Coffeyville Regional Medical Center
Employee Vision Plan

Summary Plan Description
&
Plan Document

CONCIERGE
Third Party Administrator

COFFEYVILLE REGIONAL MEDICAL CENTER

EMPLOYEE VISION PLAN

TABLE OF CONTENTS

COFFEYVLLE REGIONAL MEDICAL CENTER

EMPLOYEE VISION PLAN

PLAN INTRODUCTION

This document serves as the Summary Plan Description and controlling Plan Document, as required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. (ERISA), for the Employee Vision Plan, and will herein be referred to as the "Plan". Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

All eligible individuals who apply and are accepted as members of the Plan agree to abide by all terms and conditions set forth in this document. It is the Employee's responsibility to read this document and share it with any Dependents covered by the Plan.

The Plan is considered an Excepted Benefit, ERISA health and welfare benefit plan and the responsibility for the administration of the Plan is with the Plan Administrator. For the name, address and other important information regarding the Plan Administrator, refer to the Information Section of this Plan Document. Concierge Administrative Services is the Benefits Administrator for the Plan. For questions regarding claims processing and benefit information, contact the Benefits Administrator at:

Concierge Administrative Services
P.O. Box 4070
Bartlesville, OK 74006
Toll-Free: 888.820.5687
Fax: 918.333.9505
Email: www.cbscas.com

The Plan Administrator reserves the right to terminate or modify the provisions of this Plan at any time without notice or the consent of any person. Such termination or modification will be made in writing and communicated to Plan Members by the Plan Administrator. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Plan Member or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Employer with the bargaining representatives of any Employees.

PARTICIPATING VISION PROVIDER NETWORKS

The Vision Plan does not participate in a vision network; therefore, Plan Members may receive services from any Vision Professional who is licensed for the vision service being provided.

SUMMARY OF VISION BENEFITS

This Summary of Benefits is intended to provide an outline of the benefits provided in the employer's group employee Vision Plan. This Plan is considered an Excepted Benefit and therefore, HIPAA Portability Rules and ACA requirements do not apply. See the specific benefit under the Covered Vision Benefits as well as the Vision Exclusions and Limitations section in the Plan Document for complete details of each benefit.

All services must be Medically Necessary and can be rendered by any Vision Professional who is licensed to perform the services. Plan Members will have a 90-day waiting period prior to benefits being paid by the Plan for Hardware & Other Services. All eligible vision services apply to a combined maximum Plan payment of $600 per Plan Member per Benefit Year. Charges that exceed the maximum Plan Benefit Year payment, or that are not covered benefits of the Plan, will be the Plan Member's responsibility for payment.

Benefit Year, Annual Deductible, Benefit Year Maximums	
Benefit Year	January 1st-December 31st
Annual Deductible	None
Benefit Year Maximum Payment by the Plan	$600 per Plan Member for combined services
Waiting Period for Hardware & Other Services	90 days
Lasik Services	Not Covered by the Plan
Cosmetic Services	Not Covered by the Plan

Vision Service	Plan Member Pays	Plan Pays	Applies to Annual Max	Explanation & Limitations
Routine Eye Examination	$25 Co-pay	100%	Yes	1 routine exam per Benefit Year per Plan Member to include: • Physician exam • Visual acuity test • Glaucoma test • Refraction • Other Medically Necessary testing performed in the Physician's office
Hardware & Other Services 90-day waiting period prior to benefits being paid by the Plan.	$0 Co-pay	100%	Yes	Includes: • Frames • Single lenses • Bifocal lenses • Trifocal lenses • Progressive lenses • Lenticular lenses • Contacts (conventional or disposable) • Anti-Scratch Coating • Anti-Reflective Coating • Prescription Sunglasses • Other Medically Necessary Hardware & Services

DEDUCTIBLES/CO-PAY/BENEFIT YEAR MAXIMUM

Benefit Year Deductible: The Plan does not include any Benefit Year deductibles that must be met.

Co-Pay: A Co-pay is the amount the Plan Member pays each time they receive certain covered benefits. If a Co-Pay applies to a benefit, it will be specifically stated.

Benefit Year Maximum: The Routine Eye Examination and Hardware & Other Services have a combined Benefit Year maximum payment of $600 per Plan Member.

Benefit Year: Is a twelve-month period during which the Benefit Year Maximum is applicable. The Benefit Year begins January 1st and ends December 31st, of each year. Each January 1st, the full Benefit Year Maximum is available for use.

COVERED VISION BENEFITS

This is a description of vision services which are normally covered for a Plan Member if such services are determined to be Medically Necessary and are not excluded or limited by other paragraphs or sections of this document. Always refer to the Vision Exclusions and Limitations Section of this document for more information on services not covered by the Plan.

Services can be rendered by any Vision Professional who is licensed to perform the services. The Plan contains benefits for Routine Eye Examinations and Hardware & Other Services. The Plan applies a 90-day waiting period prior to Hardware & Other Services being paid by the Plan. The Plan pays a Benefit Year maximum per Plan Member of $600 for Routine Eye Examinations and Hardware & Other Services combined. Referrals for specialty care are not required by the Plan.

Routine Eye Examinations: The Plan will pay for one routine eye examination per Plan Member each Benefit Year. The exam may include, but is not limited to:

- Physician exam
- Visual acuity test
- Glaucoma test
- Refraction
- Other Medically Necessary testing performed in the Physician's office.

