Clemens Family Corporation

Health Benefit Plan

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Effective June 30, 1951
As amended and restated effective May 1, 2019

This document, along with certain component documents, constitutes both the plan document and the summary plan description of the Clemens Family Corporation Health Benefit Plan pursuant to the Employee Retirement Income Security Act of 1974, as amended.

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INTRODUCTION

This plan document and summary plan description provides information about the benefits offered under the Clemens Family Corporation Health Benefit Plan (the "Plan") and your rights and benefits as a Plan participant. You should also refer to the applicable descriptions of benefits, certificates of coverage, evidence of coverage booklets, or other documents for more details on specific provisions of the benefit. These other documents and incorporated by reference into the Plan and together with this document constitute the summary plan description for the Plan and is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974. This plan document and summary plan description has been prepared for participating Team Members of Clemens Family Corporation.

You should review the plan document and summary plan description carefully and keep it along with the other documents described your benefits for future reference.

If you have any questions about the Plan and your benefits, you should contact:

Clemens Family Corporation
2700 Clemens Road
Hatfield, PA 19440
(215) 368-2500

PLAN INFORMATION

The following identifying information is disclosed to participants to comply with the requirements of ERISA.

Plan Name(s):	**Clemens Family Corporation Health Benefit Plan**
Plan Sponsor	Clemens Family Corporation
Plan's Sponsor's EIN:	75-2990438
Plan Number:	501
Effective Date:	July 1, 1951, as amended and restated effective May 1, 2019.
Plan Year:	The Plan Year is the 12-month period beginning on each May 1 and ending on the following April 30.
Source of Contributions:	From Clemens Family Corporation general assets and/or Team Member contributions, when required.
Plan Administrator and Named Fiduciary:	Clemens Family Corporation 2700 Clemens Road, Hatfield, PA 19440 (215) 368-2500
Agent for Service of Legal Process:	Clemens Family Corporation 2700 Clemens Road, Hatfield, PA 19440 (215) 368-2500
Type of Administration:	As indicated in Appendix A, certain benefits under the Plan are insured and are administered by the insurance companies. Others are self-insured and are administered by third party administrators, under contracts with Clemens Family Corporation

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Definitions

Benefit. "Benefit" means a benefit offered under the Plan. More information about the Benefits are set forth in Appendix A.

Claims Administrator. The "Claims Administrator" is the Plan fiduciary with final authority for determining the disposition of any claim for a self-insured Benefit under the Plan. Unless the Plan Administrator appoints another person or committee to serve as the Claims Administrator of the Plan, the Plan Administrator shall serve as the Claims Administrator. The Claims Administrator for each self-insured Benefit is set forth in Appendix A.

Code. "Code" means the Internal Revenue Code of 1986, as amended

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

Component Document. "Component Document" means certain insurance policies, certificates of coverage, summary plan descriptions, or other relevant documents provided to Team Members by the provider of each applicable Benefit option and incorporated herein by reference, including, without limitation, any plan document and Benefit descriptions, under which such Benefit is established or maintained.

Contributions. "Contributions" means the amount contributed to pay the cost of Benefits (including both self-insured and fully insured Benefits).

Covered Person. "Covered Person" has the meaning set forth in the section entitled "Subrogation and Right of Recovery."

Dependent. "Dependent" means, subject to any additional requirements set forth in a Component Document, any individual who is a tax dependent (as defined in Code Section 152) of a Team Member, with the following exceptions:

- For respect to group health Benefits, a Dependent is (1) a dependent as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B); (2) any child (as defined in Code Section 152(f)(1)) of a Team Member who has not attained age 26, and (3) any child to whom IRS Rev. Proc. 2008-48 applies will be treated as a Dependent of both parents; and

- Notwithstanding the foregoing, the Plan will provide Benefits in accordance with the applicable requirements of any QMCSO, even if a child does not otherwise meet the definition of "Dependent."

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

Insurance Coverage. "Insurance Coverage" has the meaning set forth in the section entitled "Subrogation and Right of Recovery."

Insurer. "Insurer" means a group policy issuer for an insured Benefit under the Plan. The Insurers for each insured Benefit are listed in Appendix A.

Participant. "Participant" means a Team Member who meets the eligibility requirements for participating in a Benefit and who has enrolled in such Benefit.

Plan. "Plan" means the Clemens Family Corporation Health Benefit Plan.

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Plan Administrator. "Plan Administrator" means Clemens Family Corporation, or such other person or committee as may be appointed from time to time by Clemens Family Corporation to administer the Plan or to supervise the administration of any Benefit under the Plan.

PHI. "PHI" has the meaning set forth in the section entitled "HIPAA Privacy and Security Rules."

Plan Year. "Plan Year" means the 12-month period beginning on January 1 and ending on the following December 31.

QMCSO. "QMCSO" means a Qualified Medical Child Support Order, as defined in ERISA Section 609.

Responsible Party. "Responsible Party" has the meaning set forth in the section entitled "Subrogation and Right of Recovery."

Spouse. "Spouse" means a Team Member's spouse in accordance with applicable state law. "Spouse" does not include an individual divorced or legally separated from a Team Member.

Team Member. "Team Member" means any person employed by Clemens Family Corporation, or an designated affiliate of Clemens Family Corporation, as a common law employee. Independent contractors and other persons who are not treated by Clemens Family Corporation as employees for purposes of withholding federal income taxes are not eligible to participate regardless of any contrary governmental or judicial determination related to such employment status or tax withholding.

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PLAN ADMINISTRATION

In General

Clemens Family Corporation has the duty and authority to interpret and construe the Plan with respect to all questions of eligibility, the status and rights of any Participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each Team Member must, from time to time, upon request of Clemens Family Corporation, furnish to Clemens Family Corporation, such data and information as Clemens Family Corporation will require in the performance of its duties under the Plan.

Clemens Family Corporation may designate any individual, partnership, corporation, or other entity as the Administrator to carry out its duties and responsibilities with respect to the administration of the Plan. Such designation will be in writing and such writing will be kept with the records of the Plan.

Clemens Family Corporation may adopt such rules and procedures, as it deems desirable for the administration of the Plan, provided that any such rules and procedures will be consistent with provisions of the Plan and ERISA.

Clemens Family Corporation will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Named Fiduciary

Pursuant to ERISA Section 402(a)(1), Clemens Family Corporation is a named fiduciary of the Plan.

Clemens Family Corporation, as Plan Administrator, will retain the authority to delegate to officers and Team Members of Clemens Family Corporation such responsibilities as are imposed on Clemens Family Corporation by ERISA and this Plan, together with the authority to control and manage the operation and administration of the Plan.

Clemens Family Corporation has appointed each Insurer listed in Appendix A as a named fiduciary with such powers as may be necessary to determine the benefits payable under the applicable fully insured Benefit and resolve all questions pertaining to the applicability of the provisions of such fully insured Benefit.

Establishment and Purpose

Clemens Family Corporation has established the Plan to provide certain welfare benefits to its, and its designated affiliates', eligible Team Members, and their eligible Spouses and Dependents. This Plan is established in conformance with and is to be construed as an employer provided welfare benefit plan as defined in ERISA Section 3(1).

Amendment and Termination

Clemens Family Corporation intends to maintain the Plan indefinitely, but is under no obligation to continue the Plan and can terminate the Plan by providing written notice to Participants. Clemens Family Corporation has the right to amend, modify, or terminate any benefits provided

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under the Plan at any time. No consent of any participant or beneficiary is required for Clemens Family Corporation to exercise its right to do so.

Sources of Plan Contributions

Contributions for coverage may be made solely by Clemens Family Corporation, solely by Participants, or by a combination of Clemens Family Corporation and Participants.

No Right to Employment

Eligibility or participation in the Plan does not give you any right with respect to continuation of your employment with Clemens Family Corporation, nor will eligibility or participation in the Plan interfere in any way with your right, or Clemens Family Corporation's right, to terminate your employment at any time for any reason, which right is hereby expressly reserved.

Foreign Language Requirement

The Plan booklet contains a summary in English of Participants' rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Plan Administrator, at its office at 2700 Clemens Road, Hatfield, PA 19440 during normal business hours. You may also call the Plan Administrator's office at (215) 368-2500, for assistance.

Choice of Law and Severability

The Plan shall be governed by, and construed in accordance with, ERISA and, to the extent not preempted by ERISA, the laws of the Commonwealth of Pennsylvania. If any provision of this Plan or application thereof to any individual or circumstance, is deemed invalid or unenforceable by a court of competent jurisdiction, then the remainder of the Plan or the application of such term or provision to individuals or circumstances shall be valid and enforceable to the fullest extent permitted by law. No right hereunder shall inure to any third-party beneficiary.

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ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Eligibility and Participation

Except as otherwise provided in an applicable Component Document, if you are a Team Member who is regularly scheduled to work 30 hours or more per week, you are eligible to participate in the Plan on the first day of the month after 60 days of employment; provided, however that, notwithstanding anything in this document or a Component Document to the contrary, if you are a newly hired Team Member who commences work at Clemens Family Corporation's Coldwater, Michigan facility during calendar year 2017 and you are regularly scheduled to work 30 hours or more per week, you are eligible to participate in the medical, dental, and vision Benefits immediately upon commencing employment. If you are eligible for and enroll in the medical Benefit, you will automatically be eligible to use the onsite medical clinic Benefit. Except as otherwise set forth in an applicable Component Document, your Spouse and Dependent(s) may also participate in the Plan.

Need for Enrollment: Time Limits

In general, you, as an eligible Team Member, start participating in the Plan by enrolling you and/or your eligible Spouse and/or Dependents in accordance with Clemens Family Corporation procedures. After initial enrollment, subsequent enrollment is generally limited to the annual open enrollment period that occurs before May 1 of each year.

Special Enrollment Rights

If you or your Dependents (i) become eligible for premium assistance under the Children's Health Insurance Program (CHIP) or Medicaid, or (ii) become ineligible for CHIP or Medicaid and lose coverage under such program, you (and/or your eligible Dependent(s)) will have 60 days from the date of that event in which to request enrollment in a medical and prescription drug benefit offered under this Plan.

When Participation Begins

Once you, as an eligible Team Member, have enrolled in the Plan, your coverage under the Plan may begin. Requirements for starting participation in a particular Benefit may vary depending on the terms and conditions of such Benefit as described in this document or in an applicable Component Document.

Termination of Participation

When you terminate employment with Clemens Family Corporation, subject to the right to continue coverage under applicable law, your coverage under Plan will terminate as of the date you terminate employment. Coverage in a Benefit also terminates if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, and for certain other reasons as may be described in an applicable Component Document. Coverage for your Spouse and Dependents stops when your coverage stops and for other reasons as may be described in an applicable Component Documents (for example, divorce or a Dependent reaching an age limit). Coverage also ceases for Team Members, Spouses, and Dependents upon termination of the Plan. Coverage under each Benefit terminates according to the terms and conditions as set forth in an applicable Component Document. If you terminate employment and are rehired within 13 weeks, you will not be required to satisfy the waiting period set forth under "Eligibility and Participation."

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CLAIMS AND APPEALS PROCEDURES

Claims for Group Health Plan Benefits

Under ERISA, the Plan is required to establish and maintain reasonable claims and appeals procedures. A claims and appeals procedure will be considered reasonable only if it satisfies certain specific requirements. The following procedures are intended to comply with those requirements.

The internal claim review procedures for each type of Benefit are governed by the procedures described below. These procedures will not apply, however, to the extent that different claims procedures are set forth in an applicable Component Document, except to the extent such claim procedures fail to comply with applicable law. Claim information materials from the Plan's Insurers and Claims Administrators with respect to certain Benefits are located in the applicable Component Document. The addresses and phone numbers for making claims to each of the Insurers and Claims Administrators are set forth in Appendix A. In general, you, your Dependents, and your authorized representative (as applicable) must file a written claim on the proper form and submit it to the Insurer or Claims Administrator responsible for reviewing the claim.

If your claim or appeal of a medical claim is not determined in accordance with the requirements of applicable law (other than by reason of certain de minimis violations), you will be deemed to have exhausted the internal claims and appeals process described below.

What is a "Claim"?

A request for Benefits is a "claim" subject to these procedures only if it is a communication that is filed in accordance with the applicable Benefit's claim filing guidelines. In general, claims must be filed with the responsible Insurer or Claims Administrator. If a claim is received, but there is not enough information to allow the applicable Insurer or Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

Group Health Benefit Claims

There are potentially four different types of claims that you may bring for group health benefits under the Plan. Group health benefits include the medical, onsite medical clinic, dental, vision, 98point6, and employee assistance program Benefits. The types of claims that you generally may bring under the Plan are as follows:

- *Pre-Service Claim* – A "pre-service claim" is a claim for a particular service that is conditioned upon you receiving prior approval in advance of receiving the service. A pre-service claim must contain, at a minimum, the name of the individual for whom coverage is being claimed, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is being requested.

- *Post-Service Claim* – A "post-service claim" is a claim for payment for a particular service after the service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable Insurer or Claims Administrator and must be submitted within 12 months after the service has been provided.

- *Urgent Care Claim* - An "urgent care claim" is a claim for services involving a sudden and urgent need for such services. A claim will be considered to involve urgent care if the application of the claims review procedures for non-urgent claims (1) could

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seriously jeopardize your life or your health, or your ability to regain maximum function or (2) in the opinion of a physician with knowledge of your condition, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.

- *Concurrent Care Review Claim* - A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.

Designation of an Authorized Representative

If you want to bring a claim for coverage under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the applicable Insurer or Claims Administrator identifying such authorized representative. In the case of a claim involving urgent care, a health care professional with knowledge of your medical condition may act as your authorized representative.

Reviewing Your Claim

The Insurers and Claims Administrators have a specified amount of time to evaluate and process claims for services from the date the claim is first filed, as follows:

- For claims other than those specifically mentioned below, the time period is 90 days. If more time is needed, you will be notified of the reasons for the extension within 90 days of the date the claim was first filed. In no event can this extension exceed an additional 90 days.

- For long-and short-term disability Benefits, the time period is 45 days. If more time is needed, you will be notified of the reasons for the extension within 45 days of the date the claim was first filed. In no event will such extension exceed 30 days. If, prior to the end of the first 30-day extension period, it is determined that a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days (for a maximum claim determination period of 105 days).

- For claims involving group health Benefits, the time periods vary depending on whether the claim is an urgent care claim, pre-service claim, post-service claim or concurrent care review claim. Specific details on the time periods for these types of claims are outlined below:

    1. *Pre-Service Claim* – In the case of a pre-service claim, the applicable Insurer or Claims Administrator will respond to you within a reasonable period given the medical exigencies but in any event within 15 days after receipt of the claim. If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Insurer or Claims Administrator will notify you within the initial 15-day period that the Insurer or Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Insurer or Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

    2. *Post-Service Claim* – In the case of a post-service claim, the applicable Insurer or Claims Administrator will respond to you within a reasonable period but in any

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event within 30 days after receipt of the claim. If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Insurer or Claims Administrator will notify you within the initial 30-day period that the Insurer or Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Insurer or Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

3. *Urgent Care Claim* – In the case of an urgent care claim, the applicable Insurer or Claims Administrator will respond to you within a reasonable period given the medical exigencies but in any event within 72 hours after receipt of the claim. If the Insurer or Claims Administrator determines that it needs additional information to review your claim, the Insurer or Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, the Insurer or Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information.

