Plan benefit, made by a Claimant (Covered Person or by an Authorized Representative of a Covered Person that complies with the Plan's procedures for filing benefit claims).

A Claimant may appoint an Authorized Representative to act upon their behalf with respect to the claim. Only those individuals who satisfy the Plan's requirements to be an Authorized Representative will be considered an Authorized Representative. A healthcare Provider is not an Authorized Representative simply by virtue of an assignment of benefits; however, a healthcare Provider can represent the Claimant in claims involving Urgent Care. Contact the Claims Administrator for information on the Plan's procedures for Authorized Representatives. There are four types of claims:

A **pre-service claim** is a reduction in benefits for certain Covered Services because the Covered Person did not obtain the required Plan approval before receiving the care or treatment. This Plan does require Pre-certification for certain Covered Services or treatments as a condition to receiving benefits under the Plan. The review program is known as Pre-certification. See the Medical Benefits Schedule and Medical Management Services sections in this Plan for more information.

An **urgent care claim** is any pre-Service claim where the application of the time periods for review and determination of the pre-service claim could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or – in the opinion of the Covered Person's treating Physician, would subject the Covered Person to severe pain that cannot be managed without the proposed care or treatment.

A **concurrent care determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If case management is appropriate for a Covered Person, case management is not considered a concurrent care determination. Please refer to the Medical Management Services section of this Plan.*

A **post-service claim** is a claim for medical care, treatment, or services that a Claimant has already received.

INITIAL BENEFIT DETERMINATION

All questions regarding claims should be directed to the Claims Administrator. All claims will be considered for payment according to the Plan's terms and conditions, limitations and Exclusions, and industry standard guidelines in effect at the time charges were Incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims involving specialized medical knowledge or judgment.

A claim will not be deemed submitted until it is received by the Claims Administrator.

The initial benefit determination will be made as follows:

Pre-Service Claims for Urgent Care. If the pre-service claim is determined by the Claims Administrator to be a claim involving urgent care, notice of the Plan's decision will be provided to the Covered Person as soon as possible but no later than 72 hours after receipt of the pre-service claim by the Claims Administrator.

The exception is if the Covered Person does not provide sufficient information to decide the pre-service claim. In that case, notice requesting specific additional information will be provided to the Covered Person within 24 hours of receipt of the pre-service claim.

The Plan's decision regarding the pre-service claim will be made as soon as possible but no later than 48 hours after the earlier of:

- The Plan's receipt of the requested information or
- The expiration of the time period set by the Plan for the requested information (at least 48 hours).

Pre-Service Claims for non-Urgent Care. If the pre-service claim is not an urgent care claim, written notice of the Plan's decision will generally be provided to the Covered Person within a reasonable period of time, but no later than 15 days after receipt of the pre-service claim by the Claims Administrator.

If matters beyond the control of the Claims Administrator so require, one 15-day extension of time for processing the pre-service claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to the Covered Person before the end of the initial 15-day period. If an extension is required because the Covered Person did not provide the information necessary to make a determination on the claim, the notice of extension will specifically describe the required information.

The time-period for processing the pre-service claim will be deferred beginning on the date this extension notice is sent to the Covered Person and ending on the earlier of:

- The date the Plan receives a response to the request for additional information, or
- The date set by the Plan for a response (which will be at least 45 days).

Concurrent Care Determination. The initial benefit determination on a concurrent care determination will be made within 15 days of the Claim Administrator's notice of a concurrent care claim. If additional information is necessary to process the concurrent care claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant or the healthcare Provider must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a concurrent care claim is suspended until the earlier of:

- The date the Plan receives the Claimant's or healthcare Provider's response for additional information, or
- The date set by the Plan for the Claimant or healthcare Provider to respond (which will be at least 45 days).

A benefit determination on the concurrent care claim will be made within 15 days of the Plan's receipt of the additional information.

Post-Service Claim. The initial benefit determination on a post-service claim will be made within 30 days of the Claim Administrator's receipt of the claim. If additional information is necessary to process the claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a post-service claim is suspended until the earlier of:

- The date the Plan receives the Claimant's additional information; or
- The date set by the Plan for the Claimant to respond (which will be at least 45 days).