Plan Member pays ..... $25 Co-Pay per visit
Plan pays, after Co-Pay, ... 100%
Benefit Year Maximum per Plan Member ..... $600 for all combined vision services covered by the Plan
Waiting Period .....None

Hardware & Other Services: The Plan will pay for Medically Necessary Hardware and Other Services as noted below:

Plan Member pays $0
Plan pays 100%
Benefit Year Maximum per Plan Member ..... $600 for all combined vision services covered by the Plan
Waiting Period 90-Days

VISION EXCLUSIONS AND LIMITATIONS

The following are exclusions and limitations for which the Plan does not pay benefits, and these shall apply to services described herein:

Charges for which Payment is not Required: Charges which the Plan Member is not legally obliged to pay;

Complications of Non-Covered Treatments: Includes care, services or treatment required as a result of complications from a treatment not covered under the Plan;

Cosmetic Treatment: Charges in connection with any type of treatment primarily for the purpose of improving appearance, including complications resulting from cosmetic treatment;

Experimental or Investigational Care: Charges for expenses for treatments, procedures, devices or drugs which the Plan determines are experimental, investigational or done primarily for research;

Government Services: Charges for vision care furnished by or paid for by any government or government agency are not covered. However, this exclusion will not apply where prohibited by law;

Illegal Acts: Any injury which is incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Vision Records: To include payment for any records or documents associated with a determination of eligible charges or any appeal by a Plan Member;

Medically Unnecessary: Charges for the care or treatment of unnecessary care or treatment of an illness or injury;

Non-Insured Charges: Charges which would not have been made had no coverage existed;

Non-Physician Care: Charges for care or services not provided by a licensed Physician or which is not within the scope of his/her license;

Occupational Injury/Sickness: Any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit. Claims would be considered for payment if denied by workers' compensation and otherwise an Eligible Expense of the Plan;

Other Charges: Charges for services or non-Physician consultations, missed appointments, requests for reports or filling out claim forms;

Services by a Relative: Charges for vision care furnished by any of the following persons: The Plan Member's Spouse, parent, child, grandparent, brother, sister or parent-in-law are not covered;

Services Outside the United States: Charges for vision care outside the United States is not covered where the Plan Member can reasonably receive treatment within the United States or its territories. This exclusion will not apply to a person traveling on vacation or holiday, a person working in a foreign country, or a foreign exchange student;

Surgery, to include but is not limited to Lasik or Cataract**;**

Telephone Charges: Telephone consultations.

PLAN ELIGIBILITY AND MEMBERSHIP

Who is Eligible to Participate: Participation in the Plan shall be limited to the following categories:

- All active regular, Full-Time Employees who have completed an approved application form, and who meet the Actively-At-Work requirement.

- A Dependent of an eligible Employee, as defined in the Plan and by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, in addition to Dependents designated as Alternate Recipients under Qualified Medical Child Support Orders.

- An Employee Plan Member on an official company approved Leave of Absence, to include the Family Medical Leave Act (FMLA) as defined by the Employer's policy.

- A terminated Plan Member who subsequently enrolled as a COBRA Plan Member.

- All Plan Members must be full-time residents of the United States residing within the 50 states or a U.S. territory.

- A retired Employee that has been consecutively covered under the dental Plan of the Employer since December 31, 2016, is eligible under the Plan.

Waiting Period: First day of the month following completion of an Actively-At-Work period of 30 days. Part-time Employees who become Full-Time Employees will be given credit towards satisfaction of the waiting period while employed part-time. An Employee who has completed one month of part-time employment will be eligible on the first of the month following full-time status.

Rehiring a Terminated Employee: A rehired employee is considered a new employee if they are not credited with any hour of service for 13 consecutive weeks. Upon return, coverage will be effective on the first of the month following the date of rehire, provided all other eligibility criteria are satisfied.

New Members and First Enrollment Period: The eligible employee must elect to participate in the Plan by completing the required enrollment application form. The application form must be signed and submitted for the coverage tier available by the Employer within 31 days after becoming eligible. If the application is approved, coverage will begin at 12:01 a.m. on the first day of the month following the waiting period.

Special Enrollment: Special enrollment rules shall apply to individuals who are eligible but not enrolled for coverage in this Plan where the individual loses coverage in another vision plan, COBRA coverage is exhausted, the employer stops paying the contributions, or the plan no longer offers benefits to a class of individuals that include the Plan Member or Dependent. Special enrollment rules do not apply for loss of eligibility due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (e.g. making a fraudulent claim or intentional misrepresentation).

The employee Plan Member and Dependent have 31 days from the loss of the coverage to make an application to

become members in this Plan. For an eligible person or Dependent who did not enroll during the initial enrollment period or the Open Enrollment period because they had existing vision coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Coverage will begin only if the Plan receives the completed enrollment form and any required premium within 31 days of the date coverage under the prior plan ended.

If a Spouse is covered by their own employer group vision plan and that employer group vision plan has a different open enrollment period than this Plan, the Employee Plan Member and any Dependents on this Plan may choose to drop coverage in this Plan to join the Spouse's employer group vision plan during the Spouse's open enrollment period. Coverage in this Plan will terminate on the day before the Spouse's employer group vision plan's new plan year begins. Proof of enrollment in the Spouse's employer group vision plan is required to terminate coverage in this Plan.

Additional Special Enrollment Rights: This Plan will permit employees and Dependents who are eligible but not enrolled for coverage to enroll in two additional circumstances:

1. The employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the Plan within 60 days after the termination, or
2. The employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

Special Enrollment for New Dependents: If an eligible employee acquires a new Dependent and requests enrollment within 31 days after the event occurs, the effective date of coverage will be:

- on the date of marriage;
- at the date of the Dependent's birth;
- at the date of the Dependent's adoption or the date of placement of adoption;
- on the date of awarded legal guardianship;
- on the date specified on a court or administrative order.

Annual Enrollment: Employees and Dependents will be allowed to change some of their benefit decisions each year during the Plan's Annual Enrollment period. The Annual Enrollment period will be a designated time each year with coverage change effective the first day of the Benefit Year.

Family Coverage: Family coverage includes the eligible employee, his or her Spouse and any married or unmarried Dependent children who qualify until they attain age 26 (coverage from newborn through age 25). Spouses and children of an adult Dependent child are not eligible under the Plan.

Disabled, unmarried Dependent children may be covered regardless of age. Proof of disability will be required for any Dependent over the age of 25. The disabled Dependent must not be able to be self-supporting because of mental or physical handicap or disability and who is dependent mainly on the Employee for support. The eligible employee must apply for Dependent coverage on a form provided by the Plan and agree in writing to pay the required contributions for Dependents. Coverage will continue as long as the Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan. Proof of disability must be provided within 31 days of the date coverage would otherwise end because the child reached a certain age. If proof of the child's disability and dependency is not provided within the 31 days as previous described, coverage for that child will end.