4. *Concurrent Care Review Claim* – If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the Benefits relative to the treatment, the Insurer or Claims Administrator will notify you sufficiently in advance of the reduction or termination to allow you to appeal the Insurer or Claims Administrator's decision and obtain a determination on review before the Benefits are reduced or terminated. There is a special time period for responding to a request to extend concurrent if the request is an urgent care claim. For these types of claims, the Insurer or Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided that you make the claim within 24 hours prior to the expiration of the ongoing course of treatment otherwise the normal period apply depending on the type of claim).

If Your Claim Is Denied

If your claim is denied in full or in part and is an adverse benefit determination (as defined below), the applicable Insurer or Claims Administrator will provide you with written notice of the denial (a denied urgent care claim will generally be provided orally) to include:

- the specific reason or reasons for the adverse benefit determination;
- reference to the specific Plan provisions upon which the determination is based;
- a description of additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan's appeal procedures and time limits applicable to such procedures. If the adverse benefit determination is based upon:
    - an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that

such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or

- a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- the reason or reasons for the adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;

- a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and the external review process described below.

For purposes of these claims procedure, an "adverse benefit determination" means, for a claim for medical Benefits, any of the following:

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in the Plan;

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit under the Plan, resulting from the application of precertification procedures or other utilization review procedures;

- a failure to cover an item or service for which benefits under the Plan are otherwise provided because it is determined to be experimental and/or investigational or not medically necessary or because another exclusion applies under the Plan; or

- a rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

Appealing a Denial

If you receive notice that your initial claim for Benefits was denied by an Insurer or Claims Administrator or a decision has been made to discontinue or reduce Benefits relating to an ongoing course of treatment, you may appeal the denial by filing a written request (or an oral request in the case of an appeal of urgent care claim) with the applicable Insurer or Claims

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Administrator. The appeal process described herein must be exhausted before you can pursue the claim in court. If you decide to appeal a denied claim for Benefits, under the Plan you are entitled to a "full and fair review" that must include the following:

- Provide the opportunity for you to submit written comments, documents, records, and other information relating to your claim for Benefits (regardless of whether such information was considered in your initial claim for Benefits) to the applicable Insurer or Claims Administrator for review and consideration;

- Provide for access to, and copies of, all documents, records and other information that are relevant to your appeal, free of charge;

- Provide for a review that has no bearing on the initial claim's denial and is conducted by a named fiduciary of the Plan who is neither the individual who issued the first denial nor the subordinate of that person;

In regards to group health plan and short- and long-term disability claims; the following criteria, in addition to the above criteria, must be satisfied in order for you to receive a "full and fair review" of your appeal:

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

- Provide the identification of any expert whose advice was obtained on behalf of the Plan in regards to the appeal regardless of whether the advice was relied upon in making the Benefit determination;

- Provide for an expedited review process, in the case of an urgent care claim, and allow for the appeal to be requested orally or in writing and maintain that all necessary information relating to the appeal shall be transmitted between you and the Plan by telephone, fax, or other similar expeditions method.

You (or your appointed representative) can appeal and request a claim review within 60 days after you have received the denial notice (180 days in the case of a claim involving group health plan and disability Benefits). You must file your appeal in writing with the applicable Insurer or Claims Administrator responsible for reviewing the claim. Your appeal must state the specific reasons that you believe entitle you to Benefits or to greater or different Benefits.

Timing of Notification on Appeal

In general, the applicable Insurer or Claims Administrator must notify you of its determination of the appeal within a reasonable amount of time, but not to exceed 60 days, from the receipt of your request for review. In the case of appeals of group health and disability claims, specific details on the response time for these claims are outlined below:

- *Pre-Service Claim* – the Insurer or Claims Administrator will review your appeal and respond to you within a reasonable period given the medical exigencies but in any event within 30 days after receipt of the appeal.

- *Post-Service Claim* – the Insurer or Claims Administrator will review your appeal and respond to you within a reasonable period but in any event within 60 days (45 days in the case of a claim involving disability Benefits) after receipt of appeal. If more time is needed, the reviewer may take up to an additional 60 days (45 days in the

case of a claim involving disability benefits), so long as you are notified in advance of the need and reasons for the delay.

- *Urgent Care Claim* – the Insurer or Claims Administrator will review your appeal and respond within a reasonable period given the medical exigencies but in any event within 72 hours after receipt of appeal.

- *Concurrent Care Review Claim* – the Insurer or Claims Administrator will review your appeal and respond to you before benefits relating to the concurrent or ongoing treatment in question are reduced or terminated.

Denial of Appeal

If your appeal is denied in whole or in part and is a adverse benefit determination (as defined above), you will be notified in writing of the Insurer's or Claims Administrator's final decision. This notice will include:

- the specific reason or reasons for the denial;

- reference to the specific portion(s) of the Plan on which the denial is based;

- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;

- if the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request;

- 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";

- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- the reason or reasons for the adverse benefit determination on appeal including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim including a discussion of the decision;

- a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

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- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Voluntary External Review Program (Medical Plans Only)

If, after exhausting the internal appeals process described above, you are not satisfied with the final determination, you may choose to participate in an external review process in accordance with applicable law. The external review process only applies if the adverse benefit determination is based on a medical judgment or a rescission of coverage.

The external review process is not available in the case of an adverse benefit determination that is based on your failure to meet the eligibility requirements for a Benefit.

The external review process is binding on both you and the Plan except to the extent other remedies are available under state or federal law. Contact Clemens Family Corporation for more information.

Statute of Limitations for Plan Claims

No legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the applicable Insurer or Claims Administrator has been rendered (or deemed rendered).

Nonassignment of Benefits

Notwithstanding anything in a Component Document to the contrary, the right of any Participant to receive any benefit payments under a self-insured benefit under the Plan is personal to such Participant and is not assignable in whole or in part to any person or entity, including a health care provider, nor may benefits of coverage under a self-insured benefit under the Plan be transferred at any time. Under no circumstances will a self-insured benefit's direct payment of any amounts to a network provider under such self-insured benefit constitute a waiver of this nonassignment provision with respect to any party, including a non-participating provider.

SUBROGATION AND RIGHT OF RECOVERY

Definitions. As used throughout this subrogation and right of recovery provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness, or condition. The term Responsible Party includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or Dependent of any participant or person entitled to receive any benefits from the Plan.

Subrogation. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement. In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Lien Rights. Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury, or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person that is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not

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required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments. The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any settlements or judgments, even those designated as pain and suffering, non-economic damages, or general damages only.

Cooperation. The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and the Covered Person's agents shall provide all information requested by the Plan, the applicable Insurer or Claims Administrator, or their representatives including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery obtained by the Covered Person, may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The Plan reserves the right to notify Responsible Party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation. In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the designated claims administrator of the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of such Covered Person's present or future domicile.

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SELECTED STATUTORY PROVISIONS

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Under this Plan, under certain circumstances you will be allowed to continue group health plan coverage for you and your covered Dependents, under a federal law -- the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). It is important that you are aware of this Plan provision, since you will be required to take specific actions to exercise your rights to continuation coverage. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this plan document and summary plan description is intended to expand your rights beyond COBRA's requirements. You should review the following information carefully and save it for future reference.

Coverage may be continued under COBRA when you, your Spouse, or a covered Dependent (called a qualified beneficiary) experience a situation (called a "qualifying event") that would otherwise result in your loss of coverage under the Plan.

As a participant covered by the Plan, you have a right to choose continuation coverage if you lose your group health coverage because of:

- a reduction in your hours of employment; or
- the termination of your employment (for reasons other than your gross misconduct).

If you are a participant's Spouse covered by the Plan, you have the right to choose continuation coverage if you lose group health coverage under the Plan for any of the following reasons:

- the death of your Spouse;
- a termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment;
- your divorce or legal separation from your Spouse; or
- your Spouse becomes enrolled in Medicare (Part A, Part B, or both).

In the case of participant's child covered by the Plan, the child has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

- the death of a covered parent;
- the termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment;
- the child's parents' divorce or legal separation;
- a covered parent becoming entitled to Medicare; or
- the child ceases to be eligible to participate in the Plan.

Cost of Continuation Coverage. You are required to pay the full cost of continuation coverage plus a 2% charge to cover the cost of Plan administration. You will be asked to pay for the coverage in monthly installments and your first payment must be made no later than 45 days

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after the date that you elect continuation coverage. Contact the Plan Administrator for current cost information.

As discussed below, if a qualified beneficiary is disabled (as determined by the Social Security Administration) within 60 days following a qualifying event, and if a copy of the Social Security Administration's disability determination is provided to the plan administrator within 60 days after its issuance and before the end of the initial 18-month COBRA continuation period, an additional 11 months of continuation coverage will be made available. If that occurs, the cost of COBRA continuation coverage will increase to 150 percent of the applicable premium for the additional period of coverage.

Benefits Offered Under Continuation Coverage. If you choose continuation coverage, you will be entitled to the same coverage you had on the day prior to your qualifying event, and neither you nor your Dependents can be asked to furnish evidence of insurability. During the time you and your Dependents are covered by COBRA continuation, you will be entitled to the same coverage options that are available to active Team Members, including, the right to change coverage at open enrollment and the right to modify coverage in the event of a change in your coverage needs. You will be notified by mail of these options at the same time as active Team Members. If you do not choose continuation coverage, your group health coverage will end.

Length of Continued Coverage. In general, coverage may be continued for a maximum of 18 months after the date of the qualifying event -- in the case of termination of employment or reduction of hours or for 36 months for all other events listed on the previous page. If your maximum continuation coverage period would normally be 18 months, but you qualify for the disability extension discussed above, the maximum coverage period will be 29 months.

COBRA coverage will end before the expiration of the maximum period if the qualified beneficiary becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. In other words, a beneficiary who becomes covered under a group health plan with a pre-existing condition clause must be allowed to retain COBRA coverage.

Once your continuation coverage has been exhausted, you may have the right to convert to an individual policy (depending on the Benefit). Contact the Plan Administrator to find out if a conversion option is available under the Plan for a particular Benefit.

You will be eligible to extend your period of continuation coverage from 18 to a maximum of 29 months (for yourself and all related qualified beneficiaries) if you or another qualified beneficiary was disabled (as determined under Title II or XVI of the Social Security Act) at the time of the initial qualifying event or during the first 60 days of COBRA coverage. In order for you to obtain this 11-month extension, the Social Security Administration must make a disability determination within the first 18 months of your COBRA coverage, and you must notify the plan administrator of that determination within 60 days after receiving it.

Coverage will be terminated earlier than the above dates if:

- You, your Spouse, or your dependent child first becomes covered, after the date of the qualifying event, under another group health plan;
- You or your Spouse become covered by Medicare after the date of the COBRA election;
- You (or other qualified beneficiary) fail to make a required premium payment;

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- Clemens Family Corporation terminates all of its group health plans;

- If your coverage has been extended due to the disability of a qualified beneficiary, if the disabled individual ceases to be disabled after the first 18 months on continuation coverage.

You must notify the Plan Administrator upon the occurrence of events (1) and (2) above.

What Must I Do To Obtain Continuation Coverage?

You have the responsibility of notifying the Plan Administrator when certain events occur which qualify you for continuation coverage:

You or your covered Dependent(s) must notify the Plan Administrator within 60 days of the occurrence of either of the following qualifying events:

- a divorce or legal separation; or

- a Dependent child losing eligibility under the Plan.

Within 14 days of receiving notification of either of these events, the Plan Administrator will notify you or your covered Dependents of the right to elect continuation coverage.

The Plan Administrator will notify you or your covered Dependents, within 44 days, of your right to elect continuation coverage in the event of:

- Your termination of employment

- Your reduction in hours (if it results in loss of eligibility for health coverage)

- Your death

- Your entitlement to Medicare (if it results in loss of eligibility for health coverage)

You or your covered Dependents will have a 60-day election period during which continuation coverage may be elected. The period begins the later of (1) the date your coverage terminates by reason of the qualifying event or (2) the date you or your covered Dependents were notified of your right to elect continuation coverage.

Family and Medical Leave Act of 1993 (FMLA)

If you go on a qualified unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the following rules will apply. Only to the extent required by FMLA (among other things, this means only for the duration of a qualifying leave), Clemens Family Corporation will continue to maintain your health plan benefits on the same terms and conditions as though you were still an active Team Member. Except as otherwise provided by FMLA, your Plan participation will cease when the Plan Administrator learns that you do not intend to return to work after your leave. If earlier, your Plan participation will immediately cease upon expiration of your FMLA leave, if you fail to return to work at such time. Except as otherwise provided in the FMLA, if you fail to return to work after the FMLA leave, you will be required to reimburse Clemens Family Corporation for the cost of the coverage provided to you while you were on FMLA leave (the cost equals the COBRA premium, without a 2% add-on, and minus any Team Member contribution you already made). For more information on FMLA, contact Clemens Family Corporation, where you may obtain a summary of your rights under FMLA without charge.

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Uniformed Services Employment and Reemployment Rights Act (USERRA)

Team Members going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage upon return from service. These rights apply only to Team Members and their Dependents covered under the Plan before leaving for military service. Contact Clemens Family Corporation for more information about your rights under USERRA.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A. Special Enrollment Provisions. Pursuant to HIPAA, the provides for special enrollment periods for you and your Dependents to enroll in coverage, even if your or you Dependent previous declined coverage under the Plan.

Loss of Other Coverage.

If you or your dependent lose coverage under another health plan, the Plan will permit you or your Dependent, as applicable, to enroll in the Plan, if:

- you and the Dependent, if applicable, is eligible for coverage under the terms of the Plan;
- you or your Dependent had coverage under the other health plan when coverage was previously offered and declined; and
- the other coverage:
    - was not continuation coverage under COBRA and was terminated as a result of:
        - a loss of eligibility for any reason; or
        - termination of all employer contributions towards such coverage; and
        - coverage under the Plan is requested no later than 30 days after the loss of such other coverage; or
    - was continuation coverage under COBRA that was exhausted and coverage under the Plan is requested no later than 30 days after the loss of COBRA coverage.

The Plan may request proof of the loss of coverage under the other plan prior to allowing you or your Dependents to enroll in the Plan.

B. Late Enrollees. Late enrollees are individuals who declined or were denied coverage when they were first eligible to enroll in the Plan. These include:

- Those Individuals who declined coverage because they had other coverage;
- Individuals who were denied coverage because of health reasons before the plans were subject to HIPAA; and,
- Individuals who declined coverage but did not have other coverage.

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Individuals who decline enrollment because they had other coverage, must be allowed to enroll late without evidence of insurability as described above. Individuals who decline coverage and who do not have other coverage may enroll later.

HIPAA Privacy and Security Rules

A. Use and Disclosure of Protected Health Information

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

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

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing Team Member contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities, and related health care data processing;
- claims management and related health care data processing, including auditing payments,
- investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and
- reimbursement to the Plan.

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

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
    - management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
    - customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- resolution of internal grievances; and
- due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

B. For Purposes of This Section, Clemens Family Corporation Is the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that this plan document and summary plan description has been amended to incorporate the following provisions.

C. With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

- 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;

- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;

- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

- make PHI available to an individual in accordance with HIPAA's access requirements;

- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

- make available the information required to provide an accounting of disclosures;

- make internal practices, books, and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

- 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 (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

D. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following Team Members or classes of Team Members may be given access to PHI:

- the benefits manager;

- staff designated by the benefits manager; and

E. Limitations of PHI Access and Disclosure

The persons described in section D may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

F. Noncompliance Issues

If the persons described in section D do not comply with this plan document and summary plan description, the Plan sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

G. HIPAA Security Requirements Applicable to Electronic PHI

The Plan Sponsor will:

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- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

- ensure that the adequate separation between the Plan and the Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures;

- ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

- report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Qualified Medical Child Support Orders (QMCSO)

This Plan will also provide benefits as required by any qualified medical child support order, as defined in ERISA Section 609(a), and will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries, in accordance with ERISA Section 609(c). For more information on QMCSOs, contact Clemens Family Corporation, where you may obtain, without charge, a copy of the Plan's QMCSO procedures.