A benefit determination on the claim will be made within 15 days of the Plan's receipt of the additional information.

NOTICE OF DETERMINATION

1. The Plan shall provide written or electronic notice of the determination on a claim in a manner meant to be understood by the Claimant. If a claim is denied in whole or in part, notice will include the following:
2. Specific reason(s) for the denial.
3. Reference to the specific Plan provisions on which the denial was based.

4. Description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
5. Description of the Plan's claims review procedures and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following a notice of the determination on final review.
6. Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

If applicable:

1. Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the notice of the determination and that a copy will be provided free of charge to the Claimant upon request).
2. If the notice of the determination is based on the Medical Necessity or Experimental and/or Investigational Exclusion or similar such Exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the claim, or a statement that such explanation will be provided free of charge, upon request.
3. Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the notice of determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Covered Person's failure to timely pay required premiums.

CLAIMS REVIEW PROCEDURE - GENERAL

A Claimant may appeal an Adverse Benefit Determination as follows:

- The Plan offers a one-level internal review process for pre-service claims for urgent care; or
- The Plan offers a two-level internal review procedure for a pre-service claim (non-urgent care), concurrent care claim, and post service claim.

The Plan Administrator will provide for a review that does not give deference to the previous benefit determination and that is conducted by either an appropriate plan fiduciary or the Claims Administrator on the Plan's behalf who was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final notice of the determination so that the Claimant has a reasonable amount of time to respond.
- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's benefit determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the initial benefit determination.

Note: Providers who have submitted claims to the Plan that are subject to the NSA, cannot avail themselves to the internal and external claims procedure set forth herein. All disputes regarding all payments for claims subject to NSA must be resolved through open negotiating or through a Certified Independent Dispute Resolution (IDR) Entity as outlined in the NSA.

INTERNAL APPEAL PROCEDURE

First Level of Internal Review. To appeal a denial of a claim, the Claimant must submit in writing, a request for a review of the claim. The Claimant should include in the appeal letter: their name, ID number, group health plan name, and a statement of why the Claimant disagrees with the denial. The Claimant may include any additional supporting information, even if not initially submitted with the claim.

The written request for review must be submitted within 180 days of the Claimant's receipt of an Adverse Benefit Determination.

The written request for review should be addressed to:

Claims Administrator
Personify Health Solutions, LLC
Attn: Appeals
P.O. Box 1590
Covington, LA 70434

An appeal will not be deemed submitted until it is received by the Claims Administrator. Failure to appeal the initial denial within the prescribed time period will render that determination final. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the initial benefit determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic notice of determination to the Claimant within:

- 72 hours of the receipt of the appeal for an urgent care claim;
- 15 days of the receipt of the appeal for a pre-service claim or a concurrent care claim; or
- 30 days of the receipt of the appeal for a post service claim.

Second Level of Internal Review

If the Claimant does not agree with the Claims Administrator's determination from the first level of internal review, the Claimant may submit a second level appeal in writing. The Claimant may request a second level appeal on pre-service claims (non-urgent care) and post-service only along with any additional supporting information.

The written request for review of the first level of internal review must be submitted within 60 days of the Claimant's receipt of the first level of internal review.

The written request for review should be addressed to:

Claims Administrator
Personify Health Solutions, LLC
Attn: Appeals
P.O. Box 1590
Covington, LA 70434

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. Failure to appeal the determination from the first level of review within the prescribed time period will render that determination final. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The second level of internal review will be done by the Plan Administrator, or its designee. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Final Internal Adverse Benefit Determination for the second level of review to the Claimant within:

- 15 days of the Plan's receipt of Claimant's second level appeal on a pre-service claim (non-urgent care);
- 15 days of the Plan's receipt of Claimant's second level appeal on a concurrent care determination; or
- 30 days of the Plan's receipt of Claimant's second level appeal on a post-service claim.

If the Claimant is not satisfied with the outcome of the final determination on the second level of internal review, the Claimant may be eligible for an external review. The Claimant must exhaust both levels of the internal review procedure before requesting an external review. In certain circumstances, the Claimant may also request an expedited external review.