Who is a Dependent: A Dependent will include a Plan Member's Spouse (if not legally separated from the covered Plan Member). The term "Spouse" excludes non-married, same sex marriage, or common law Spouses, unless such relationship is recognized in statute or case law for a state of residence. Common law marriage must be documented as requested by the Benefit Administrator to include proof of an ongoing common law marriage relationship.

All Dependent's must reside within the United States. A Dependent will include the covered Plan Member's married or unmarried children by birth or marriage, including a stepchild, children by legal guardianship, legally adopted children and Dependent children placed for adoption as defined by a court order. If a husband and wife are both covered under the Plan as Employees, they cannot be dependents of each other, and their Dependent children may be covered Dependents of either the husband or the wife but not both. Spouses and children of an adult Dependent child are not eligible under the Plan.

Adopted Child: A child who is adopted by the Plan Member under the state laws in which the member resides or placed with a Plan Member in anticipation of adoption, will be considered a Dependent for the purposes of enrollment in the Plan. To become and remain covered, proof of adoption or proof that the adoption legal process has commenced must be provided to the Plan, as requested.

Court Ordered Guardianship: The Plan will accept the application of a Dependent child who is under the legal guardianship of the Plan Member. The Plan will accept the application of such a child if the Plan Member can show that the child is a Dependent of the employee Plan Member, or if his or her Spouse has legal guardianship of the child. The enrollment will be treated as a Special Enrollment. The Plan will require proof of legal guardianship and Dependent status.

Court Order: If an Employee or the Employee's Spouse is required by court order to obtain coverage for a Dependent child due to divorce, the Dependent child listed on the court order will be allowed to enroll in the Plan on the date as specified in the court order. If the Employee is not currently covered by the Plan, the Employee will be added to the Plan along with the applicable Dependent child.

Dependent Child Coverage Ends: An eligible and enrolled Dependent child will be eligible for coverage from live birth until the end of the month in which the child attains age 26. There will be no coverage after the end of the month that the child attains age 26 (coverage will be provided up to and through age 25)

Qualified Medical Child Support Order: This Plan will provide Dependent coverage (to the extent such coverage is provided under the Plan) with no waiting period for any child of an employee who is recognized under an eligible Qualified Medical Child Support Order as having a right to enrollment in the group health option. Such coverage is contingent on the employee being enrolled in the Plan, completing the appropriate enrollment form and making the appropriate contribution for Dependent coverage. A copy of the QMCSO procedure may be obtained upon request at no cost to the Plan Member by the Employer.

Premium and Employee Contributions: The employer reserves the right to have employees contribute, in full or in part, Premiums to the Plan. Coverage for persons under COBRA is solely the responsibility of the Plan Member(s). Employees on unpaid Leave of Absence or other leave are responsible for paying their portion of the premiums to the Plan on a timely basis, as determined by the employer.

Acquired Companies: Eligible Employees of an acquired company who are Actively at Work and were covered under the prior plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be

eligible on the date of the acquisition.

TERMINATION OF COVERAGE

Termination of Plan Membership: A Plan Member's coverage will terminate with the Plan for any one of the reasons outlined in this section. This termination language will apply to each class of eligible Employee or Dependents. Unless otherwise stated, a Dependent's coverage ends on the date the Employee's coverage ends. Coverage ends:

1. Termination of Employment or Reduction in Hours. The Employee and Dependents are terminated the last day of the month in which the Employee is no longer considered an eligible Employee for benefits.

2. Dependent Eligibility and Notice. Coverage will end the last day of the month in which the Dependent child ceases to be an eligible Dependent.

3. Employee Death. Dependent's coverage will end on the last day of the month in which the death of the Employee Plan Member occurred.

4. Legal Separation or Divorce. Coverage will end on the date designated by a court order.

5. Contributions. If the covered Plan Member or beneficiary fails to remit required contributions within thirty (30) days when such payment is due, then coverage will terminate at the end of the period for which a contribution is made.

6. Leave. At the end of a company approved Leave of Absence or the end of an approved period of disability.

7. COBRA. The day the COBRA Plan Member is no longer eligible for COBRA or after electing COBRA, the day the Plan Member becomes eligible for Medicare or another insurance plan (unless defined otherwise by federal regulations).

8. Military Duty. The date the Plan Member becomes a full-time member of the Armed Forces of any United States on a full-time active duty basis, or a government unit covered by or Uniformed Services Employment and re-employment Rights Act of 1993 (USERRA). Reserve duty, drills and summer camp shall be excluded from the definition of active duty unless such duty lasts over 30 days as defined by the act. Once eligibility in the Plan ends, the Plan Member and eligible Dependents may have continuation rights with the Plan under COBRA as defined by USERRA.

9. Plan Termination. The date the Plan is terminated.

Rescission of Coverage: Coverage under this Plan may be rescinded under certain circumstances. A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Plan Member whose coverage is being rescinded will be provided a thirty (30) day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the thirty (30) day notice period, coverage shall be terminated retroactive to the date identified in the notification. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

CONTINUATION OF COVERAGE

Employer Continuation Coverage: Continued coverage ***may*** be available for eligible Plan Members and their covered Dependents as provided by the Employer. Please contact the Plan Sponsor for further details regarding any continuation of coverage provisions that may apply. *

***Note:** For any Employer sponsored continuation of coverage that exists, coverage will be considered to run concurrently with COBRA continuation coverage.*

Continuation During Family and Medical Leave Act (FMLA) Leave: Regardless of the established leave policies mentioned, the Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

Family and Medical Leave Act of 1993 (FMLA): This applies to Employers with 50 or more Employees for at least 20 work weeks in the current or preceding calendar year. The following are some definitions identified by the FMLA:

Covered Service Member: Shall Mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious Injury or Illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible Employee takes FMLA Leave to care for the covered veteran.

Eligible Employee: Shall mean an individual who has been employed by the Plan Sponsor for at least 12 months, has performed at least 1250 hours of service during the previous 12-month period, and has worked at a location where at least 50 Employees are employed by the Employer within 75 miles.