Newborns' and Mothers' Health Protection Act of 1996

Under federal law, group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA)

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

- all stages of reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction on the other breast to produce a symmetrical appearance;

- prostheses; and

- treatment for physical complications of the mastectomy, including lymphedema.

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These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. See the applicable Component Document for the applicable deductible and coinsurance for these benefits.

If you would like more information on the WHCRA, call the Plan Administrator at (215) 368-2500.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of Jul 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

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ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

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STATEMENT OF ERISA RIGHTS

As a participant in the Clemens Family Corporation Health Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain upon a written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated 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 participant 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 summary plan description on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps that you can take to enforce your rights. For instance, if you request copies of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happened that Plan fiduciaries are misusing 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

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court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

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

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APPENDIX A

Claims Administrators and Insurers of the Benefits

Claims Administrator/Insurer	Group/Policy Number	Type	Funding
Health Benefits			
Independence Administrators P.O. Box 21794 Eagan, MI 19034	104100	Medical Insurance	Self-Insured
R-Health	N/A	Onsite Medical Clinic	Self-Insured
Delta Dental One Delta Drive Mechanicsburg, PA 17055	04476	Dental Insurance	Self-Insured
Davis Vision Capital Region Health Park, Suite 301 711 Troy-Schenectady Road Latham, NY 12110	104100	Vision Insurance	Self-Insured
Carebridge Corporation www.myliferesource.com	N/A	Employee Assistance Program	Fully Insured
98point6 701 5th Avenue, Suite 2300, Seattle, WA, 98104	N/A	Telemedicine	Fully Insured
Non-Health Benefits			
Sun Life Assurance Company of Canada One Sun Life Executive Park Wellesley Hills, MA 02481	230523-001	Life and AD&D Insurance	Fully Insured
Sun Life Assurance Company of Canada One Sun Life Executive Park Wellesley Hills, MA 02481	N/A	Short-Disability Insurance	Self- Insured
Sun Life Assurance Company of Canada One Sun Life Executive Park Wellesley Hills, MA 02481	007-4648-0	Long-Term Disability Insurance	Fully Insured

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Addresses and Phone Numbers for Claims and Appeals

Medical: Independence Administrators, P.O. Box 1010, 602 Office Center Drive, Suite 350, Fort Washington, PA 19034 (888) 234-2393.

Onsite Medical Clinic: R-Health, 2nd Floor, Family Wellness Center, 2700 Clemens Road, Hatfield, PA, 19440 (215) 607-7256.

Dental: Delta Dental, One Delta Drive, Mechanicsburg, PA 17055 (800) 932-0783.

Vision: Davis Vision, Inc. P.O. Box 791, Latham, NY 12110 (800) 932-0783

Employee Assistance Program: Carebridge Corporation, 40 Lloyd Avenue, Suite 204, Malvern, PA (800) 437-0911.

Telemedicine: 98point6, 701 5th Avenue, Suite 2300, Seattle, WA, 98104 (866) 657-7991

Life and AD&D Insurance: Sun Life Assurance Company of Canada, One Sun Life Executive Park, P.O. Box 81365, Wellesley Hills, MA 02481 (800) 247-6875.

Short-Term Disability Insurance: Sun Life Assurance Company of Canada, One Sun Life Executive Park, P.O. Box 81915, Wellesley Hills, MA 02481 (800) 247-6875.

Long-Term Disability Insurance: Sun Life Assurance Company of Canada, One Sun Life Executive Park, P.O. Box 81830, Wellesley Hills, MA 02481 (800) 247-6875.

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Independence

Independence Administrators

Your Group Health Plan

Clemens Family Corporation

HDHP HSA Plan

Effective Date: May 1, 2021

This booklet describes your Clemens Family Corporation Employee Medical Plan (the "Plan"). All benefits becoming due under the Plan are funded directly by Clemens Family Corporation (the "Plan Sponsor"). The Plan Sponsor has the right to amend, modify, or discontinue the Plan at any time and for any reason.

The Plan Sponsor has entered into an agreement with QCC Insurance Company d/b/a Independence Administrators ("Independence Administrators") which provides for Independence Administrators to process benefit claims and provide certain other administrative services under the Plan.

Independence Administrators does not insure or guarantee the benefits described in this booklet.

Your health benefits are entirely funded by the Plan Sponsor. Independence Administrators provides administrative and claims payment services only. Independence Administrators has the authority to interpret claim policy on behalf of the Plan Sponsor. Independence Administrators is not the administrator of the Plan for the purposes of the Employee Retirement and Income Security Act ("ERISA").

Under the HSA Plan, it is intended that the benefits provided under this Plan be provided as a compliant Health Savings Account Plan. Benefit determinations will be made consistent with High Deductible Health Plans applicable under Section 223 of the Internal Revenue Code.

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

Independence Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Administrators does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independence Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence Administrators has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

There are four ways to file a grievance directly with Independence Administrators:

- by mail: Independence Administrators,
  ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 888-356-7899 (TTY 711);
- by fax: 215-761-0920; or
- by email: **IACivilRightsCoordinator@ibxtpa.com**.

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Language Access Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en su tarjeta de identificación (TTY: 711).

注意：如果您使用简体中文，您可以免费获得语言协助服务。请致电您ID卡上的电话号码。

LƯU Ý: Nếu quý vị nói tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin gọi số điện thoại trên thẻ ID của quý vị.

ВНИМАНИЕ: Если вы говорите по-русски, вам предлагаются бесплатные услуги переводчика. Позвоните по телефону на вашем удостоверении.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf die Nummer uff dei ID-Card uff.

알림: 한국어 통역서비스가 필요한 분은 귀하의 ID 카드에 나와있는 번호로 전화하십시오. 통역서비스를 무료로 받으실 수 있습니다.

ATTENZIONE: se parla italiano, sono disponibili per lei servizi di assistenza linguistica gratuiti. Contatti il numero che vede sulla sua carta d'identità.

انتباه: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على الرقم الموجود على بطاقة التعريف الخاصة بك.

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le numéro indiqué sur votre carte d'identité.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen über Language Assistance Services ein Dolmetscher kostenlos zur Verfügung. Wenden Sie sich an die Nummer auf Ihrer ID-Karte.

ધ્યાન આપો : જો તમે ગુજરાતી બોલી શકતા હો, તો તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. તમારા ID કાર્ડ પરના નંબર પર કૉલ કરો.

UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer podany na Twojej karcie identyfikacyjnej.

ATANSYON: Si ou pale kreyòl ayisyen, gen asistans ak lang disponib pou ou gratis. Rele nimewo ki sou do kat idantifikasyon ou a.

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសា មន-ខ្មែរ ប្រទេសខ្មែរ សេវាជំនួយភាសាដែលឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខនៅលើកាតសំគាល់ខ្លួនរបស់អ្នក។

ATENÇÃO: se você fala português, serviços de assistência a idioma estão disponíveis gratuitamente para você. Ligue para o número no seu cartão de identificação.

BAA ÁKONÍNÍZIN: Diné bizaad bee yáníłti'go, ata' hane' bee áká i'iilyeed t'áá jíík'e bee ná ahóót'i'. Naaltsoos bee nééhózingo nanitinígíí bik'ehgo hane'í bikáá'ígíí bich'į' hólne'.

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tawagan ang numero sa ID card ninyo.

注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。IDカードの番号にお電話ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به رایگان در اختیار شما می باشد. با شماره نوشته شده روی کارت عضویت خود تماس بگیرید.

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SCHEDULE OF BENEFITS HDHP HSA PLAN

This Schedule of Benefits lists benefits, maximums, and allowances that your Plan provides for each enrolled person. The coinsurance rates shown in this table are based on your Plan's allowance for each service. *Read the section on* ***The Preferred Provider Network*** *carefully* to see how you can save money by receiving your care from Preferred Providers.

Remember…Your Plan has Clinical Services requirements for all inpatient admissions. It may also require pre-certification for certain outpatient procedures. If you do not comply with these provisions, your Plan may reduce the benefits for those services or may not cover them at all. *Read the sections on* ***Clinical Services*** *carefully*.

Service	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Plan Year Deductible		
• Individual	$2,000	$3,000
• Family Aggregate	$4,000	$6,000
Out-of-pocket maximum expense you could pay in a Plan Year (includes deductible, coinsurance and copayments; Preferred Provider and Non-Preferred Provider expenses accumulate separately)		
Single Account (no dependents)		
• Individual	$3,500	$6,000
Family Account		
• Individual	$3,500	$6,000
• Family Aggregate	$7,000	$12,000
Coinsurance — This table shows the percentage of the Plan's allowance your Plan pays for different covered services. *All payments are based on your Plan's allowance* for the service performed. Your Plan begins to pay for eligible expenses, at the rate shown in the table, *after you meet your Plan Year Plan Year Deductible*.		
Coinsurance rates for various services *(based on the Plan's allowance)*		
HOSPITAL BENEFITS		
Inpatient Hospital Facility	100% after deductible	80% after deductible *Limited to 60 days combined with Inpatient Maternity per benefit period*
Inpatient Hospital Physician	100% after deductible	80% after deductible
Outpatient Surgery Facility	100% after deductible	80% after deductible
Outpatient Surgery Physician	100% after deductible	80% after deductible

Service	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Inpatient Maternity *Includes delivery and inpatient services*	100% after deductible	80% after deductible *Limited to 60 days combined with Inpatient Hospital Facility per benefit period*
EMERGENCY SERVICES		
Emergency Accident Treatment Facility	100% after deductible	100% after preferred deductible
Non-Emergency Accident Treatment Facility	Not Covered	Not Covered
Urgent Care Facility	100% after deductible	80% after deductible
Ambulance	100% after deductible	100% after preferred deductible
OUTPATIENT SERVICES		
Physician Office Visit/Telehealth Visit	100% after deductible	80% after deductible
Specialist Office Visit/Telehealth Visit	100% after deductible	80% after deductible
Prenatal/Postnatal Office Visits	100% after deductible	80% after deductible
Chiropractic Office Visit *Benefit maximum of 20 visits per benefit period*	100% after deductible	80% after deductible
Diagnostic Test (X-Ray, Blood Work)	100% after deductible	80% after deductible
Diagnostic Imaging *MRI/MRA, CT/CTA Scan, PET Scan*	100% after deductible	80% after deductible
THERAPY SERVICES		
Physical & Occupational Therapy *Benefit maximum of 30 visits combined per benefit period*	100% after deductible	80% after deductible
Speech Therapy *Benefit maximum of 20 visits per benefit period*	100% after deductible	80% after deductible
MISCELLANEOUS SERVICES AND SUPPLIES		
Durable Medical Equipment	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
Hospice Care	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
Skilled Nursing Facility *Benefit maximum of 120 days per benefit period*	100% after deductible	80% after deductible

Service	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Injectable Medications	100% after deductible	80% after deductible
ADULT PREVENTIVE CARE-Age and Frequency limits may apply		
Adult Physical Examination	100% deductible waived	80% after deductible
Routine Gynecological Exams	100% deductible waived	80% after deductible
PAP Test	100% deductible waived	80% after deductible
Mammogram	100% deductible waived	80% after deductible
Colonoscopy *No age or time restriction for this benefit: Some generic prep included*	100% deductible waived	80% after deductible
Other Preventive Care	100% deductible waived	80% after deductible
CHILD PREVENTIVE CARE- Age and Frequency limits may apply		
Well-Child Care Examination	100% deductible waived	80% after deductible
Pediatric Immunizations	100% deductible waived	80% after deductible
MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT		
Inpatient Facility	100% after deductible	80% after deductible
Outpatient Facility	100% after deductible	80% after deductible
Outpatient Visit	100% after deductible	80% after deductible
PRESCRIPTION DRUGS - *Administered by FutureScripts* *(Your medical deductible must be met before your coinsurance and copayments apply.)*		
Retail Pharmacy *30-day supply*		
Generic Drugs **Preferred-Brand Drugs** **Non-Preferred Drugs**	$5 copay $20 copay $45 copay	$5 copay $20 copay $45 copay
Mail Order *90-day supply*		
Generic Drugs **Preferred-Brand Drugs** **Non-Preferred Drugs**	$10 copay $40 copay $90 copay	$10 copay $40 copay $90 copay
Generic High Blood Pressure and Diabetic medications are covered at 100%, deductible waived		

ELIGIBILITY

CLASS(ES) ELIGIBLE FOR COVERAGE

The following classes are eligible for coverage under the terms of the Plan:

All Active, Full-time Employees who work on average 30 hours or more per week per Affordable Care Act (ACA) requirements.

EMPLOYMENT WAITING PERIOD

Active, Full-time: First of the month coincident with or next following sixty (60) days from the date of hire with the Company.

ELIGIBILITY DATE — EMPLOYEE COVERAGE

An Employee will be eligible for coverage upon completion of the Employment Waiting Period.

ELIGIBILITY DATE — DEPENDENT COVERAGE

Each eligible Employee will be eligible for Dependent coverage on the later of:

1. the date the Employee becomes eligible for coverage, if he has Dependents on that date; or
2. the date the Employee acquires a Dependent, if application is made within thirty-one (31) days.
3. Coverage of a newborn child will become effective immediately for routine nursery care, treatment for prematurity, birth abnormalities, congenital defects, or any other Illnesses. The newborn child will be entitled to receive all benefits, in accordance with the terms of the Plan, from birth for thirty-one (31) days. Upon application within the thirty-one (31) day period, the Employee may continue coverage beyond that period for a newborn child who qualifies as an eligible Dependent, subject to payment of any additional contribution if required by the Plan.

No Employee or Dependent may be covered simultaneously as an Employee and Dependent under the Plan. Also, a person may be covered under the Plan as the Dependent of only one Employee.

DEPENDENTS NOT ELIGIBLE FOR COVERAGE

The following Dependents are not eligible for coverage under the Plan in any case:

1. an eligible Employee's spouse if legally separated or divorced from the eligible Employee, unless a court decree directs otherwise, and then only until either the Employee or ex-spouse remarries;
2. an eligible Employee's child 26 or more years of age, with the exception of (a) an unmarried child, 26 or more years of age, who is unable to earn his own living due to physical or Mental Illness or handicap;

3. a foster child;
4. a grandchild; unless legal guardianship is granted.

CONTINUATION OF ELIGIBILITY

Mental or Physical Handicap

An unmarried child who is unable to earn his own living due to physical or Mental Illness or handicap, and is at or reaches a terminating age under the terms of the Plan, will be eligible for coverage if Independence Administrators receives proof, satisfactory to Independence Administrators, that he is unable to earn his own living.

If the dependent wants to be considered for handicap status, they must work with their physician to complete a handicap application/questionnaire. Once the application for handicap status is received, AmeriHealth Medical Management will make a determination whether the child should be approved or denied. Approved dependents can receive a lifetime approval or renewable (non-lifetime). Dependents with non-lifetime approvals (e.g., one year, two year) must complete another questionnaire when the approval term is complete.

Such proof must be received:

a. within thirty (30) days of such Dependent's eligibility date; or
b. within thirty (30) days of the date such Dependent reaches a terminating age under the terms of the Plan.

The Plan reserves the right to require subsequent proof of incapability during the time such Dependent coverage is in effect. Such proof will not be required more than once per year.