EXTERNAL REVIEW PROCEDURE

This Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within 4 months from the date of receipt of the notice of the final internal Adverse Benefit Determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or services is not Medically Necessary;
- Determination that a treatment is Experimental and/or Investigational;
- Rescission of coverage, whether or not the rescission involved a claim; or
- Determination on whether the Plan is complying with the No Surprises Act, as applicable.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an external review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within 6 business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four-month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for external review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law.

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

Generally, a Claimant must exhaust the Plan's Claims Procedures in order to be eligible for the external review process. However, in some cases the Plan provides for an expedited external review if:

1. The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal claims and appeal procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

2. The Claimant receives a final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the Claimant and the Plan.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Covered Person may designate another individual to be an Authorized Representative and act on their behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Covered Person, and include all the information required in the Authorized Representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator. The Plan does not recognize the appointment of an Authorized Representative by any other instrument.

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

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

CONDITIONS AND LIMITATIONS OF AN ASSIGNMENT OF BENEFITS

The validity of an assignment of benefits by a Covered Person to a Provider is limited by the terms of this Plan Document. An assignment of benefits is considered valid on the condition that the Provider accepts the payment received from the Plan as consideration, in full, for Covered Expenses. This amount does not include any cost sharing amounts (i.e. Copayments or Coinsurance), or charges for non-Covered Expenses; the Provider may bill the Covered Person directly for these amounts.

A Provider with a valid assignment of benefits does **not** have the right to exhaust, on behalf of the Covered Person, the administrative remedies available under this Plan. This right is reserved exclusively for the Covered Person or their Authorized Representative. An assignment of benefits by a Covered Person to a Provider will not constitute the appointment of an Authorized Representative. The Covered Person does not, under any circumstances, have the right to assign to any Provider (or their representative) through an assignment of benefits any right to initiate any cause of action against the Plan that the Covered Person them self may be afforded under applicable law and the terms of the Plan. This includes, but is not limited to, any right to bring suit as such is afforded to Covered Persons under ERISA section 502(a). The assignment of any right to initiate suit against the Plan to a Provider is strictly prohibited.

An assignment of benefits does not grant the Provider any rights other than those specifically set forth herein.

The Plan Administrator may disregard an assignment of benefits at its discretion and continue to treat the Covered Person as the sole recipient of the benefits available under the terms of the Plan.

By submitting a claim to the Plan and accepting payment by the Plan, the Provider is expressly agreeing to the foregoing conditions and limitations of an assignment of benefits in addition to the terms of the Plan Document. The Provider further agrees that the payments received constitute an "accord and satisfaction" and consideration in full for the Covered Expenses rendered. The Provider agrees that the conditions and limitations of an assignment of benefits as set forth herein shall supersede any previous terms and/or agreements. The Provider agrees to the specific condition that the Covered Person may not be balance billed for any amount beyond applicable cost sharing amounts (i.e. Copayments or Coinsurance), or charges for non-Covered Expenses; the Provider may bill the Covered Person directly for these amounts.

If a Provider refuses to accept an assignment of benefits under the conditions and limitations as set forth herein, any benefits payable under the terms of the Plan Document will be payable directly to the Covered Person and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Expenses.

ARTICLE XII -
COORDINATION OF BENEFITS

DEFINED TERMS

Allowable Expense(s) means the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Application to Benefit Determinations provision in this section, this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses.

When some "other plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any other plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Other plan includes, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Covered Person.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third-party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

Standard Coordination of Benefits. The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charges.

Benefits Subject to This Provision. The following shall apply to the entirety of the Plan and all benefits described therein.

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

The Plan's benefits will be excess to, whenever possible, any of the following:

1. Any primary payer besides the Plan.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation. When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

EFFECT ON BENEFITS

Application to Benefit Determinations. The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a claim determination period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the other plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

1. The other plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.

2. The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the other plan.

Order of Benefit Determination. For the purposes of the provision entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan.

2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such person as a Dependent.

3. If the person for whom claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

4. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody.