Family Member: Shall mean the (a) Employee's biological, step, or foster parent or (b) a natural, adopted, foster, or stepchild, or a legal ward under 18 years of age, or 18 years and older and incapable of self-care because of a mental or physical disability or (c) Spouse.

Serious Illness or Injury (of a service member of covered veteran): Shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious Injury or Illness for a current service member includes an Injury or Illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious Injury or Illness for a covered veteran means an Injury or Illness that was Incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

Basic Leave Entitlement: FMLA requires covered Employers to provide up to 12 weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

1. For incapacity due to pregnancy, prenatal medical care or childbirth;
2. To care for the Employee's child after birth, or placement for adoption or foster care;
3. To care for the Employee's Spouse, son, daughter or parent, who has a serious health condition; or
4. For a serious health condition that makes the Employee unable to perform the Employee's job.

Military Family Leave Entitlements: Eligible Employees whose Spouse, son, daughter or parent is on covered active duty or call to covered active-duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible Employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is:

1. A current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness*; or
2. A veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible Employee takes FMLA Leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious Injury or Illness.

***Note:** The FMLA definitions of "serious Injury or Illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition.")*

Benefits and Protections: During FMLA Leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same terms as if the Employee had continued to work. Upon return from FMLA Leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA Leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

Definition of Serious Health Condition: A serious health condition is an Illness, Injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care Provider for a condition that either prevents the Employee from performing the functions of the Employee's job or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave: An Employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when Medically Necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the Employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave: Employees may choose, or Employers may require use of accrued paid leave while taking FMLA Leave. In order to use paid leave for FMLA Leave, Employees must comply with the Employer's normal paid leave policies.

Employee Responsibilities: Employees must provide 30 days advance notice of the need to take FMLA Leave when the need is foreseeable. When a 30-day notice is not possible, the Employee must provide notice as soon as practicable and generally must comply with an Employer's normal call-in procedures.

Employees must provide sufficient information for the Employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the Employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the Employer if the requested leave is for a reason for which FMLA Leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities: Covered Employers must inform Employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the Employees' rights and responsibilities. If they are not eligible, the Employer must provide a reason for the ineligibility.

Covered Employers must inform Employees if leave will be designated as FMLA-protected and the amount of leave counted against the Employee's leave entitlement. If the Employer determines that the leave is not FMLA-protected, the Employer must notify the Employee.

Unlawful Acts by Employers: FMLA makes it unlawful for any Employer to:

1. Interfere with, restrain, or deny the exercise of any right provided under FMLA; and
2. Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement: An Employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an Employer. FMLA does not affect any Federal or State law prohibiting discrimination or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered Employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For Additional Information: 1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV
U.S. Department of Labor Wage and Hour Division
WHD Publication 1420 · Revised February 2013

Continuation During USERRA: Plan Members who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to 24 months. To continue coverage, Plan Members must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Plan Member elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Plan Members should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Continuation During COBRA – Introduction: The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Employee Plan Members when they otherwise would lose their group health coverage. It also can become available to Dependent's who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Employee Plan Member or their covered

Dependent fail to make timely payment of contributions or premiums. Plan Members should check with their Employer to see if COBRA applies to them and/or their covered Dependents.

COBRA Continuation Coverage: Is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the Employer's plan) are not considered for continuation under COBRA.

Qualifying Events: Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Plan Member." The Employee, the Employee's Spouse, and the Employee's Dependent Children could become Qualified Plan Members if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an Employee covered under the Plan) will become a Qualified Plan Member if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason other than gross misconduct.

The Spouse of a covered Employee will become a Qualified Plan Member if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The Spouse dies;
2. The Spouse's hours of employment are reduced;
3. The Spouse's employment ends for any reason other than his or her gross misconduct;
4. The Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The Spouse becomes divorced from his or her Spouse.

If a proceeding in bankruptcy is filed with respect to the Plan Sponsor, and that bankruptcy results in the loss of coverage of any retired Employee, Spouse or surviving Spouse covered under the Plan, such member will become a Qualified Plan Member with respect to the bankruptcy.

Employer Notice of Qualifying Events: When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

Employee Notice of Qualifying Events: Each covered Employee or Qualified Dependent is responsible for providing the COBRA Administrator* with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce of a covered Employee (or former Employee) from his or her Spouse;

2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;

3. Notice of the occurrence of a second Qualifying Event after a Qualified Plan Member has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;

4. Notice that a Qualified Plan Member entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage; and

5. Notice that a Qualified Plan Member, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

Deadline for Providing the Notice for Qualifying Events: As described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;

2. The date on which the Qualified Plan Member loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

3. The date on which the Qualified Plan Member is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;

2. The date on which a Qualifying Event occurs;

3. The date on which the Qualified Plan Member loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

4. The date on which the Qualified Plan Member is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be furnished before the end of the first 18 months of COBRA Continuation Coverage. For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Plan Member is no longer disabled; or

2. The date on which the Qualified Plan Member is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate

on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who Can Provide the Notice: Any individual who is the covered Employee (or former Employee), a Qualified Plan Member with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Plan Member, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Plan Member with respect to the Qualifying Event.

Required Contents of the Notice: The notice must contain the following information:

1. Name and address of the covered Employee or former Employee;

2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;

3. A description of the Qualifying Event (for example, divorce, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Plan Member or loss of disability status);

4. In the case of a Qualifying Event that is divorce, name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan, date of divorce, and a copy of the decree of divorce;

5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan;

6. In the case of a Qualifying Event that is a Dependent child's cessation of Dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible Dependent (for example, attained limiting age, lost student status or other);

7. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan;

8. In the case of a Qualifying Event that is disability of a Qualified Plan Member, name and address of the disabled Qualified Plan Member, name(s) and address(es) of other members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Plan Member who is no longer disabled, name(s) and address(es) of other members covered under the Plan, the date the disability ended and the date of the SSA's determination; and

10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Plan Member, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage: Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event if COBRA is administered by the Employer or within 44 days if the COBRA is being administered by a third party. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions is mailed. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Plan Member will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their eligible Spouses and Dependent child(ren). In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

Duration of COBRA Continuation Coverage: COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage. When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Plan Members other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her eligible Spouse and Dependent child(ren) can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability Extension of COBRA Continuation Coverage: If an Employee or anyone in an Employee's family is covered under the Plan and is determined by the SSA to be disabled and the Employee notifies the COBRA Administrator as set forth above, the Employee and his or her Dependents 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. An extra fee will be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event Extension of COBRA Continuation Coverage: If an Employee experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the eligible Dependents can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the Dependents receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, but only if the event would have caused the Dependents to lose coverage under the Plan had the first Qualifying Event not occurred.