COST OF THE COVERAGE

You will be informed of the amount of your contribution when you are invited to enroll.

EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT PERIOD

Once in each plan year, the Company will hold an open enrollment period. During this period, an Employee may enroll for coverage, if he or she elected not to enroll when first eligible.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within thirty (30) days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because you or your dependents were enrolled in Medicaid or your state's State Children's Health Insurance Program and you or your dependent cease to be enrolled in such program as a result of no longer being eligible for the program, you may be able to enroll yourself or your dependents in this Plan in the future, provided that you request enrollment within sixty (60) days after coverage ends. If you or your dependents become eligible for premium assistance for this Plan from Medicaid or your state's State Children's Health Insurance Program and choose to enroll in this Plan, you must request coverage under this Plan within sixty (60) days after the date you or your dependent become eligible for premium assistance.

EFFECTIVE DATE

Employee and/or Dependent coverage shall become effective on the applicable date set forth below.

1. **Non-contributory Funding**

   If contribution from an Employee toward the cost of Employee and Dependent coverage is not required under the Plan, coverage will become effective on the date of eligibility.

2. **Contributory Funding**

   If contribution from an Employee toward the cost of Employee or Dependent coverage is required, and the Employee agrees to make the required contribution, coverage will become effective, upon the payment of such contribution, on the date shown below:

a. the date of eligibility if the application is made and is received by Independence Administrators on or before that date; or

b. the date Independence Administrators receives application, if the application is made within thirty (30) days after the date of eligibility.

3. Dependent(s)

No Dependents' coverage will become effective for an Employee unless the eligible Employee is, or simultaneously becomes, covered.

Coverage of a newborn child will become effective immediately for routine nursery care, treatment for prematurity, birth abnormalities, congenital defects, or any other Illnesses. The newborn child will be entitled to receive all benefits, in accordance with the terms of the Plan, from birth for thirty-one (31) days. Upon application within the thirty-one (31) day period, the Employee may continue coverage beyond that period for a newborn child who qualifies as an eligible Dependent, subject to payment of any additional contribution if required by the Plan.

THE PREFERRED PROVIDER NETWORK

Your PPO Network Plan is a program, which allows you to maximize your health care benefits by utilizing the PPO Network, which is comprised of Providers that have a contractual arrangement with Independence Administrators and BlueCard PPO providers. These Providers are called "Preferred Providers." You may think of them as "in-network" providers. Preferred Providers are doctors, hospitals and other health care professionals and institutions that are part of the PPO Network, which is designed to provide access to care through a selected managed network of providers. Services by Preferred Providers are delivered through a selected, managed network of providers designed to provide quality care. The PPO Network includes hospitals, primary care physicians and specialists, and a wide range of ancillary providers, including suppliers of Durable Medical Equipment, Hospice and Home Health agencies, Skilled Nursing Facilities, free standing dialysis facilities and Ambulatory Surgical Centers.

When you receive health care through a Provider that is a member of the PPO Network, you incur lower out-of-pocket expenses and there are no claim forms to fill out. Benefits are also provided if you choose to receive health care through a Provider that is not a Preferred Provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses, and the amount of your expenses could be substantial. You may have to reach a deductible before receiving benefits, and you may be required to file a claim form.

To locate a BlueCard PPO network provider, go to www.IBXTPA.com or call 1-800-810-BLUE (2583). Independence Administrators covers only care that is Medically Necessary. Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in short procedure units and care in a hospital outpatient department.

Some of the services you receive through this Plan must be pre-certified before you receive them, to determine whether they are Medically Necessary. Failure to pre-certify services to be provided by a Non-Preferred Provider, when required, may result in a reduction of benefits. Pre-certification of services is a vital program feature that reviews the Medical Necessity of certain procedures/admissions. In certain cases, Pre-certification helps determine whether a different treatment may be available that is equally effective. Pre-certification also helps determine the most appropriate setting for certain services. Innovations in health care enable doctors to provide services, once provided exclusively in an inpatient setting, in many different settings – such as an outpatient department of a hospital or a doctor's office.

If the request for Pre-certification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

1. Acknowledge this in writing.
2. Request to have services provided.
3. State your willingness to assume financial liability.

When you seek treatment from a Non-Preferred Provider or a BlueCard Provider, you are responsible for initiating the Pre-certification process. You or your provider should call the Pre-certification number listed on the back of your Identification Card, and give your name, facility's name, diagnosis, and procedure or reason for admission. Failure to pre-certify required services will result in a reduction of benefits payable to you.

For more Information regarding pre-certification please see the ***Clinical Services*** section of this Booklet.

REGARDING USE OF NON-PREFERRED PROVIDERS

While the PPO has an extensive network, it may not contain every Provider that you elect to see. To receive the maximum benefits available under this program, you must obtain Covered Services from Preferred Providers that participate in the PPO Network or is a Blue Card PPO Provider.

In addition, your PPO program allows you to obtain Covered Services from Non-Preferred Providers. If you use a Non-Preferred Provider you will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles and Coinsurance. The Non-Preferred Provider may charge you for the balance of the Provider's bill. This is true whether you use a Non-Preferred Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a Provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense.

For specific terms regarding Non-Preferred Providers, please refer to the following sections: ***Definitions***, including but not limited to the definition of Covered Expense and Non-Preferred Provider, and the Payment of Providers subsection under ***General Provisions***.

BLUECARD PPO PROGRAM

Out-of-Area Services

Overview

Independence Administrators has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside of the geographic area Independence Administrators serves, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Independence Administrators' service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. Independence Administrators explains below how it pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Independence Administrators to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Independence Administrators will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside Independence Administrator' service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Independence Administrators.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider.

Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Independence Administrators has used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Independence Administrators through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If Independence Administrators has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on the Member's behalf, Independence Administrators will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

Nonparticipating Providers Outside Independence Administrators' Service Area

Please refer to the Covered Expense definition in the Defined Terms section of the Benefit Booklet for a description of Independence Administrator's reimbursement for Nonparticipating/Non-Preferred Providers.

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue.

As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) (TTY: 711) or call collect at 1.804.673.1177 (TTY: 711), 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact Independence Administrators to obtain pre-certification for non-emergency inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

PAYMENT OF COVERED MEDICAL CHARGES

1. The Plan Year Deductible is as shown in the ***Schedule of Benefits***. A Covered Person must Incur covered medical charges of at least this amount within a plan year before any benefits are payable during that year, unless otherwise stated in the ***Schedule of Benefits***.

   A Covered Person must satisfy the individual deductible amount only once during a plan year. In the case of family coverage, without regard to which family Covered Person or Covered Persons incur expenses, no amounts are payable as covered medical charges until a family has Incurred annual covered medical charges in excess of the minimum annual deductible. Deductible calculations are subject to the Health Savings Accounts rules set forth in the Internal Revenue Code.

2. When a Covered Person is confined in a Hospital, Rehabilitation Facility, or Skilled Nursing Facility, benefits payable will be determined by the condition primarily being treated. Determination will be made by Independence Administrators based on the Covered Person's medical history and will be conclusive.

3. In counting the number of days of medical care furnished to a Covered Person while confined in a Hospital, Rehabilitation Facility, or Skilled Nursing Facility, either the day of admission or the day of discharge will be counted, but not both.

4. No benefits will be payable under the Plan for charges Incurred after the Hospital's regular discharge hour, provided the Covered Person has been advised by his attending Doctor prior to such discharge that further confinement is not required.

5. Pregnancy benefits will be provided under the same conditions and limitations as any other Illness.

   This Plan does not restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than the following:

   a. 48 hours following a normal vaginal delivery; or
   b. 96 hours following a caesarean section.

   This Plan does not require that a Provider obtain authorization from the Plan for prescribing a length of stay that does not exceed these periods.

COVERED MEDICAL CHARGES

Subject to "Exceptions and Exclusions" which follows, covered medical charges include the charges described below that are Medically Necessary and Incurred while covered under the Plan. (A charge is deemed Incurred as of the date of the service, treatment, or purchase giving rise to the charge.)

FACILITY SERVICES

1. Room and Board
   a. Semiprivate Room — Includes special diets and general nursing care.
   b. Private Room — In a Facility having primarily private accommodations, the Covered Person is entitled to either the Facility's most common semiprivate room charge, if any, or an allowance agreed upon by Independence Administrators and the Facility. The difference between the Plan's allowance and the Facility's charge is the Covered Person's responsibility.

      Private Room accommodations will be covered in full if Medically Necessary.
   c. Special care accommodations — Special care accommodations include intensive care, cardiac care, and burn treatment or such other special care accommodations approved by Independence Administrators.
2. Ancillary Services — Includes those services and Supplies that are regularly provided and billed by a Facility, such as:
   a. use of operating, delivery, and treatment rooms and equipment;
   b. administration of blood and blood processing including blood and blood plasma to the extent that it is not donated or otherwise replaced;
   c. oxygen and other gases and their administration;
   d. prescribed drugs and medications that are dispensed for use in the Facility;
   e. anesthesia and the administration of anesthetics when performed by an employee of the Facility;
   f. medical and surgical dressings, Supplies, casts, and splints; and
   g. diagnostic services.

   When counting the number of days of care furnished to an Inpatient, either the day of admission or the day of discharge will be counted, but not both.

   Charges Incurred after a Facility's regular discharge hour are not covered provided the Covered Person has been advised by his attending Professional Provider prior to such discharge that further confinement is not required.

MEDICAL CARE

Medical care and Facility services rendered to an Inpatient by the Doctor in charge of the case for a condition not related to Surgery or pregnancy, except as specifically provided. Such care includes Inpatient intensive medical care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period.

1. Concurrent Care

   Medical care rendered to an Inpatient by a Professional Provider who is not in charge of the case, but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations, or medical care routinely performed in the preoperative or postoperative or prenatal or postnatal periods, or medical visits required by a Facility's rules and regulations.

2. Consultation Services

   Consultation services rendered to an Inpatient by a Professional Provider at the request of the attending Professional Provider. Consultation services do not include staff consultations that are required by a Facility's rules and regulations.

   Benefits are provided for one consultation per consultant during each period of confinement.

REHABILITATION HOSPITAL CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Rehabilitation Hospital.

No benefits are provided for services in a Rehabilitation Facility:

1. once the Covered Person reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment; or
2. when the services are primarily provided to maintain the Covered Person's level of functioning; or to assist the Covered Person with the activities of daily living; or to provide an institutional environment for the convenience of the Covered Person.

SKILLED NURSING FACILITY CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Skilled Nursing Facility as described in the ***Schedule of Benefits***.

Benefits for medical care in a Skilled Nursing Facility are provided for up to two visits during the first week of confinement and one visit a week for each consecutive week of confinement thereafter.

No benefits are provided for services in a Skilled Nursing Facility:

1. once the Covered Person reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment;

2. when the services are primarily provided to maintain the Covered Person's level of functioning; or to assist the Covered Person with the activities of daily living; or to provide an institutional environment for the convenience of the Covered Person.

SURGICAL SERVICES

Surgery for the treatment of Illness or Accidental Injury.

Covered Surgery includes sterilization procedures regardless of their Medical Necessity.

If more than one surgical procedure is performed by the same Professional Provider during the same operative session, benefits will be provided for the highest paying procedure plus an allowance of 50% of eligible charges for the additional procedure(s), plus any additional payment beyond the 50% that is deemed appropriate due to the nature or circumstances of the procedure. No additional allowance will be provided for those surgical procedures determined by Independence Administrators to be incidental to or an integral part of another surgical procedure performed during the same operative session.

1. Preoperative and Postoperative Medical Care

   The payment allowance for Surgery includes related preoperative and postoperative care rendered by the surgeon within the timeframe based on the surgical procedure.

2. Maternity Delivery

   The payment for maternity delivery includes prenatal and postpartum care normally provided by a Doctor for the care and management of pregnancy.

3. Surgical Assistance

   Services rendered by an assistant surgeon who actively assists the operating surgeons in the performance of Surgery.

   The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

4. Anesthesia

   Anesthesia and the administration of anesthetics in connection with the performance of covered medical services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon, or attending Professional Provider.

5. Second Surgical Opinion Consultation

   Consultation services rendered by a surgeon or specialist to determine the Medical Necessity of an Elective Surgery. Such services must be performed and billed by a

surgeon or specialist who is not in association with the one who initially recommended the Surgery.

Benefits are provided for one additional consultation, as a third opinion, in cases where the second opinion disagrees with the first recommendation. In such instances, benefits will be provided for a maximum of two consultations, but limited to one consultation per consultant.

6. Transplant Services

   If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

   a. When both the donor and recipient are covered by the Plan, each is entitled to the benefits of the Plan.

   b. When only the recipient is covered by the Plan, both the donor and recipient are entitled to the benefits of the Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be charged against the recipient's coverage under the Plan.

   c. When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program available to the recipient. No benefits are provided under the Plan to the non-Covered Person transplant recipient.

   d. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue. However, other costs related to evaluation and procurement are covered up to the Covered Person recipient's Plan limit.

PREADMISSION TESTING

Diagnostic tests and studies performed on an Outpatient basis prior to Elective Surgery. Benefits are provided for preadmission testing if:

1. the Covered Person was scheduled for Surgery prior to the testing;
2. the Surgery is not delayed beyond the 14 day period immediately following the testing; and
3. the Surgery to which the testing is related is covered by the Plan.

EMERGENCY ACCIDENT TREATMENT

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of an Emergency Accident, as defined.

Benefits are provided for emergency treatment that commences within 72 hours following the accident.

EMERGENCY MEDICAL TREATMENT

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of a condition with acute symptoms of sufficient severity that the absence of immediate medical attention could:

1. permanently place the Covered Person's health in jeopardy;
2. cause other serious medical consequences;
3. cause serious impairment to bodily functions; or
4. cause serious and permanent dysfunction of any bodily organ or part.

Benefits are provided for emergency treatment that commences within 72 hours following the onset of the medical emergency.

Should any dispute arise as to whether an emergency condition existed, the determination by Independence Administrators will be final.

HOME VISITS, OFFICE VISITS, AND OTHER OUTPATIENT VISITS

Medical visits and consultation services for the examination, diagnosis, and treatment of a condition not related to Surgery, or pregnancy, except as specifically provided.

1. Well-child care and immunizations

   Well-child care including routine physical examinations and immunizations. Benefits are provided for these services as prescribed by the American Pediatric Association. Immunizations as recommended by the Department of Health.

   Well-child care and immunizations are subject to a maximum described in the ***Schedule of Benefits***.

2. Routine physical examinations

   Examinations including a complete medical history.

   Benefits are provided for these services as prescribed by the American Medical Association. Services provided under a Vision Care program or plan are not covered.

   Routine physical examinations are subject to a maximum described in the ***Schedule of Benefits***.

3. Preventive care services

   100% coverage for certain designated preventive care services. There will be no cost sharing (copayments, coinsurance, deductibles) for the following preventive care services if provided by a Participating Provider:

   a. Evidence-based items/services with a rating of "A" or "B" in the current recommendations of the U.S. Preventative Services Task Force.

b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
c. Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents.
d. With respect to women, additional preventive care and screenings provided for in guidelines supported by HRSA.

You can find online links to these lists of services at www.Healthcare.gov. Click the *Learn About Prevention* tab.