5. When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

6. Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the Child as a Dependent Child.

7. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

8. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information. The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any other plan. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment. A payment made under any other plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery. Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Person or their Dependents.

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

Applicable to Active Employees and Spouses Ages 65 and Over. An Active Employee and their spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Covered Persons Eligible for Medicare Benefits. To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Covered Persons Who Are Covered Under This Plan. If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XIII -
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

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

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

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

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

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

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

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

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

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

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

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

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

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

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

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

Covered Person is a Trustee Over Plan Assets. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement,

judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that they are required to:

1. Notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

2. Instruct their attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on all settlement drafts.

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

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

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

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

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

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

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

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

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

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

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

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

1. Names, addresses and telephone numbers of all parties to the arrangement;

2. Names, addresses and telephone numbers of any escrow or trustee;

3. Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for the services of baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive;

4. A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and

5. Any other information the Plan requests in order to satisfy its rights.

Information must be sent to:

Plan Administrator
Salad Collective, LLC
14143 Denver West Parkway, Suite 260
Golden, CO 80401
(303) 880-4236

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

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

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

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

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

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

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

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

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

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

7. To notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement.

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

9. To instruct their attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on any settlement draft.

10. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its Authorized Representative as a payee on the settlement draft.

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

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

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

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

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

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

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

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

ARTICLE XIV -
COBRA CONTINUATION COVERAGE

INTRODUCTION

The right to COBRA Continuation Coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Covered Persons and Dependents when group health coverage would otherwise end. For more information about a Covered Persons rights and obligations under the Plan and under federal law, review this section thoroughly. For any additional questions, contact the Plan Administrator.

Covered Persons may have other options available when group health coverage is lost. For example, a Covered Person may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, a Covered Person may qualify for lower costs on monthly premiums and out-of-pocket costs. Additionally, Covered Persons may qualify for a 30-day special enrollment period for another group health plan for which they are eligible (such as a spouse's (or domestic partner's) plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage otherwise would end because of a life event. This is also known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Covered Persons and Dependents could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

An eligible Employee, who is properly enrolled in the Plan, will become a qualified beneficiary if coverage under the Plan is lost due to one of the following qualifying events:

- Hours of employment are reduced; or
- Employment ends for any reason other than gross misconduct.

A spouse of an eligible Employee will become a qualified beneficiary if coverage under the Plan is lost due to one of the following qualifying events:

- The Active Employee dies;
- The Active Employee's hours of employment are reduced;
- The Active Employee's employment ends for any reason other than gross misconduct;
- The Active Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- There is a divorce or legal separation from the Active Employee.

Dependent Children will become qualified beneficiaries if they lose coverage under the Plan due to one of the following qualifying events:

- The Active Employee dies;
- The Active Employee's hours of employment are reduced;
- The Active Employee's employment ends for any reason other than gross misconduct;
- The Active Employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- Failure to continue to qualify as a Dependent Child as defined by this Plan.

Note: Medicare entitlement means that Covered Persons are eligible for and enrolled in Medicare.

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary. The retired Employee's spouse, surviving spouse, and Dependent Children also will become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer (for covered retirees only), or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the qualifying event.

For all other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), Covered Persons must notify the Plan Administrator within 60 days after the qualifying event occurs. This notice must be provided in writing to:

Plan Administrator
Salad Collective, LLC
14143 Denver West Parkway, Suite 260
Golden, CO 80401
(303) 880-4236

Notice must be postmarked (if mailed) or dated (if emailed or hand-delivered) on or before the 60th day following the qualifying event.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives 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 on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying even during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which the 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Cobra Continuation Coverage. If an Active Employee or Dependent covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and they notify the Plan Administrator in a timely fashion, as outlined below, Covered Persons may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a qualifying event occurs;
- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or

- The date on which the qualified beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18-months of COBRA continuation coverage.