Shorter Duration of COBRA Continuation Coverage: COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the Employer ceases to provide a group health plan to any Employee;

2. The date on which coverage ceases by reason of the Qualified Plan Member's failure to make timely payment of any required contributions or premium;

3. The date that the Qualified Plan Member 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); or

4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Plan Member 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.

Contribution and/or Premium Requirements: Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not mailed (post marked) by the end of the month in which the payment is due, COBRA Continuation Coverage will be canceled and will not be reinstated.

Current Addresses: In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator informed of any changes in the addresses of the family members.

Marketplace: HHS regulations provide special enrollment periods for plans in the Marketplace to individuals eligible for COBRA when: 1) such individuals initially are eligible for COBRA due to a loss of other minimum essential coverage; and 2) when such individual's COBRA coverage is exhausted. In addition, COBRA beneficiaries can choose plans in the Marketplace during the annual open enrollment period and if they are determined eligible for any other special enrollment periods outside of the open enrollment period.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third-Party Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Third-Party Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of

the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator: The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with these provisions. 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 shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Plan Member'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 decides, in its discretion, that the Plan Member is entitled to them.

If due to errors in drafting, any Plan provision that do 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, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

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 Plan Member's rights and/or availability of benefits;
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 Third-Party Administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
11. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan: The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, 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).

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable Federal and State law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion. If the Plan is terminated, the rights of the Plan Members are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Misuse of Identification Card: If an Employee or covered Dependent permits any person who is not a covered Plan Member to use any identification card issued, the Plan Sponsor may give the Employee a written notice that his (and his Dependent's) coverage will be terminated at the end of 31 days from the date written notice is given.

CLAIMS PROCEDURES /PAYMENT OF CLAIMS

The procedures outlined below must be followed by Plan Members to obtain payment of health benefits under this Plan.

Health Claims: All claims and questions regarding health claims should be directed to the Third-Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Plan Member is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third-Party Administrator. The Third-Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Plan Member claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Plan Member has not incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Plan Member shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A phone call from a provider checking eligibility of an individual or checking to see if a certain procedure is covered by the Plan prior to providing treatment, is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a clean claim must be filed with the Plan (which will be a "Post service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Plan Member has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Adverse Benefit Determination. If the Plan Member receives notice of a Final Adverse Benefit Determination, or if the Plan does not

follow the claims procedures properly, the Plan Member then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Plan Member or to a provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

1. his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

   The Plan does not require the Plan Member to obtain approval of any urgent care or Emergency services or prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-Service, Urgent Care Claims" under the Plan. The Plan Member simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

2. Pre-Admission Certification of a Non-Emergency Hospital Admission. Is a "claim" only to the extent of the determination made that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Plan Member has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-Service Claim.

When Claims Must Be Filed: Post-Service Claims must be filed with the Third-Party Administrator within 180 days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Third-Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Third-Party Administrator within 45 days from receipt by the Plan Member of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions: The Plan Administrator shall notify the Plan Member, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-Service, Urgent Care Claims:
   - If the Plan Member has provided all the necessary information, as soon as possible, taking into account the vision exigencies, but not later than 72 hours after receipt of the claim.
   - If the Plan Member has not provided all of the information needed to process the claim, then the Plan Member will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.
   - The Plan Member will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the vision exigencies, after the earliest of:
     - The Plan's receipt of the specified information; or
     - The end of the period afforded the Plan Member to provide the information.

- If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Plan Member. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Plan Member by telephone, facsimile, or other similarly expeditious method. Alternatively, the Plan Member may request an expedited review under the external review process.

2. Pre-Service, Non-Urgent Care Claims:
    - If the Plan Member has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the vision circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    - If the Plan Member has not provided all of the information needed to process the claim, then the Plan Member will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Plan Member will be notified of a determination of benefits in a reasonable period of time appropriate to the vision circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Plan Member (if additional information was requested during the extension period).

3. Concurrent Claims:
    - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Plan Member of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Plan Member will be notified sufficiently in advance of the reduction or termination to allow the Plan Member to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
    - Request by Plan Member Involving Urgent Care. If the Plan Administrator receives a request from a Plan Member to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the vision exigencies, but not later than 72 hours after receipt of the claim, as long as the Plan Member makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Plan Member submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
    - Request by Plan Member Involving Non-Urgent Care. If the Plan Administrator receives a request from the Plan Member to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
    - Request by Plan Member Involving Rescission. With respect to rescissions, the following timetable applies:

        - Notification to Plan Member . . . . . 30 days
        - Notification of Adverse Benefit Determination on appeal . . . . . 30 days

4. Post-Service Claims:
    - If the Plan Member has provided all of the information needed to process the claim, in a reasonable

period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

- If the Plan Member has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Plan Member will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Plan Member will be notified of the determination by a date agreed to by the Plan Administrator and the Plan Member.

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

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

Notification of an Adverse Benefit Determination:
The Plan Administrator shall provide a Plan Member with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. Information sufficient to allow the Plan Member to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

2. A reference to the specific portion(s) of the Plan Document upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

4. A description of any additional information necessary for the Plan Member to perfect the claim and an explanation of why such information is necessary.