Be aware that you may be required to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

DIAGNOSTIC SERVICES

The following procedures when ordered by a Professional Provider to determine a definite condition because of specific symptoms:

1. diagnostic X-ray consisting of radiology, ultrasound, and other diagnostic X-ray procedures.
2. diagnostic laboratory and pathology tests;
3. diagnostic medical procedures consisting of EKG, EEG, and other diagnostic medical procedures; and
4. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

THERAPY SERVICES

The following Therapy Services:

1. Radiation Therapy, including the cost of radioactive materials;
2. Chemotherapy by intravenous, intra-arterial, or intracavity injection infusion or perfusion, subcutaneous and intramuscular routes. Oral chemotherapy, including its administration, is also covered. The cost if listed as approved or indicated for the diagnosis under treatment by one or more of the following: FDA, NCCN, NIH, NCI. Notwithstanding experimental and investigational use of chemotherapy agents is not covered. All chemotherapy is subject to medical necessity review as antineoplastic agents is covered, provided they are administered as described in this paragraph;
3. Dialysis Treatment;
4. Physical Therapy;
5. Cardiac Rehabilitation;
6. Any other therapy services Independence Administrators determines necessary to treat Accidental Injury or Illness.

HOME HEALTH CARE SERVICES

The following services, as described in the ***Schedule of Benefits***, when provided to an essentially homebound Covered Person by a Home Health Care Agency:

1. Skilled Nursing Care; and
2. Therapy Services;
3. Medical Social Work;
4. Nutritional Services
5. Health services furnished by a home health aide;
6. Medical appliances;
7. Medical equipment;
8. Special meals;
9. Diagnostic or therapeutic services, including surgical services furnished;
    a. In an outpatient department of a Hospital;
    b. In a Physician's office; or
    c. At any other licensed health care facility.

Benefits are also provided for certain other medical services when furnished along with a primary service. Such other services include prescription drugs, diagnostic services, Supplies, and other Medically Necessary services.

No benefits are provided for services in connection with:

1. Custodial Care, food, housing, homemaker services, home delivered meals, and supplementary dietary assistance;
2. services provided by a member of the Covered Person's Immediate Family;
3. patient transportation, including Ambulance services;
4. visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational therapy or social services;
5. services provided to Covered Persons who are not essentially home bound for medical reasons; or
6. visits solely for the purpose of assessing the Covered Person's condition and determining whether or not the Covered Person requires and qualifies for home health care services.

HOSPICE SERVICES

Hospice benefits, as described in the ***Schedule of Benefits***, are provided when the Covered Person's attending Doctor certifies that the Covered Person has a terminal Illness with a medical prognosis of six months or less to live.

Hospice benefits are provided for the following services when rendered by a Hospice or under arrangements made by a Hospice in accordance with a Hospice care program and approved by Independence Administrators.

1. Medical care by a Doctor affiliated with the Hospice care program;
2. Nursing care by an R.N., or L.P.N., or home health aide;
3. Medical social services;
4. Therapy services except for dialysis treatments;
5. Dietary services;
6. Laboratory services;
7. Prescribed drugs and medicines;
8. Family counseling services;
9. Ambulance services when Medically Necessary to transport the Covered Person to and from the nearest Inpatient Hospice Facility;
10. The following medical services, Supplies, and equipment:
    a. oxygen, including the rental of oxygen equipment;
    b. artificial limbs or other prosthetic devices, but not including replacement;
    c. rental of Durable Medical Equipment;
11. Inpatient Hospice care when needed to control pain and other symptoms associated with the terminal Illness, but only if the Covered Person's attending Doctor certifies that it is Medically Necessary for the care to be provided on an Inpatient basis rather than in a home setting or on an Outpatient basis;
12. Inpatient respite care in a Hospice, which may be subject to a benefit maximum.

Special Exclusions and Limitations

1. The Hospice care program must deliver Hospice care in accordance with a treatment plan approved by and periodically reviewed by Independence Administrators.
2. No Hospice care benefits will be provided for:
    a. Medical care rendered by the Covered Person's private Doctor;
    b. Volunteers who do not regularly charge for services;
    c. Pastoral services;
    d. Homemaker services;
    e. Food or home delivered meals;
    f. Legal or financial services or counseling;

g. Curative treatment or services;

h. Bereavement counseling.

PRIVATE DUTY NURSING SERVICES

The following services, as described in the ***Schedule of Benefits***, when provided by an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) and ordered by a Doctor. **Prior authorization of services is required.**

1. Home Services

   Nursing services that Independence Administrators determines require the skills of an R.N. or L.P.N. No benefits are provided for the services of a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Immediate Family.

AMBULANCE SERVICES

Ambulance service by an authorized agency or a Facility providing local transportation of a sick or injured Covered Person:

1. from the site of injury or medical emergency to the nearest Facility; or
2. from the first Facility to the nearest Facility that can provide services Medically Necessary for the treatment of the Covered Person's condition, but only if the services necessary to treat the condition are not available at the first Facility.

Benefits are provided for air Ambulance transportation only if Independence Administrators determines that the Covered Person's condition, and the type of service required for the treatment of the Covered Person's condition, and the type of Facility required to treat the Covered Person's condition justify the use of air Ambulance instead of another means of transport.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC APPLIANCES

1. Durable Medical Equipment

   The rental or purchase of Durable Medical Equipment when prescribed by a Doctor and required for therapeutic use.

   a. Rental — Benefits are provided for rental fees up to an amount that equals, but does not exceed, the purchase price of the equipment.

   b. Purchase — Benefits may be provided for the purchase of Durable Medical Equipment at the option of the Plan.

   If a Claim is filed for equipment containing features of an aesthetic nature or features of a medical nature that are not required by the Covered Person's condition or if there exists a reasonable or feasible and medically appropriate alternative piece of equipment that is less costly than the equipment furnished, the benefit provided is based on the charge for the equipment that meets the Covered Person's medical

needs. **Payment for the purchase or rental of Durable Medical Equipment may require preauthorization. Preauthorization may be obtained by calling Independence Administrators' Clinical Services Department at the number listed on your identification (ID) card.**

2. Prosthetic Appliances

   The first purchase and fitting of artificial limbs, eyes, and other prosthetic appliances that replace all or part of an absent or inoperative or malfunctioning body organ but only if required for the replacement of natural parts of the body lost or becoming inoperative while covered by the Plan (excluding dental appliances).

3. Replacement and Modification

   Benefits are provided for the replacement or modification of Durable Medical Equipment, orthotics, and prosthetic appliances when Medically Necessary due to a change in the Covered Person's physical condition. Benefits for the replacement of such items are provided to the extent that the cost of the purchase is less expensive than the modification. In no event will the Plan pay for contact lenses other than the initial pair of contact lenses following cataract surgery.

4. Diabetic Education

5. Orthotics

   Benefits are provided if orthotics are an integral part of a leg brace and the cost is included in the orthotist's charges, including the initial purchase, fitting and repair of orthotic appliance that are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or illness.

6. Cranial prosthesis (wigs) are covered only in relation to baldness as a result of burns, chemotherapy, radiation therapy, or surgery.

DENTAL SERVICES

1. Dental treatment performed within six months following Accidental Injury to sound natural teeth, but only if such injury occurs while covered by the Plan. Accidental Injury does not include injuries that result from biting or chewing.
2. Oral Surgery performed for the removal of impacted teeth partially or totally covered by bone.

ROUTINE NEWBORN CARE

Professional visits to examine the newborn while an Inpatient in a Hospital or Birthing Center. Facility charges for ordinary nursery care of the newborn as well as routine newborn circumcisions are also covered.

MENTAL ILLNESS BENEFITS

Treatment of Mental Illness is eligible anywhere when performed by a Professional Provider as follows:

1. Psychiatric Visits
2. Electro-Convulsive Therapy
3. Individual Psychotherapy
4. Group Psychotherapy
5. Psychological Testing
6. Family Counseling

   Counseling with family members to assist in the Covered Person's diagnosis and treatment.

Facility Services for Mental Illness

1. Inpatient Facility Services

   Facility services provided for Inpatient treatment of Mental Illness by a Facility.

2. Partial Hospitalization

   Treatment of Mental Illness in a planned therapeutic program when such services are rendered during the day only or during the night only.

3. Outpatient Mental Illness Services

   Facility services and supplies provided to an Outpatient by a Facility.

SUBSTANCE ABUSE BENEFITS

1. Inpatient Detoxification Services

   Benefits are payable for a detoxification program provided either in a Hospital or in a licensed Substance Abuse Treatment Facility.

   a. Room and board
   b. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services
   c. Diagnostic X-ray
   d. Psychiatric, psychological, and medical laboratory testing
   e. Drugs, medicine, equipment, and Supplies

2. Inpatient Rehabilitation Services

   Benefits are payable for Inpatient services provided in a licensed Substance Abuse Treatment Facility provided the Covered Person: (a) has been certified by a Doctor

or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

a. Room and board
b. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services
c. Rehabilitation therapy and counseling
d. Family counseling and intervention
e. Psychiatric, psychological, and medical laboratory testing
f. Drugs, medicine, equipment, and Supplies

3. Outpatient Rehabilitation Services

Benefits are payable for Outpatient services provided in a licensed Substance Abuse Treatment Facility provided the Covered Person: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

a. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services;
b. rehabilitation therapy and counseling;
c. family counseling and intervention;
d. psychiatric, psychological, and medical laboratory testing; and
e. drugs, medicine, equipment, and Supplies.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS

Benefits are provided for Routine Patient Costs Associated with Participation in a Qualifying Clinical Trial (see ***Definitions*** section). To ensure coverage and appropriate claims processing, the Plan must be notified in advance of the Covered Person's participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by a Preferred Professional Provider and conducted in a Preferred Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by a Preferred Professional Provider, and in a Preferred Facility Provider, then the Plan will consider the services by a Non-Preferred Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial (see ***Definitions*** section) by the Plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In accordance with this law, the required mastectomy coverage includes:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications of all stages of a mastectomy, including lymphedemas.

The benefits for these services must be provided in a manner determined in consultation with the attending doctor and the patient. These services may be subject to the deductibles and coinsurance amounts applicable to your group health plan.

CHILD IMMUNIZATION COVERAGE

Coverage will be provided for those child immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with standards of the Advisory Committee on Immunization Practices of the Center of Disease Control, U.S. Department of Health and Human Services. Benefits will be exempt from deductibles or dollar limits.

ANNUAL GYNECOLOGICAL EXAMINATION AND ROUTINE PAP SMEARS

- Annual gynecological examination, including a pelvic examination and clinical breast examination; and
- Routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

These gynecological examination/pap smear benefits are exempt from any deductible or dollar limit provisions in the contract. However, they may be subject to any copayment or coinsurance amounts applicable to your group health plan.

COLORECTAL CANCER SCREENING COVERAGE

Coverage for colorectal cancer screening may be subject to annual deductibles, coinsurance, and copayment requirements applicable to your group health plan.

Benefits for preventive care colorectal cancer screening are subject to the requirements as established by the U.S. Preventive Services Task Force Recommendations and may be different from the benefits detailed below. For more information on preventive care colorectal cancer screening, please visit www.healthcare.gov.

Symptomatic individuals;

Colonoscopy
Sigmoidoscopy
Colorectal Screening Tests (any combination thereof as determined by the treating Physician)

Non-symptomatic individuals covered over age 50;

Annual Fecal Occult Blood Test
Sigmoidoscopy – a screening barium enema test once every five years
Colonoscopy – no age or time restriction for this benefit
Colon Cancer test at least once every 5 years

Non-symptomatic coverage for individuals at high or increased risk of colorectal cancer under age 50;

Colonoscopy
Any combination of colorectal cancer screening tests.

PRESCRIPTION DRUG COVERAGE

Your prescription drug coverage is administered by FutureScripts. One (1) ID card is used for access to both Medical and Prescription drug benefits.

You are responsible for a copayment for each prescription drug or refill. You may also be responsible for a prescription drug OR plan deductible that must first be met before any benefits are payable. This amount is shown in the ***Schedule of Benefits***.]

If you purchase your prescription at a pharmacy that accepts FutureScripts, simply present your ID card and pay the copayment and/or deductible.

If you purchase your prescription at a Doctor's office or pharmacy that does not accept FutureScripts, pay the full cost of the prescription and have the Doctor or pharmacist complete their portion of a "Direct Reimbursement" form. Submit this form to FutureScripts and they will reimburse you for the cost of the prescription minus your copayment and/or deductible.

PRIOR AUTHORIZATION

Your prescription drug coverage requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing physicians and pharmacists.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on: clinical data; information submitted by the plan member's prescribing physician; and the plan member's available prescription drug therapy history. Their review includes a determination that: there are no drug interactions or contra indications; that dosing and length of therapy are appropriate; and that other drug therapies, if necessary, were used.

Without prior authorization, the plan member's prescription will not be covered at your health benefits program's retail or mail order pharmacy.

The prior authorization process may take up to two working days once FutureScripts receives complete information from the prescribing physician. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, the approval will include an expiration date. If the physician wants a plan member to continue the drug therapy after the expiration date, he or she will need to get approval for a new prior authorization request in order for coverage to continue.

DRUGS THAT REQUIRE PRIOR AUTHORIZATION

You can see what drugs require prior authorization online. Visit the website listed on your identification (ID) card and click Prescription Drug Program > More information.

If you prefer to talk with a FutureScripts representative, please call 1-888-678-7013.

APPEALING A DECISION

If a request for prior authorization/preapproval or override results in a denial, the plan member or physician, on the plan member's behalf, may file an appeal. Both the plan member and the physician will receive written notification of a denial, which will include the telephone number and address to which they can direct an appeal. In all cases, the physician must be involved in the appeals process to provide the required medical information for the basis of the appeal.

REQUEST PRIOR AUTHORIZATION/PREAPPROVAL OR OVERRIDE

The physician prescribing the medication completes a prior authorization form or writes a letter of medical necessity and faxes it to FutureScripts at 215-241-3073 or 1-888-671-5285. Or the physician may request the form by calling 1-888-678-7013. Plan members may request the form through FutureScripts Customer Service on the physician's behalf, but the physician must complete and submit it.

FutureScripts will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review it.

CLINICAL SERVICES

You MUST CALL the number for Clinical Services listed on your identification (ID) card to fulfill the requirements of Clinical Services.

The pre-certification process reviews the Medical Appropriateness/Medical Necessity of the requested services only. Pre-certification is not a guarantee of eligibility for the coverage or payment of a Claim. Coverage and payment are dependent upon, among other things, the Covered Person being eligible, i.e., actively enrolled in the health benefits plan when the services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

A. UTILIZATION REVIEW PROCESS

A basic condition of the Plan's benefit plan coverage is that in order for a health care service to be covered or payable, the service must be Medically Appropriate/Medically Necessary. Medically Appropriate/Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and care in a Hospital Outpatient Department. To assist Independence Administrators' delegate in making coverage determinations for requested health care services, Independence Administrators uses established medical policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Covered Person's benefit plan is called utilization review.

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by Independence Administrators to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/Medical Necessity of the procedure itself, the diagnosis reported, or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an emergency room which has been approved by Independence Administrators' delegate based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g. rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed,

it is called a pre-certification review. Reviews occurring during a Hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. Independence Administrators' delegate follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Appropriateness/Medical Necessity review, nurses perform the initial case review using medical policies, established guidelines and evidence-based clinical criteria and protocols; however, only a medical director employed by Independence Administrators or its delegate may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable guidelines and evidence-based clinical criteria and protocols, taking into consideration the Covered Person's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a medical director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and the Covered Person in accordance with applicable law.

Independence Administrators' utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to Independence Administrators' or its delegate's medical directors to discuss coverage of a case. Medical directors and nurses receive salaries. Contracted external physicians and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. Neither Independence Administrators nor its delegates specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

B. CLINICAL CRITERIA, GUIDELINES AND RESOURCES

The following guidelines, clinical criteria and other resources are used to help make Medically Appropriate/Medically Necessary coverage decisions.