The notice must include the name of the qualified beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

Covered Persons must provide this notice to:

Plan Administrator
Salad Collective, LLC
14143 Denver West Parkway, Suite 260
Golden, CO 80401
(303) 880-4236

Second Qualifying Event Extension of 18-Month Period of Cobra Continuation Coverage. If a Covered Person experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second qualifying event. This extension may be available to the spouse and any Dependent Children receiving COBRA continuation coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan. This extension is only available if the second qualifying event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Notice of a second qualifying event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant qualifying event occurs;
- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or
- The date on which the qualifying beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the qualified beneficiary experiencing the second qualifying event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

Covered Persons must provide this notice to:

Plan Administrator
Salad Collective, LLC
14143 Denver West Parkway, Suite 260
Golden, CO 80401
(303) 880-4236

DOES COBRA CONTINUATION COVERAGE EVER END EARLIER THAN THE MAXIMUM PERIODS ABOVE?

COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date the Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the qualified beneficiary's failure to make timely payment of any required premium;
- The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Covered Person.

HOW DOES ONE PAY FOR COBRA CONTINUATION COVERAGE?

Once COBRA continuation coverage is elected, Qualified Beneficiaries must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Covered Persons can learn more about many of these options at www.HealthCare.gov.

CAN ONE ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER GROUP HEALTH PLAN COVERAGE ENDS?

In general, if a Covered Person does not enroll in Medicare Part A or B when they are first eligible because they are still employed, after the Medicare initial enrollment period, they have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after the employment ends; or
- The month after group health plan coverage based on current employment ends.

If a Covered Person does not enroll in Medicare and elects COBRA continuation coverage instead, they may have to pay a Part B late enrollment penalty and they may have a gap in coverage if they decide they want Part B later. If they elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate the continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if they enroll in the other part of Medicare after the date of the election of COBRA coverage.

If an individual is enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF THERE ARE QUESTIONS

Questions concerning this Plan and COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Employee rights including COBRA, the Patient Protection

and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

ADDITIONAL INFORMATION

Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator:

Plan Administrator
Salad Collective, LLC
14143 Denver West Parkway, Suite 260
Golden, CO 80401
(303) 880-4236

CURRENT ADDRESSES

Let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. Covered Persons should also keep a copy, for their records, of any notices sent to the Plan Administrator.

ARTICLE XV -
RESPONSIBILITIES FOR PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible. The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator, in its discretion, that the Covered Person is entitled to them.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, shall be considered ambiguous and shall be interested by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may amend retroactively to cure such ambiguity, notwithstanding anything in the Plan to the contrary.

DUTIES OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;

2. To determine all questions of eligibility, status and coverage under the Plan;

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

4. To make factual findings;

5. To decide disputes which may arise relative to a Covered Person's rights;

6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

7. To keep and maintain the Plan Documents and all other records pertaining to the Plan;

8. To appoint and supervise a Claims Administrator to pay claims;

9. To perform all necessary reporting as required by ERISA;

10. To establish and communicate procedures to determine whether a Medical Child Support Order or National Medical Support Notice is a QMCSO;

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

12. To approve, in its sole discretion, payment of, or reimbursement for, Covered Expenses rendered by a Provider which has agreed to a charge for its services that are less than, or equal to, the charges that would otherwise be paid by the Plan; provided, reimbursement to a Covered Person for a Provider that accepts only cash payments from the Covered Person, shall be subject to the applicable Deductibles, Copayments or out-of-pocket requirements of the Plan;

13. To negotiate or approve contracts with specific Providers as the Plan Administrator deems is in the best interest of the Plan; including payment of a different amount payable under the Plan, taking into consideration specific circumstances;

14. To adjust, settle, contest, compromise and arbitrate any claims, debts or damages due and owing to or from the Plan, and to sue, commence or defend any legal proceedings in reference thereto. If the Plan Administrator considers it in the best interest of the Plan, they may abstain from enforcing any right, obligation or claim, or abandon any property held by the Plan;

15. To impose limitations of benefits and/or Providers as the Plan Administrator deems necessary or appropriate to ensure the fiscal viability of the Plan; provided, such limitations shall be applied in a uniform and consistent manner to all persons in similar circumstances; and

16. To perform each and every function necessary for or related to the Plan's administration.

Plan Administrator Compensation. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties. A fiduciary must carry out their duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. In accordance with the Plan Documents to the extent that they agree with ERISA.