5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Plan Member's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;

6. A statement that the Plan Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Plan Member's claim for

benefits;

7. The identity of any vision or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Plan Member, free of charge, upon request);

9. In the case of denials based upon a vision judgment (such as whether the treatment is Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Member's vision circumstances, or a statement that such explanation will be provided to the Plan Member, free of charge, upon request; and

10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

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

1. Plan Members at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

2. Plan Members the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. Plan Members the opportunity to review the claim file and to present evidence and testimony as part of the internal claims and appeals process;

4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

5. For a review that takes into account all comments, documents, records, and other information submitted by the Plan Member relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;

6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a vision judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the vision judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

7. For the identification of vision or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

8. That a Plan Member will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Plan Member's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Plan Member's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Member's medical and vision circumstances; and

9. That a Plan Member will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Plan Member to respond to such new evidence or rationale.

Requirements for Appeal: The Plan Member must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Plan Member chooses to orally appeal, the Plan Member may telephone the number shown below. To file an appeal in writing, the Plan Member's appeal must be addressed as follows and mailed or faxed as follows:

Concierge Administrative Services, LLC
P.O. Box 4070
Bartlesville, OK 74006
Fax: 918-333-9505
Phone: 888-820-5687

It shall be the responsibility of the Plan Member to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Plan Member;
2. The Employee/Plan Member's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Plan Member will lose the right to raise factual arguments and theories which support this claim if the Plan Member fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Plan Member has which indicates that the Plan Member is entitled to benefits under the Plan.

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

1. Information sufficient to allow the Plan Member to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

4. A description of any additional information necessary for the Plan Member to perfect the claim and an explanation of why such information is necessary;

5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

6. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Plan Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

7. A statement that the Plan Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Plan Member's claim for benefits;

8. The identity of any vision or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

9. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Plan Member, free of charge, upon request;

10. In the case of denials based upon a vision judgment (such as whether the treatment is Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Member's vision circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Plan Member, free of charge, upon request; and

11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination: In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review: The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

Appointment of Authorized Representative: A Plan Member is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An Assignment of Benefits by a Plan

Member to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Plan Member must complete a form which can be obtained from the Plan Administrator or the Third-Party Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Plan Member's vision condition to act as the Plan Member's authorized representative without completion of this form. In the event a Plan Member designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Plan Member, unless the Plan Member directs the Plan Administrator, in writing, to the contrary.

Physical Examinations: The Plan reserves the right to have a Physician of its own choosing examine any Plan Member whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Plan Member must comply with this requirement as a necessary condition to coverage.

Autopsy: The Plan reserves the right to have an autopsy performed upon any deceased Plan Member whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits: All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her 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 Employee.

Assignments: Benefits for vision expenses covered under this Plan may be assigned by a Plan Member to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

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

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

Benefits due to any Network Provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Non-U.S. Providers: Vision expenses for care, supplies, or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;

2. The Plan Member is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements;
5. Claims for benefits must be submitted to the Plan in English; and
6. Travel outside the U.S. cannot be for the express (sole) purpose of obtaining vision care.

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

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Member, Provider or other person or entity to enforce the provisions of this section, then that Plan Member, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Members and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Members) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Member(s) are entitled, for or in relation

to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

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

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Member fails to comply with the Plan's Third-Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

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

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

Medicaid Coverage: A Plan Member's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Plan Member. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Plan Member, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

COORDINATION OF BENEFITS

Benefits Subject to This Provision: This provision shall apply to all benefits provided under any section of this Plan.

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

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through vision payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or

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

Allowable Expenses: "Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some other plan pays first in accordance with the Application to Benefit Determinations section herein, 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, in the amount that would be payable in accordance with the terms of the Plan, 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.

Effect on Benefits

Application to Benefit Determinations: The plan that pays first according to the rules in the section 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 vision 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:

1. The other plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section 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 section 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. If an individual is covered under one plan as a dependent and another plan as an employee, the plan that covers the person as an employee is considered primary. The primary plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from his or her Employer's benefit plan.
3. The plan that covers a person as a dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See the section on Medicare below for exceptions to this rule.

Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee) and is also covered under another plan as a retired or laid off employee (or dependent of a retired or laid off employee), the plan that covers the person as an active employee (or dependent of an active employee)

will be primary. This rule does not apply if the rule in the third paragraph above can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four items above applies. (See exception in the Medicare section.)

Longer or Shorter Length of Coverage: The plan that covered the person as an employee or the retiree the longest is the primary.

1. If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee is considered primary.
2. If the above rules do not determine the primary plan, the covered expenses may be shared equally between the plans. This plan will not pay more than it would have paid, had it been primary.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any other plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, 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, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery: In accordance with the recovery of payments provision, 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 article, 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 Plan Member or his or her Dependents. Please the recovery of payments provision above for more details.

MISCELLANEOUS PROVISIONS

Applicable Law: This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Claims Audit: In addition to the Plan's vision record review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority

for selection of claims subject to review or audit.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document. Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accordance with the terms of this Plan Document.

Clerical Error/Delay: Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Plan Members have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity With Applicable Laws: This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

Fraud: The following actions by any Plan Member, or a Plan Member's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the Employee and covered Spouse:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Member of the Plan;
2. Attempting to file a claim for a Plan Member for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Headings: The headings used in this Plan Document are used for convenience of reference only. Plan Members are advised not to rely on any provision because of the heading.

No Waiver or Estoppel: No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Plan Contributions: The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Plan Member.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and

sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payments.

In the event that the Employer terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Right to Receive and Release Information: For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Plan Member for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Plan Member claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Written Notice: Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery: In accordance with the recovery of payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, 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 amount, and any future benefits payable to the Plan Member or his or her Dependents. See the recovery of payments provision for full details.

Statements: All statements made by the Employer or by a Plan Member will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Plan Member.

Any Plan Member who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Plan Member may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors: No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Plan Member, the Plan Administrator in its sole discretion may terminate the interest of such Plan Member or former Plan Member in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Plan Member or former Plan Member, his/her

Spouse, parent, adult child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Plan Member or former Plan Member, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

Unclaimed Self-Insured Plan Funds: In the event a benefits check issued by the Third-Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Plan Member subsequently requests payment with respect to the voided check, the Third-Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA.

HIPAA PRIVACY

The Plan provides each member with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling the Plan Sponsor at the phone number included in Article II -Introduction and Purpose; General Plan Information.