Clinical Decision Support Criteria — Clinical Decision Support Criteria is an externally validated and computer-based system used to assist Independence Administrators or its delegate in determining Medical Appropriateness/Medical Necessity. This

evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of Illness, these criteria assist clinical staff in evaluating the Medical Appropriateness/Medical Necessity of services based on a Covered Person's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in plan determinations for similar medical issues and requests; and, reduces practice variation among Independence Administrators' or its delegate's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following: some elective Surgeries - settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery), Inpatient hospitalizations, Inpatient and Outpatient rehabilitation, diagnostic procedures, Home Health Care, Durable Medical Equipment, and Skilled Nursing Facility.

Medical Policies — Independence Administrators and its delegates maintain an internally developed set of policies, which document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which Medical Polices are applied include, but are not limited to: Ambulance, Infusion, Speech Therapy, Occupational Therapy, Durable Medical Equipment, and review of potential cosmetic procedures.

Internally Developed Guidelines — A set of guidelines developed with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting medical policies for coverage.

C. DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

Independence Administrators has agreements with state licensed utilization review entities, where required, and a NCQA (National Committee for Quality Assurance) accredited utilization management program. Independence Administrators has delegated certain utilization review activities, including pre-certification review, concurrent review, and case management, to entities with an expertise in medical management of certain conditions and services (such as, mental illness/substance abuse), or certain membership populations (such as, neonates/premature infants), or after-hours pre-certification services. In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with Independence Administrators' approval.

D. PRE-CERTIFICATION REVIEW

When required, Pre-certification review evaluates the Medical Necessity, including the appropriateness of the setting, of proposed services for coverage under the Covered Persons benefit plan. Examples of these services include planned or

elective Inpatient admissions and selected Outpatient procedures. For Covered Persons located in the PPO Network service area, Pre-certification review may be initiated by the Provider or the Covered Person depending on whether the Provider is a PPO Network Provider. For Covered Person's located outside Independence Administrators PPO Network who are accessing BlueCard PPO Providers, the Covered Person is responsible for initiating or requesting the Provider to initiate the Pre-certification review. Where Pre-certification review is required, Independence Administrators' coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Pre-certification review is required for a procedure but is not obtained.

1. INPATIENT PRE-ADMISSION REVIEW

Inpatient Admissions

In accordance with the criteria and procedures described above, Inpatient admissions, other than an emergency admission, must be pre-certified in accordance with the standards of Independence Administrators as to the Medical Appropriateness/Medical Necessity of the admission. The pre-certification requirements for emergency admissions are set forth in the "Emergency Admission Review" subsection immediately following below. The Covered Person is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.

a. To obtain Pre-certification, the Covered Person is responsible to contact or have the admitting Physician or other Facility Provider contact Independence Administrators prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. Independence Administrators will notify the Covered Person, admitting Physician and the Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits at the Preferred or Non-Preferred level shown in the ***Schedule of Benefits*** if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this booklet.

b. If such prior approval for a Medically Appropriate/Medically Necessary Inpatient Admission has not been certified as required, there will be a penalty for non-compliance and benefits for Covered Services will be reduced 100%, up to a maximum benefit reduction of $200, per hospitalization to the Covered Person. Such penalty, and any difference in what is covered by the Plan and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

c. If a Covered Person elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient

level of care, Inpatient benefits will not be provided and the Covered Person will be financially liable for non-covered Inpatient charges.

d. If Pre-certification is denied, the Covered Person, the Physician or the Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Covered Person, Physician, or Facility Provider will be so notified.

2. EMERGENCY ADMISSION REVIEW

Emergency Admissions

a. Covered Persons are responsible for notifying Independence Administrators of an emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by Independence Administrators.

b. Failure to initiate Emergency admission review will result in a penalty for non-compliance and benefits for Covered Services will be reduced 100%, up to a maximum benefit reduction of $200, per hospitalization to the Covered Person. Such penalty will be the sole responsibility of, and payable by, the Covered Person.

c. If the Covered Person elects to remain hospitalized after Independence Administrators and the attending Doctor have determined that an Inpatient level of care is not Medically Appropriate/Medically Necessary, the Covered Person will be financially liable for non-covered Inpatient charges from the date of notification.

3. CONCURRENT AND RETROSPECTIVE/POST-SERVICE REVIEW, PRE-NOTIFICATION AND DISCHARGE PLANNING

Concurrent review may be performed while services are being performed. If concurrent review is performed during an Inpatient stay, the expected and current length of stay is evaluated to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Covered Person and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent review may not be performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with a Facility does not require such review.

Retrospective/post-service review occurs after services have been provided. This may be for a variety of reasons, including when Independence Administrators has not been notified of a Covered Person's admission until after discharge, or where medical charts are unavailable at the time of a concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, Independence Administrators may determine coverage of certain procedures and other benefits available to Covered Persons through pre-notification as required by the Covered Person's benefit plan and discharge planning.

Pre-notification is advance notification to Independence Administrators of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Covered Persons for concurrent review needs, to ascertain discharge planning needs proactively, and to identify Covered Persons who may benefit from case management programs.

Discharge planning is performed during an Inpatient admission and is used to identify and coordinate a Covered Person's needs and benefit coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge planning involves Independence Administrators' authorization of covered post-Hospital services along with identifying and referring Covered Persons for disease management or case management services.

E. TRANSPLANT SERVICES

Independence Administrators requests notification of transplant services as soon as the need for an organ or tissue transplant is known. For a complete list of services requiring Pre-certification please call the number for Clinical Services or visit the website listed on your identification (ID) card. This list may be subject to change.

F. MATERNITY SERVICES

Independence Administrators requests maternity care notification as soon as the pregnancy is confirmed by a Doctor.

Pre-certification requirements apply when:

1. a Covered Person is admitted for any condition or procedure other than delivery of the baby;
2. the type of delivery anticipated or place of service changes before admission for delivery;
3. the Covered Person's medical condition requires a stay longer than 48 hours after a vaginal delivery or 96 hours after an approved cesarean section. Independence Administrators must pre-certify additional Inpatient days;
4. the baby is required to stay after the mother is discharged. Independence Administrators must pre-certify additional Inpatient days.

A Covered Person is encouraged to call Independence Administrators if medical problems develop during the pregnancy.

G. OTHER PRE-CERTIFICATION REQUIREMENTS

Pre-certification is required by Independence Administrators in advance for Home Health Care, Hospice Care, certain surgical and diagnostic procedures, Inpatient and Partial Hospitalization services for Substance Abuse, Mental Illness and Serious Mental Illness. For a complete list of Pre-certification requirements please call the number for Clinical Services listed on your identification (ID) card or visit the website listed on your identification (ID) card. This list may be subject to change. When a Covered Person plans to receive any of these listed procedures, Independence Administrators will review the Medical Appropriateness/Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures that are performed during an emergency, as determined by Independence Administrators, do not require pre-certification. However, Independence Administrators should be notified within two (2) business days of emergency services for such procedures, or as soon as reasonably possible, as determined by Independence Administrators. A complete list of Pre-certification requirements is available by calling the number for Clinical Services listed on your identification (ID) card or by visiting the website listed on your identification (ID)card. This list may be subject to change.

The Covered Person is responsible to have the Provider performing the service contact Independence Administrators to initiate pre-certification. Independence Administrators will notify the Covered Person, the Doctor and the Facility, if applicable, of the determination.

If such prior approval is not obtained and the Covered Person undergoes the Surgical Procedure, diagnostic or other procedure, or treatment then benefits will be provided for Medically Appropriate/Medically Necessary treatment, but there will be a penalty for non-compliance. Benefits for Covered Services will be reduced 100%, up to a maximum benefit reduction of $200, per service to the Covered Person. Such penalty, and any difference in what is covered by Independence Administrators and the Covered Person's obligation to the Provider, may be the sole responsibility of, and payable by, the Covered Person.

H. SERVICES REQUIRING PRE-CERTIFICATION

For a complete list of services requiring Pre-certification please call the number for Clinical Services listed on your identification (ID) card or visit the website listed on your identification (ID) card. This list may be subject to change.

I. CASE MANAGEMENT

Case management serves individuals who have been diagnosed with a complex, catastrophic, or chronic Illness or injury. The objectives of case management are to facilitate access by the patient to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve outcomes of Covered Persons. Case management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic Illness and/or injury across various levels and sites of care.

Independence Administrators will provide case management services for those identified Covered Persons that would benefit from:

- Support during the continuum of care;
- Improved self-management skills;
- Improved transition and coordination among multiple Providers and/or levels of care;
- Assistance to maximize the effective use of health plan benefits;
- Reduction of acute exacerbation of a chronic Illness; and,
- Reduction of preventable complications.

Covered Persons may be identified for case management through the pre-certification process or through claims review. External referrals are also accepted from Covered Persons' Providers or family members. Covered Persons referred to case management are screened and accessed prior to acceptance into the program. Only those Covered Persons likely to benefit from case management are accepted into case management.

A case manager will consult with the patient, the patient's authorized representative, the caregiver and the attending Doctor in order to develop a plan of care for approval by the patient's attending Doctor and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the care giver to offer assistance and support;
- monitoring Inpatient care;
- identifying available resources for appropriate care;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The attending Doctor, the patient and the patient's caregiver must all agree to the alternate treatment plan. Once agreement has been reached, Independence Administrators may reimburse necessary expenses in the treatment plan, even if some expenses normally would not be paid by the benefit plan.

Case management is a voluntary service. Covered Persons must provide their consent for enrollment into case management. There is no reduction in benefits if the patient and the patient's family choose not to participate.

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

J. DISEASE MANAGEMENT AND DECISION SUPPORT PROGRAMS

Disease Management and Decision Support programs help Covered Persons to be effective partners in their health care by providing information and support to Covered Persons with certain chronic conditions as well as those with everyday health concerns. Disease Management is a systematic, population-based approach that involves identifying Covered Persons with certain chronic conditions, intervening with specific information or support to follow a Provider's treatment plan, and measuring clinical and other outcomes. Decision Support involves identifying Covered Persons who may be facing certain treatment option decisions and offering them information to assist in informed, collaborative decisions with their Doctors. Decision Support also includes the availability of general health information, personal health coaching, Provider information, or other programs to assist in health care decisions.

Disease Management interventions are designed to help Covered Persons manage their chronic conditions in partnership with their Doctors. Disease Management programs, when successful, can help such Covered Persons avoid long term complications, as well as relapses that would otherwise result in Hospital or emergency room care. Disease Management programs also include outreach to Covered Persons to obtain needed preventive services, or other services recommended for chronic conditions. Information and support may occur in the form of telephonic health coaching, print, audio library or videotape, or Internet formats.

AmeriHealth Administrators will utilize medical information such as claims data to operate the Disease Management or Decision Support program, e.g. to identify Covered Persons with chronic conditions, to predict which Covered Persons would most likely benefit from these services, and to communicate results to Covered

Persons' treating Doctors. AmeriHealth Administrators will decide what chronic conditions are included in the Disease Management or Decision Support program.

Participation by a Covered Person in the Disease Management or Decision Support program is voluntary. A Covered Person may continue in the Disease Management or Decision Support program until either of the following occurs:

1. the Covered Person declines participation; or
2. AmeriHealth Administrators determines that the program, or aspects of the program, will not continue.

EXCEPTIONS AND EXCLUSIONS

Except as specifically provided in this booklet, no benefits will be provided for services, supplies or charges:

1. Which are not Medically Necessary as determined by the Plan for the diagnosis or treatment of illness or injury;
2. Which are Experimental/Investigative in nature, except, a) as approved by the Plan, or b) Routine Patient Costs Associated With Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under the Plan;
3. Which were Incurred prior to the Covered Person's effective date of coverage;
4. Which are in excess of the Covered Expense, as defined herein;
5. Which were or are Incurred after the date of termination of the Covered Person's coverage;
6. For any loss sustained or expenses Incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared;
7. For which a Covered Person would have no legal obligation to pay, or another party has primary responsibility;
8. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
9. Paid or payable by Medicare when Medicare is primary. For purposes of this plan, a service, supply or charge is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;
10. For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation;
11. To the extent a Covered Person is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Covered Person;
12. For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the state's Motor Vehicle Financial Responsibility Law or similar law;
13. Which are not billed and performed by a Provider as defined under this coverage as a "Professional Provider", "Facility Provider" or "Ancillary Provider" except as otherwise indicated under the subsections entitled: (a) Therapy Services" (that identifies covered therapy services as provided by licensed therapists) and (b) "Ambulance Services" in the ***Covered Medical Charges*** section;
14. Rendered by a member of the Covered Person's Immediate Family;

15. Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a Hospital or university;
16. For ambulance services except as specifically provided under this Plan;
17. For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, injury or congenital birth defect. This exclusion does not apply to mastectomy related charges as provided for in this booklet;
18. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
19. For alternative therapies/complementary medicine, including but not limited to, acupuncture (covered only as a form of anesthesia in connection with a covered surgical procedure), music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;
20. For marriage counseling;
21. For Custodial Care, domiciliary care or rest cures;
22. For equipment costs related to services performed on high cost technological equipment as defined by the Plan, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the pre-certification process and/or by the Plan;
23. For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this booklet/certificate. Services not covered include, but are not limited to, apicoectomy (dental root resection), prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated;
24. For dental implants for any reason;
25. For dentures, unless for the initial treatment of an Accidental Injury/trauma;
26. For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;
27. For injury as a result of chewing or biting (neither is considered an Accidental Injury);
28. For palliative or cosmetic foot care including treatment of bunions (except for capsular or bone surgery), toenails (except surgery for ingrown nails), the treatment of subluxations of the foot, care of corns, calluses, fallen arches, pes planus (flat

feet), weak feet, chronic foot strain, and other routine podiatry care, unless associated with the Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes;

29. For supportive devices for the foot (orthotics), such as, but not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes. This exclusion does not apply to orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
30. For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such Surgery;
31. For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury;
32. For treatment of obesity, except for surgical treatment of obesity when the Plan (a) determines the surgery is Medically Necessary; and (b) the surgery is limited to one surgical procedure per lifetime regardless of whether such procedure was covered by the Plan or another Plan. Any new or different obesity surgery, revisions, repeat, or reversal of any previous surgery are not covered. The exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure results in technical failure or when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person;
33. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
34. For diagnostic screening examinations, except for mammograms and preventive care as provided in the ***Covered Medical Charges*** section;
35. For routine physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for college, camp or travel, and examinations for insurance, licensing and employment;
36. For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;
37. For immunizations required for employment purposes, or for travel except for those immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee for Immunization Practices;
38. For care in a nursing home, home for the aged, convalescent home, school, camp, institution for intellectually disabled children, Custodial Care in a Skilled Nursing Facility;
39. For counseling or consultation with a Covered Person's relatives, or Hospital charges for a Covered Person's relatives or guests, except as may be specifically provided;
40. For home blood pressure machines, except for Covered Persons: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, or (c) with end-stage renal disease receiving home dialysis;
41. As described in the "Durable Medical Equipment" section in the ***Covered Medical Charges*** section for personal hygiene, comfort and convenience items; equipment and devices of a primarily nonmedical nature; equipment inappropriate for home use; equipment containing features of a medical nature that are not required by

the Covered Person's condition; non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicate equipment, whether or not rented or purchased as a convenience; devices and equipment used for environmental control; and customized wheelchairs;

42. For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits;
43. For prescription drugs, except as may be provided in the ***Prescription Drug Coverage*** section of this booklet. This exclusion does not apply to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels as provided for the treatment of diabetes;
44. For over-the-counter drugs and any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient admission;
45. For amino acid supplements, non-elementals formulas, appetite suppressants or nutritional supplements. This exclusion includes basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy;
46. For Inpatient Private Duty Nursing services;
47. For maintenance of chronic conditions;
48. For charges Incurred for expenses in excess of Benefit limits as specified in the ***Schedule of Benefits***;
49. For any therapy service provided for: the ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond this Plan's limits, if any, shown on the ***Schedule of Benefits***; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;
50. For cognitive rehabilitative therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (e.g. stroke, acute brain insult, encephalopathy);
51. For self-injectable Prescription Drugs, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered self-injectable Prescription Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration. This exclusion does not apply to self-injectable Prescription Drugs that are: (a) mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes, unless these drugs are covered by Prescription Drug coverage under the Plan or free-standing Prescription Drug Contract issued to the Group by the Plan; or (b) required for treatment of an emergency condition that requires a self-injectable drug;
52. For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension;

53. For hearing aids, including cochlear electromagnetic hearing devices, and hearing examinations or tests for the prescription or fitting of hearing aids unless otherwise indicated. Services and supplies related to these items are not covered;
54. For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);
55. For any Surgery performed for the reversal of a sterilization procedure;
56. For abortion services except when abortion is necessary to avert the death of the mother, and in cases when pregnancy is the result of rape or incest;
57. For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated;

For any other service or treatment except as provided under this Plan.