The Named Fiduciary. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Claims Administrator is not a fiduciary. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

ARTICLE XVI -
FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived from contributions made to the Salad Collective Health and Welfare Benefits Plan by the covered Employees and Employer contributions.

For Dependent Coverage: Funding is derived from contributions made by the covered Employees.

The level of any Employee contributions will be set by the Employer. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or Institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination.

The Plan Sponsor or Plan Administrator reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

DISTRIBUTION OF ASSETS

Subject to the requirements of ERISA §402, in the event of a termination or partial termination of the Plan or Trust (if applicable), Salad Collective, LLC shall direct the disposition of Plan assets pursuant to applicable law and governing documents, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by an Employer.

ARTICLE XVII -
HIPAA PRIVACY AND SECURITY

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

DISCLOSURE OF SUMMARY HEALTH INFORMATION TO THE PLAN SPONSOR

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

Summary Health Information may be individually identifiable health information, and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

Protected Health Information (PHI) means individually identifiable health information, created or received by a health care Provider, health plan, Employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; 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 is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or

employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

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

    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        - **Privacy officer; and**
        - **Other individuals trained and authorized by the privacy officer to receive PHI.**

    b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

    c. In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non- compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

        "Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

CONTACT INFORMATION

Privacy Officer Contact Information:
Privacy Officer
Salad Collective, LLC
14143 Denver West Parkway, Suite 260
Golden, CO 80401
(303) 880-4236

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

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

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

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

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

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

ARTICLE XVIII -
CERTAIN COVERED PERSONS RIGHTS UNDER ERISA

Covered Persons in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Covered Persons shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan Documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Continue health care coverage for a Covered Person, spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or Dependents may have to pay for such coverage.

- Review this summary plan description and the documents governing the Plan or the rules governing COBRA Continuation Coverage rights.

If a Covered Person's claim for a benefit is denied or ignored, in whole or in part, the Covered Person has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, they may file suit in federal court.

In addition to creating rights for Covered Persons, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Persons and their beneficiaries. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent the Covered Person from obtaining benefits under the Plan or from exercising their rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order them to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Covered Person has any questions about the Plan, they should contact the Plan Administrator. If the Covered Person has any questions about this statement or their rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Covered Person should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

ARTICLE XIX -
GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan, and the administration is provided through a Claims Administrator. The funding for the benefits is derived from contributions by Salad Collective, LLC and contributions made by the covered Employees. The Plan is not insured.

PLAN NAME: Salad Collective Health and Welfare Benefits Plan

PLAN NUMBER: 501

TAX ID NUMBER: 80-0099677

PLAN EFFECTIVE DATE: January 1, 2025

PLAN YEAR: January 1st through December 31st

APPLICABLE LAW: Employee Retirement Income Security Act of 1974, as amended (ERISA)

PLAN SPONSOR
Salad Collective, LLC
14143 Denver West Parkway, Suite 260
Golden, CO 80401
(303) 880-4236

PLAN ADMINISTRATOR
Salad Collective, LLC
14143 Denver West Parkway, Suite 260
Golden, CO 80401
(303) 880-4236

NAMED FIDUCIARY
Salad Collective, LLC
14143 Denver West Parkway, Suite 260
Golden, CO 80401
(303) 880-4236

AGENT FOR LEGAL PROCESS
(In addition, service of legal process may be made upon the Plan Administrator.)
Salad Collective, LLC
14143 Denver West Parkway, Suite 260
Golden, CO 80401
(303) 880-4236

CLAIMS ADMINISTRATOR
Personify Health Solutions, LLC
P.O. Box 1590
Covington, LA 70434
(855) 613-4330

I, Wendy Hull (Name), certify that I am the SVP of HR (Title) of Salad Collective, LLC for the above-named Plan which has an initial effective date of 01/01/2023 and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms stated herein and am hereby authorizing the implementation of the Plan as of the effective date stated above.

Signature: DocuSigned by: Wendy Hull 1437273CAA69446...

Print Name: **Wendy Hull**

Date: **7/24/2025**