Definitions:

Breach: Means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

Protected Health Information ("PHI"): Means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or 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 that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information: The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Members. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.
The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Member's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Plan Member's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Plan Member's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed: In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes: 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. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose genetic information for underwriting purposes;
7. 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;
8. 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;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. 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);
11. 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);
12. 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);
13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
14. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
15. 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

16. 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:
17. 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: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

18. In the event any of the individuals described 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. The Plan Administrator will promptly report such violation or non-compliance to the Plan and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. 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.

Disclosure of Summary Health Information to the Plan Sponsor: The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Member. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

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 un-enrolled 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 may hereby authorize and direct the Plan, through the Plan Administrator or the Third-Party 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.

Other Disclosures and Uses of PHI

Primary Uses and Disclosures of PHI:

1. Treatment, Payment and Health Care Operations. The Plan has the right to use and disclose a Plan Member's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;

2. Business Associates. The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Member's information; and

3. Other Covered Entities. The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Member, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Member has coverage through another carrier.

Other Possible Uses and Disclosures of PHI:

1. Required by Law. The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;

2. Public Health and Safety. The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

   - Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
   - Locate and notify persons of recalls of products they may be using; and
   - A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;

   The Plan may disclose PHI to a government authority when required or authorized by law, or with the Plan Member's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Member that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;

3. Health Oversight Activities. The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;

4. Lawsuits and Disputes. The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Member's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Member of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;

5. Law Enforcement. The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Member's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;

6. Decedents. The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;

7. Research. The Plan may use or disclose PHI for research, subject to certain limited conditions;

8. To Avert a Serious Threat to Health or Safety. The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;

9. Worker's Compensation. The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and

10. Military and National Security. The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI:

1. Disclosures to Plan Members: The Plan is required to disclose to a Plan Member most of the PHI in a Designated Record Set when the Plan Member requests access to this information. The Plan will disclose a Plan Member's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.
    - The Plan may elect not to treat the person as the Plan Member's personal representative if it has a reasonable belief that the Plan Member has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Member's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Member; and
    - Disclosures to the Secretary of the U.S. Dept. of Health and Human Services: The Plan is required to disclose the Plan Member's PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed from Plan Members Before Disclosing PHI:

1. Uses and disclosures for marketing;
2. Sale of PHI; and
3. Other uses and disclosures not described in this section can only be made with authorization from the Plan Member. The Plan Member may revoke this authorization at any time.

Plan Member's Rights: The Plan Member has the following rights regarding PHI about him/her:

1. Request Restrictions. The Plan Member has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Member may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;

2. Right to Receive Confidential Communication. The Plan Member has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Member would like to be contacted. The Plan will accommodate all reasonable requests;

3. Right to Receive Notice of Privacy Practices. The Plan Member is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;

4. Accounting of Disclosures. The Plan Member has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Member is entitled to such an accounting for the 6 years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Member of the basis of the disclosure, and certain other information. If the Plan Member wishes to make a request, please contact the Privacy Compliance Coordinator;

5. Access. The Plan Member has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Member requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Plan Member and the recipient must be clearly identified. The Plan must respond to the Plan Member's request within 30 days (in some cases, the Plan can request a 30-day extension). In very limited circumstances, the Plan may deny the Plan Member's request. If the Plan denies the request, the Plan Member may be entitled to a review of that denial;

6. Amendment. The Plan Member has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Member's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and

7. Fundraising Contacts. The Plan Member has the right to opt out of fundraising contacts.

Questions or Complaints: If the Plan Member wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Member may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Member with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Member for filing a complaint with the Plan or the U.S. Department of Health and Human Services. For Privacy Compliance Coordinator Contact Information, please contact the Plan Sponsor at the number indicated in Article II Purpose of Plan; General Information.

HIPAA SECURITY

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

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE"): The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

Electronic Protected Health Information (ePHI): As defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.

Security Incidents: As defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations: 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 administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI: The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Plan Member whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:

    - Written notice by first-class mail to Plan Member (or next of kin) at last known address or, if specified by Plan Member, e-mail;
    - If Plan has insufficient or out-of-date contact information for the Plan Member, the Plan Member must be notified by a "substitute form;
    - If an urgent notice is required, Plan may contact the Plan Member by telephone.

- The Breach Notification will have the following content:

    i. Brief description of what happened, including date of breach and date discovered;
    ii. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
    iii. Steps Plan Member should take to protect from potential harm;
    iv. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered;

3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by calHHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year; and

4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Plan Members may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

ERISA- PLAN MEMBERS RIGHTS

As a Plan Member in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Members are entitled to:

Receive Information About Your Plan and Benefits: Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies 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, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Plan Member with a copy of this summary annual report.

Continue Group Health Plan Coverage: Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your

COBRA Continuation Coverage rights.

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

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

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

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

DEFINITIONS

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

Actively at Work: The active expenditure of time and energy in the service of the Plan Administrator. An individual will be considered actively at work on each day of a regular paid vacation or on a regular non-working day on which he or she is on a paid or unpaid Leave of Absence, provided he or she was Actively at Work on the last preceding regular working day.

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

- A denial in benefits;
- A reduction in benefits;

- A recession of coverage;
- A termination of benefits; or
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

Amendment: Any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Benefit Year: "Benefit Year" shall mean the 12-month period from January 1st through December 31st of each year.

Co-pay: A Co-pay is the amount the Plan Member pays each time they receive certain covered benefits. If a Co-pay applies to a benefit, it will be specifically stated.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Plan.

Dependent: The legal Spouse or any married or unmarried dependent child (until they attain age 26) of the Employee or the Employee's Spouse. Spouses and children of an adult Dependent child are not eligible under the Plan. The term child includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the Employee or the Employee's Spouse
- A Dependent includes an unmarried dependent child of any age who is or becomes disabled and dependent upon the Employee.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Plan Administrator is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.
A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Eligible Expenses: For covered vision services, incurred while the Plan is in effect, Eligible Expenses are determined by the Plan as stated in the Covered Benefits section of this Plan Document.

Eligible Person: An Employee of the Employer or other person whose connection with the employee meets the eligibility requirements specified in both the application and the Plan. An eligible Employee and their eligible Dependents must reside within the United States.