COORDINATION OF BENEFITS

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS

The following special coordination rule applies regarding automobile insurance. If a covered person has automobile insurance (including, but not limited to no-fault) that provides health insurance benefits, the automobile insurance shall be the primary plan and this Plan shall be secondary for the purposes of paying benefits.

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF MOTORCYCLE ACCIDENTS

The following special coordination rule applies regarding motorcycle accidents. If a covered person is injured in an accident that involves a motor vehicle, claims will be processed in accordance with the Plan's position on motor vehicle accidents.

IF A COVERED PERSON IS OPERATING A MOTORCYCLE AND IS INJURED IN AN ACCIDENT THAT DOES NOT INVOLVE A MOTOR VEHICLE, THIS PLAN WILL EXCLUDE COVERAGE FOR THE FIRST $20,000 IN ELIGIBLE CHARGES OR, IF GREATER, THE AMOUNT OF HEALTH BENEFITS PAYABLE BY THE MOTORCYCLE INSURANCE POLICY.

It is the responsibility of any covered person who operates a motorcycle to ensure that he or she is covered under a motorcycle insurance policy that will pay at least $20,000 in health benefits for him or her per accident. This requirement applies even if the covered person is not legally required to have such health benefit coverage. If the covered person fails to maintain $20,000 of coverage through a motorcycle insurance policy, the difference between the policy's maximum payout per accident (if any) and $20,000 will be the covered person's responsibility.

A covered person who is riding a motorcycle as a passenger and is injured in an accident that does not involve a motor vehicle will not be subject to this provision and will not have his or her otherwise eligible claims excluded from Plan coverage as described.

APPLICABILITY

1. This Coordination of Benefits ("COB") provision applies to This Plan when an Employee or the Employee's covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.
2. If this COB provision applies, the Order Of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:
   a. shall not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but

b. may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in "Effect on the Benefits of This Plan."

DEFINITIONS

1. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It does not include school accident-type coverage, group or group-type hospital indemnity benefits of $100 per day or less.

   b. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid. It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

   Each contract or other arrangement for coverage under (a) or (b) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **"This Plan"** is the part of the group contract that provides benefits for health care expenses.

3. **"Primary Plan/Secondary Plan."** The Order Of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **"Allowable Expense"** means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

   The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. **"Claim Determination Period"** means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES

1. **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
   a. the other Plan has rules coordinating its benefits with those of This Plan; and
   b. both those rules and This Plan's rules, in subparagraph 2 below, require that This Plan's benefits be determined before those of the other Plan.
2. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:
   a. **Non-dependent/Dependent.** The benefits of the Plan which covers the person as other than a dependent are determined before those of the Plan which covers the person as a dependent.
   b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph 2 (c) below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
      (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
      (2) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period.

      However, if the other Plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
   c. **Dependent Child/Parents Separated or Divorced**. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      (1) first, the Plan of the parent with custody of the child;
      (2) then, the Plan of the spouse of the parent with custody of the child; and

(3) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. **Active/Inactive Employee.** The benefits of a Plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

e. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee longer are determined before those of the Plan that covered that person for the shorter time.

EFFECT ON THE BENEFITS OF THIS PLAN

1. **When this Section Applies.** This section applies when, in accordance with "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2 immediately below.

2. **Reduction in This Plan's Benefits.** The benefits of This Plan will be reduced when the sum of:

   a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

   b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

   When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Independence Administrators has the right to release or obtain benefit information in order to implement this provision.

FACILITY OF PAYMENT

If payments should have been made under this Plan but were made under any other Plan(s), Independence Administrators may make payments to such other Plan(s) to satisfy the intent of the provision. Benefits under this Plan will then be deemed paid. The Plan will no longer be liable for such payments.

RIGHT OF RECOVERY

Independence Administrators has the right to recover any excess payments made to satisfy the intent of this provision.

TERMINATION OF COVERAGE

EMPLOYEE

Coverage for an Employee will end on the earliest of:

1. the date the Plan terminates;
2. the end of the month in which coverage terminates under the Plan for the class of Employees to which the Employee belongs;
3. the end of the month in which the Employee transfers to an ineligible class of Employees;
4. the end of the period covered by the last contribution made by the Employee for coverage under the Plan;
5. the date in which the Employee's employment is terminated;
6. the date the Employee begins full-time active duty as a member of any military organization;
7. the date the Employee becomes involved in a labor dispute, strike, or work stoppage. Coverage will be reinstated only upon the return of such Employee to the Plan.

DEPENDENTS

Coverage for a Dependent will end on the earliest of:

1. the date an Employee's coverage terminates under the Plan;
2. the end of month in which the Dependent no longer satisfies the eligibility requirements for coverage as a Dependent under the Plan;
3. the end of the period covered by the last contribution made by the Employee for Dependent coverage.

CONTINUATION OF COVERAGE DURING CERTAIN LEAVES OF ABSENCE

In certain instances, the Company may allow you to continue your coverage while you are on an approved leave of absence. Please refer to the Company's leave of absence policies outlined in a separate document.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA affects employers who have employed 20 or more Employees on more than 50% of the typical business days during the previous calendar year. The employer is responsible for notifying each qualified beneficiary of their rights under COBRA.

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee. In order to be a

qualified beneficiary an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment, or a divorce from or death of the covered employee). A child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage is also a qualified beneficiary.

Each qualified beneficiary, as defined under the Consolidated Omnibus Budget Reconciliation Act of 1985, whose coverage would end under the Contract as a result of a qualifying event (listed below) will have an opportunity to elect continuation coverage under the Contract as required by law.

The employer retains full responsibility for notifying Employees of the rights of continuation coverage and for administering the exercise of continuation rights, as required by COBRA.

Each Employee has a right to continue coverage if:

1. employment with the employer ends for a reason other than gross misconduct;
2. work hours are reduced.

Each Dependent has a right to continue coverage if:

1. the Employee's employment with the employer ends for a reason other than gross misconduct;
2. the Employee's work hours are reduced;
3. the Employee dies;
4. in the case of the Employee's spouse, such spouse ceases to be an eligible Dependent as a result of divorce or legal separation;
5. the Employee is entitled to Medicare benefits, or
6. in the case of a Dependent child, such child ceases to be an eligible Dependent according to the terms of the Contract.

If any of the qualifying events occur, each qualified beneficiary, as reported to Independence Administrators by the employer, will receive a form from the employer to decide whether or not to elect COBRA continuation. Each qualified beneficiary will then have 45 days to pay the premium due. Premiums are payable from the date of the qualifying event.

In the case of the Employee's termination of employment or reduction in work hours, the coverage may be continued for up to 18 months, or 29 months if the individual is disabled either at the time of his qualifying event or during the first 60 days of COBRA coverage and has received notification of disability eligibility from the Social Security Administration and notifies the employer within 60 days after receiving such notification.

If the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29-month disabilities extension. With respect to all other events, coverage may be continued for up to 36 months.

However, coverage will cease earlier if one of the following events occurs:

1. the employer ceases to provide group health coverage to any Employee; or
2. the qualified beneficiary fails to make timely payments of any premium required; or
3. the qualified beneficiary is covered under another group health plan; or
4. the qualified beneficiary is entitled to benefits under Title XVIII of the Social Security Act (Medicare); or
5. the spouse remarries and becomes covered under another group health insurance plan.

Independence Administrators will have no obligation to ensure that any termination instructions received by it from the employer comply with the requirement of COBRA.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

THIRD PARTY RECOVERY PROVISION

To the extent payment for the Illness or injury is made, or may be made in the future, by or for the party or parties legally responsible (as a settlement, judgment or in any other way), charges arising from that Illness or injury are not considered to be eligible charges under the terms of the Plan. If, however, payment by or for the party or parties legally responsible has not yet been made and the Covered Person(s) involved (or if incapable, that person's legal representative) agrees in writing to pay back promptly the benefits paid as a result of the Illness or injury to the extent of any future payments made by or for the party or parties legally responsible for the Illness or injury, the Plan will consider charges arising from that Illness or injury as eligible charges and benefits will be paid under the terms of the Plan. The agreement is to apply whether or not: (a) liability for the payments is admitted by the party or parties legally responsible; and (b) such payments are itemized.

When a Covered Person incurs medical expenses which are payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or if medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Covered Person shall reimburse the Plan for the cost of any and all medical expenses out of any funds or monies that he recovers from any third party, whether by coverage under another program, statute, insurance policy, lawsuit, settlement, judgment or otherwise.

Because the Plan is entitled to reimbursement for any payment which a Covered Person may receive from a third party if the Plan has paid medical benefits for expenses that arose from the same circumstances that were the basis for the payment received from the third party, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Covered Person may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount and/or recovery from a third party. This right to reimbursement comes first regardless of the manner in which the recovery is structured or worded, and/or even if the Covered Person has not been paid fully or reimbursed for all of his/her damages or expenses. Therefore, the Plan's share of the recovery shall not be reduced because the Covered Person has not received the full damages or expenses claimed unless the Plan agrees in writing to such reduction.

Each Covered Person hereby consents and agrees that a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan exists with regard to any payment, amount and/or recovery from a third party; and in accordance with that constructive trust, lien and/or equitable lien by agreement, each Covered Person agrees to cooperate with the Plan in reimbursing it for the Plan's costs and expenses.

To that end, once a Covered Person has any reason to believe that he may be entitled to recovery from any third party, he must notify the Plan. And, at that time, the Covered Person (and his attorney, if applicable) must sign a subrogation/reimbursement agreement that acknowledges the Plan's subrogation rights and its right to be reimbursed for expenses arising from circumstances that entitle the Covered Person to any payment, amount and/or recovery from a third party.

If a Covered Person fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to the Covered Person and/or any of his dependents until the agreement is signed. Alternatively, if a Covered Person fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Covered Person, the Covered Person's acceptance of such benefits shall constitute his or her agreement to the Plan's right to subrogation or reimbursement from any recovery by the Covered Person from any third party that is based on the circumstances from which the expenses or benefits paid by the Plan arose, and the Covered Person's agreement to a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan on any payment, amount or recovery that the Covered Person recovers from any third party.

The Plan also may enforce its subrogation or reimbursement rights by requiring the Covered Person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorneys' fees or costs associated with the Covered Person's claim or lawsuit without express written authorization from the Plan Sponsor.

Each Covered Person consents and agrees that he/she shall not assign his/her rights to any payment, amount or recovery against a third party to any other party, including his/her attorneys without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

The Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorneys fund" doctrine, regulatory diligence or any other equitable defense that may affect the Plan's right to subrogation or reimbursement.

If the Plan shall become aware that a Covered Person has received a third party payment amount and/or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further payments related to the Covered Person and/or his or her dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to the Covered Person.

GENERAL PROVISIONS

REGARDING TREATMENT WHICH IS NOT MEDICALLY NECESSARY

Independence Administrators only covers treatment which it determines Medically Necessary. A Preferred Provider accepts Independence Administrators decision and contractually is not permitted to bill the Covered Person for treatment which Independence Administrators determines is not Medically Necessary unless the Preferred Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by Independence Administrators, and that the Covered Person will be financially responsible for such services. A Non-Preferred Provider, however, is not obligated to accept Independence Administrators determination and the Covered Person may not be reimbursed for treatment which Independence Administrators determines is not Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Preferred Provider. You can avoid these charges simply by choosing a Preferred Provider for your care. The term "Medically Necessary" is defined in the ***Definitions*** section.

LIMITATION OF LIABILITY

Independence Administrators will not be liable for any injury(ies) or damage(s) resulting from acts or omissions of any person, institution or other Provider furnishing services or supplies to the Covered Person.

No legal action may be taken to recover benefits provided by the Plan until 30 days after Independence Administrators has received a properly completed claim. In no event may such action be taken later than one year after services or Supplies were performed or provided.

NOTICE OF CLAIMS

Payments of benefits will not be made under the Plan unless proper notice is furnished to Independence Administrators that covered expenses have been provided to a Covered Person. **Written notice must be given within 60 days after expenses are Incurred for covered expenses.**

Failure to give notice to Independence Administrators within the specified time will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but **in no event will Independence Administrators be required to accept notice more than one year after covered expenses are Incurred.**

PAYMENT OF BENEFITS

Independence Administrators is authorized by the Plan to make payment directly to Facilities and Preferred Providers furnishing Covered Services for which benefits are provided under the Plan.

However, Independence Administrators reserves the right to make the payments directly to the Covered Person. The right of the Covered Person to receive payment is not otherwise assignable unless required by State law.

If any benefit remains unpaid at the death of the Employee, payment will be made to the Employee's estate. If no estate is probated or expected to be probated, Independence Administrators will have the right to make payment to a third party who has paid covered expenses for the Employee, upon receipt of proper documentation of such payment. Independence Administrators will incur no liability due to such payment made pursuant to this provision.

A request for payment of benefits will be deemed to authorize Independence Administrators to institute an investigation and to have access to all pertinent data, including all records of a Hospital and/or Doctor pertaining to the Covered Person.

COVERED PERSON/PROVIDER RELATIONSHIP

1. The choice of a Provider or choice of treatment by a Provider is solely that of the Covered Person.

2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by a Covered Person. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's rendering of, failure or refusal to render Covered Services to a Covered Person.

PAYMENT OF PROVIDERS

1. PREFERRED PROVIDER REIMBURSEMENT

Reimbursement of health care providers who participate in the Preferred Provider Network is intended to encourage the provision of quality, cost-effective care. Set forth below is a general description of the reimbursement programs, by type of Network health care provider.

Please note that these reimbursement programs may change from time to time, and the arrangements with particular Providers may be modified as new contracts are negotiated. If you have any questions about how your health care provider is compensated, please speak with your healthcare provider directly or contact Customer Service.

PHYSICIANS

Network physicians, including primary care physicians (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to the Network fee schedule for the specific medical services that the Physician performs.

INSTITUTIONAL PROVIDERS

Hospitals

For most Inpatient medical and surgical services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Hospital. These rates usually vary according to the intensity of the Covered Services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various services.