Employer: Coffeyville Regional Medical Center.

ERISA: ERISA shall mean the Employee Retirement Income Security Act of 1974, as amended.

Excepted Benefits: Benefit Plans that are exempt from ACA and HIPAA Portability Rules.

Experimental or Investigational Service(s): Treatments, procedures or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be Experimental or Investigational by the American Medical Association.

Family and Medical Leave Act (FMLA): If the employer meets the criteria of an eligible employer under the guidelines set forth by the Family and Medical Leave Act of 1993 and the Plan Member is an eligible employee under this Act, the Plan will abide by the rules adopted by the eligible employer for compliance with the Act's requirements for health care coverage.

Full-Time Employee: A Full-Time Employee is one who is considered Actively at Work with the employer, who works an average of 30 hours per week or more on an annual basis, and who is considered an employee under the U. S. Internal Revenue Service. An individual will be considered a Full-Time or eligible Employee while on paid vacation or on a regular non-working day on which he or she is on approved paid or unpaid Leave of Absence, provided he or she was Actively at Work on the last preceding regular working day.

HIPAA: The Health Insurance Portability and Accountable Act of 1996 as passed by Congress and the rules and regulations promulgated by the Department of Labor and other federal agencies.

Initial Enrollment Period: The initial period of time during which eligible Employees may enroll themselves and their Dependents under the Plan.

Injury: Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Late Enrollee: An eligible Employee or Dependent who enrolls for coverage under the Plan at a time other than the following:

- During the Initial Enrollment Period
- During an Open Enrollment Period
- During a special enrollment period
- Within 31 days of the date a new Eligible Person first becomes eligible

Leave of Absence: Any Employee of the Employer who is off work or temporarily working less than a normal schedule with the approval of the employer for medical leave, vacation or personal time off will be on a Leave of Absence. The length of leave will be defined by the employer.

Medically Necessary: To be considered for payment under the Plan, any service or charges submitted to the Plan must meet the conditions of being Necessary by a license Vision Professional. Vision care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function.

Open Enrollment Period: A period of time that follows the Initial Enrollment Period during which eligible Employees may enroll themselves and Dependents under the Plan. The Plan Administrator determines the period of time that is the Open Enrollment Period.

Physician or Licensed Vision Professional: Doctor of Optometry or Ophthalmology or other Licensed Vision Professional who is properly licensed and qualified by law to perform a service.

Plan: Defined as the Coffeyville Regional Medical Center Employee Vision Plan.

Plan Member: An eligible Employee of the Employer or his or her Spouse who has submitted an enrollment form and has been accepted as a member of the Plan. An individual who is eligible for COBRA and is enrolled as a COBRA Plan Member will also be considered a Plan Member.

Premium: The periodic fee required for each Plan Member and each enrolled Dependent, in accordance with the terms of the Plan.

Spouse: A Dependent will include a Plan Member's Spouse (if not legally separated from the covered Plan Member). The term "Spouse" excludes non-married, same sex marriage, or common law Spouses, unless such relationship is recognized in statute or case law for a state of residence. Common law marriage must be documented as requested by the Benefits Administrator to include proof of an ongoing common law marriage relationship. Spouse must reside within the United States.

Total Disability or Totally Disabled: An Employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

OTHER INFORMATION

Name of Plan: Coffeyville Regional Medical Center Employee Vision Plan

Type of Plan: Health and Welfare Plan- Vision-Excepted Benefit

Benefits Administrator:
Concierge Administrative Services
P.O. Box 4070
Bartlesville, OK 74006
Toll-Free: 888.820.5687
Fax: 918.333.9505

EIN: 48-6075501

Group Number: CRMC, Company ID 1000

Plan Administrator:
Cindy Duncan, CHHR, MBA
Senior Director of Human Resources
Coffeyville Regional Medical Center
1400 West 4th Street
Coffeyville, Kansas 6737
1-620-252-1610

Service of legal process may be made upon the Plan Administrator

Plan Sponsor:
Coffeyville Regional Medical Center
1400 West 4th Street
Coffeyville, Kansas 6737
1-620-252-1610

Plan Source of Funding: Self-Funded Plan. Contributions to this Plan may be by employer/or employees. Contributions are based on the amount necessary to provide the coverage required by the Plan.

Applicable Law: ERISA

Plan Year: January 1st through December 31st.

Benefit Year: January 1st through December 31st.

Agent for Service of Process:
Cindy Duncan, CHHR, MBA
Senior Director of Human Resources
Coffeyville Regional Medical Center
1400 West 4th Street
Coffeyville, Kansas 6737
1-620-252-1610

Loss of Benefits: Plan Member must continue to be an eligible member of the class to which the Plan pertains to qualify for benefits.

Fiduciary Name: Cindy Duncan, CHHR, MBA
Senior Director of Human Resources
Coffeyville Regional Medical Center
1400 West 4th Street
Coffeyville, Kansas 6737
1-620-252-1610

Privacy Compliance Officer: Cindy Duncan, CHHR, MBA
Senior Director of Human Resources
Coffeyville Regional Medical Center
1400 West 4th Street
Coffeyville, Kansas 6737
1-620-252-1610

Plan Amendment or Termination: Plan Administrator has the right to amend, modify, or terminate the Plan in any way, at any time, by written notification to Plan Members from the Plan Administrator.

Plan Interpretations: All interpretations of the Plan and all questions concerning its administration and application, including eligibility determinations, shall be the Plan Administrator's at his or her sole and absolute discretion. Such determinations shall be conclusive and binding on all persons. The Benefits Administrator will not have the authority to make Plan interpretations or make judgment decisions for the Plan and will at all times follow the rules of the Plan as defined in the Summary Plan Description and Plan Document. All discretionary questions regarding the payment of claims or the interpretation of the Plan shall be the exclusive right of the Plan Administrator who will have the final authority to authorize or disallow benefit payments in cases where a dispute exists.

ERISA Information: The Plan Member is entitled to certain rights and protections under ERISA. For a description of those rights, see "ERISA Rights" of the Plan.

This Employee Vision Plan Document is approved and effective January 1, 2022.

Cindy Duncan

Plan Administrator Signature