Independence Administrators is implementing a quality incentive program with a few of the Hospitals in the Network. This program will provide increased reimbursement to these Hospitals based on them meeting specific quality criteria, including "Patient Safety Measures". Such patient safety measures are consistent with recommendations by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes, higher nursing staff ratios, and electronic submissions. This is a new incentive program that is expected to evolve over time.

Skilled Nursing Facilities, Rehabilitation Hospitals, and other care facilities

Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Facility. These amounts may vary according to the intensity of the Covered Services provided.

Ambulatory Surgical Centers ("ASCs")

Most ASCs are paid specific rates based on the type of Covered Service performed. For a few services, some ASCs are paid based on a percentage of billed charges.

Physician Group Practices, Physician Associations and Integrated Delivery Systems

Certain physician group practices, independent physician associations ("IPAs") and integrated hospital/physician organizations called Integrated Delivery Systems ("IDS") employ or contract with individual physicians to provide medical services. These groups are paid as described in the Physicians reimbursement subsection outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

Ancillary Service Providers, certain Facility Providers and Mental Health/Substance Abuse Providers

Ancillary service providers, such as Durable Medical Equipment providers, laboratory providers, Home Health Care agencies, and Mental Health and Substance Abuse providers are paid on the basis of fee-for-service payments according to the Network fee schedule for the specific Covered Services performed. In some cases, such as for mental health and substance abuse benefits, one vendor arranges for all such services through a contracted set of Providers. Independence Administrators reimburses the contracted Providers of these vendors on a fee-for-service basis. An affiliate of Independence Administrators has less than a three percent ownership interest in this mental health/substance abuse vendor.

Hospitalists

Independence Administrators currently does not have a hospitalist program in place but is considering implementing such a program in the future. However, Independence Administrators continues to maintain interest in encouraging Hospitals to contract with Physicians who specialize in providing emergency room consultation and inpatient management services.

2. PAYMENT METHODS

The Covered Person or the Provider may submit bills directly to Independence Administrators and, to the extent that benefits are payable within the terms and conditions of this booklet, reimbursement will be furnished as detailed below. The Covered Person's benefits for Covered Services are based on the rate of reimbursement as set forth under "Covered Expense" in the ***Definitions*** section of this Booklet.

FACILITY PROVIDERS

Preferred Facility Providers

Preferred Facility Providers are members of the PPO Network and have a contractual arrangement with Independence Administrators for the provision of services to Covered Persons. Benefits will be provided as specified in the ***Schedule of Benefits*** for Covered Services which have been performed by a Preferred Facility Provider. Independence Administrators will compensate the Preferred Facility Providers in accordance with the contracts entered into between such Providers and Independence Administrators. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Facility Provider.

Non-Preferred Facility Providers

Non-Preferred Facility Providers include facilities that are not part of the PPO Network.

When a Covered Person seeks care from a Non-Preferred Facility Provider, benefits will be provided to the Covered Person at the Non-Preferred cost sharing level specified in the ***Schedule of Benefits***. The reimbursement rate is specified under "Covered Expense" in the ***Definitions*** section of this Booklet.

If Independence Administrators determines that Covered Services were for Emergency treatment as defined herein, the Covered Person normally will not be subject to the cost sharing penalties that would ordinarily be applicable to Non-Preferred services. Emergency admissions must be certified within two (2) business days of admission, or as soon as reasonably possible, as determined by Independence Administrators. Payment for emergency services provided by Non-Preferred Provider will be the greater of (1) the median of the amounts paid to Preferred Providers for emergency services; (2) the amount paid to non-Preferred Providers; or (3) the amount paid by Medicare.

Once Covered Services are rendered by a Facility Provider, the Plan will not honor a Covered Person's request not to pay for claims submitted by the Facility Provider. The Covered Person will have no liability to any person because of its rejection of the request.

PROFESSIONAL PROVIDERS

Preferred Professional Providers

Independence Administrators is authorized by the Covered Person to make payment directly to the Preferred Professional Providers furnishing Covered Services for which benefits are provided under this coverage. Preferred Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. Preferred Professional Providers will make no additional charge to Covered Persons for Covered Services except in the case of certain Copayments, Coinsurance or other cost sharing features as specified under this program. The Covered Person is responsible, within 60 days of the date in which Independence Administrators finalizes such services, to pay, or make arrangements to pay, such amounts to the Preferred Professional Provider.

Benefit amounts, as specified in the ***Schedule of Benefits*** of this coverage, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the Preferred Professional Provider and a Covered Person with respect to balance billing shall be submitted to Independence Administrators for determination. The decision of Independence Administrators shall be final.

Once Covered Services are rendered by a Professional Provider, Independence Administrators will not honor a Covered Person's request not to pay for claims submitted by the Professional Provider. Independence Administrators will have no liability to any person because of its rejection of the request.

Emergency Care by Non-Preferred Providers

Payment for emergency services provided by Non-Preferred Provider will be the greater of (1) the median of the amounts paid to Preferred Providers for emergency services; (2) the amount paid to non-Preferred Providers; or (3) the amount paid by Medicare. Any Non-Preferred Provider emergency care cost sharing (copayments, coinsurance) requirement will be the same as any Preferred Provider emergency care cost sharing requirement.

If Independence Administrators determines that Covered Services provided by a Non-Preferred Provider were for Emergency Care, the Covered Person will be subject to the Preferred cost-sharing levels. Penalties that ordinarily would be applicable to Non-Preferred Covered Services will not be applied. For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by Independence Administrators.

A Non-Preferred Provider who provided Emergency Care can bill you directly for their services, for either the Provider's charges or amounts in excess of Independence Administrators payment for the Emergency Care, i.e., "balance billing." In such situations, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance-billing.

Non-Preferred Hospital-Based Provider

When you receive Covered Services from a Non-Preferred Hospital-Based Provider while you are an Inpatient at a Preferred Hospital or other Preferred Facility Provider and are being treated by a Preferred Professional Provider, you will receive the Preferred cost-sharing level of benefits for the Covered Services provided by the Non-Preferred Hospital-Based Provider. For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

A Non-Preferred Hospital–Based Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of Independence Administrators payment to the Non-Preferred Hospital-Based Providers, i.e., "balance billing." In such situations, you will need to contact Independence Administrators at the

Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance billing.

Note that when you elect to see a Non-Preferred Hospital-Based Provider for follow-up care or any other service where you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Treatment, if a Non-Preferred Provider admits you to a Hospital or other Facility Provider, Covered Services provided by a Non-Preferred Hospital-Based Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Provider. The Covered Person will be responsible to reimburse the Provider for the difference between Independence Administrators payment and the Provider's charge.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

Inpatient Hospital Consultations by a Non-Preferred Professional Provider

When you receive Covered Services for an Inpatient hospital consultation from a Non-Preferred Professional Provider while you are Inpatient at a Preferred Facility Provider, and the Covered Services are referred by a Preferred Professional Provider, you will receive the Preferred cost-sharing level of benefits for the Inpatient hospital consultation.

For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

A Non-Preferred Professional Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of Independence Administrators payment to the Non-Preferred Professional Providers, i.e., "balance billing." In such situations, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance billing.

Note that when you elect to see a Non-Preferred Professional Provider for follow-up care or any other service when you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Care, if a Non-Preferred Professional Provider admits you to a Hospital or other Facility Provider, services provided by Non-Preferred Professional Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Provider. The Covered Person will be responsible to reimburse the Provider for the difference between Independence Administrators' payment and the Provider's charge.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

Non-Preferred Professional Provider

Except as set forth above, when a Covered Person seeks care from a Non-Preferred Professional Provider, benefits will be provided to the Covered Person at the Non-Preferred cost sharing level specified in the ***Schedule of Benefits***. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Professional Provider, the Covered Person will be responsible to reimburse the Non-Preferred Professional Provider for the difference between Independence Administrators payment and the Non-Preferred Professional Provider's charge. Payment for emergency services provided by Non-Preferred Provider will be the greater of (1) the median of the amounts paid to Preferred Providers for emergency services; (2) the amount paid to non-Preferred Providers; or (3) the amount paid by Medicare.

ANCILLARY PROVIDERS

Preferred Ancillary Providers

Preferred Ancillary Providers include members of the PPO Network that have a contractual relationship with Independence Administrators for the provision of services or supplies to Covered Persons. Benefits will be provided as specified in the ***Schedule of Benefits*** for the provision of services or supplies provided to Covered Persons by Preferred Ancillary Providers. Independence Administrators will compensate Preferred Ancillary Providers in the PPO Network in accordance with the contracts entered into between such Providers and Independence Administrators.

Non-Preferred Ancillary Providers

Non-Preferred Ancillary Providers are not members of the PPO Network. Benefits will be provided to the Covered Person at the Non-Preferred cost sharing level. The Covered Person will be penalized by the application of higher cost sharing. For payment of Covered Services provided by a Non-Preferred Ancillary Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this Booklet. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Ancillary Provider, the Covered Person will be responsible to reimburse the Non-Preferred Ancillary Provider for the difference between Independence Administrators payment and the Non-Preferred Ancillary Provider's charge.

ASSIGNMENT OF BENEFITS TO PROVIDERS

The right of a Covered Person to receive benefit payments under this coverage is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this coverage be transferred, either before or after Covered Services are rendered. However, a Covered Person can assign benefit payments to the custodial parent of a Dependent covered under the coverage, as required by law.

RIGHT TO RECOVER EXCESS PAYMENTS

Independence Administrators reserves the right to recover claim payments made in excess of the benefits payable for Covered Services under the Plan. Independence Administrators may request that the payee, either a Covered Person or Provider, return the excess payment to Independence Administrators.

TRANSFER OF COVERAGE

An Employee may enroll in the Plan's coverage during the annual Open Enrollment Period established by the Company.

If written application is made during the annual Open Enrollment Period, coverage under the Plan will be effective on the first of the month following the month of the established Open Enrollment Period.

Notwithstanding anything in this provision to the contrary, the Employee and/or Dependent must satisfy all other eligibility requirements under the Plan prior to or simultaneously with the date that such Employee's coverage under the Plan is effective.

WHEN YOU HAVE A CLAIM

FROM A DOCTOR OR FACILITY

If you are treated for a covered Accidental Injury or Illness at a Facility or a participating doctor's office, present your Independence Administrators identification card. Independence Administrators will pay the provider directly for covered expenses.

If you are required to pay the Facility or the Doctor, be sure to get a receipted, itemized bill. Besides the itemized charges it should show:

- your name and address
- patient's name and age
- doctor's or hospital's name and address
- Provider or Facility identification number
- date of admission or treatment

ADVERSE DETERMINATIONS

An adverse determination is a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part*) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on: a determination that a benefit is not a covered benefit; the source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or a determination that a benefit is experimental, investigational, or not medically necessary or appropriate. This can include both pre-service claims as well as post-service claims. The scope of adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

*Including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding copayments, deductibles, or other cost-sharing requirements.

COMPLAINT PROCESS

Independence Administrators has a process for a Covered Person to express complaints. To register a complaint, the Covered Person should call the Customer Service Department at the telephone number on their identification card or write to Independence Administrators at the address listed below.

Independence Administrators
c/o Processing Center
P.O. Box 21974
Eagan, MN 55121

Most Covered Persons' concerns are resolved informally at this level. However, if Independence Administrators is unable to immediately resolve the complaint, it will be investigated, and the Covered Person will receive a response within thirty (30) days.

APPEAL PROCESS

Filing an Appeal

Independence Administrators maintains procedures for the resolution of appeals. Appeals may be filed within 180 days of the receipt of a decision from Independence Administrators stating an adverse benefit determination. An appeal occurs when the Covered Person or another authorized representative requests a change of a previous decision made by Independence Administrators by following the procedures described here. In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form.

Contact Independence Administrators at the address listed above or access your online services at the address on your identification card to obtain a form to authorize an appeal by a provider or other representative or for questions regarding the requirements for an authorized representative.

The Covered Person or other authorized person on behalf of the Covered Person, may request an appeal by calling or writing to Independence Administrators, as stated in the letter notifying the Covered Person of the decision.

Types of Appeals

The following are the two types of appeals and the issues they address.

- **Medical Necessity Appeal** — An appeal by or on behalf of a Covered Person that focuses on issues of Medical Appropriateness/Medical Necessity and requests Independence Administrators to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on failure to meet established medical guidelines and peer review of medical appropriateness. It may also include the exclusions for Experimental/Investigational services or cosmetic services. Internal and External Appeals apply.*
- **Administrative Appeal** — An appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding Independence Administrators' decision that concerns coverage terms such as exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Appropriateness/Medical Necessity, these are not the primary issues that affect the outcome of the appeal. Internal Appeals apply.*

* **First Step — Internal Appeal** — An appeal filed with your health plan/plan administrator for evaluation and determination.

* **Second Step — External Appeal** — An appeal filed with your health plan/plan administrator for evaluation and determination by an independent review organization (IRO).

Timeframe Classifications

The timeframes described below for completing a review of each appeal depend on whether the appeal is classified as standard appeal or an expedited appeal for urgent care.

- Standard appeal timeframes apply to both pre-service appeals and post-service appeals that concern claims for non-urgent care.

  Standard pre-service appeal — An appeal for benefits that, under the terms of the Plan, must be pre-certified or pre-approved (either in whole or in part) *before* medical care is obtained in order for coverage to be available.

  Standard post-service appeal — An appeal for benefits that is not a pre-service appeal. (Post-service appeals concerning claims for services that the Covered Person has already obtained do not qualify for review as expedited/urgent appeals.)

  Urgent-care/Expedited appeal timeframes may apply to pre-service or on-going requests for urgent care.

- **Expedited appeal for urgent care** — An appeal that provides faster review, according to the procedures described below, on a pre-service issue. Independence Administrators will conduct an urgent-care/expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Covered Person's life, health or ability to regain maximum function or would subject the Covered Person to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

Information for the Appeal Review including Matched Specialist's Report

The Covered Person or other authorized person on behalf of the Covered Person, may submit to Independence Administrators additional information pertaining to your case. You may specify the remedy or action being sought. Upon request at any time during the appeal process, Independence Administrators will provide you or your authorized representative, free of charge, access to, and copies of, all relevant documents and records, including any additional information received and reviewed by the decision maker(s) on the appeal.

Input from a matched specialist is obtained for certain Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the initial adverse benefit determination nor can they be a subordinate of the person who made that determination.

Appeal Decision makers

Independence Administrators has representatives that have been designated to act as decision maker(s) on the appeal. The decision maker(s) did not make the initial adverse benefit determination at issue in the appeal. Each decision maker will review all relevant information for the appeal, whether from the Covered Person or his authorized representative, or obtained from other sources during the investigation of the appeal issues. If the additional information meets plan guidelines the appeal may be overturned by the decision maker(s). To avoid conflict of interest and for compliance with regulatory and accreditation requirements, Independence Administrators also utilizes peer medical reviewers including contracted external review organizations for matched-specialty (peer) reviews, and for review of administrative and medical necessity external appeal review requests. Matched specialty /peer reviewers were not involved in the initial review process and are not subordinates of the person who made the initial determination.

Full and Fair Review

If the reviewer upholds the original decision, Independence Administrator's will provide the Covered Person with the rational and new or additional evidence considered or relied upon in connection with the appeal. This is to give the Covered Person a reasonable opportunity to respond prior to the final determination.

Right to Pursue Civil Action

If you are enrolled in a group health plan that is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you have the right to bring a civil action under Section 502(a) of the Act after completing the appeal processes described here.

Changes in Appeal Processes

Please note that the Appeal processes described here may change due to changes that Independence Administrators makes to comply with applicable state and federal laws and regulations and/or accreditation standards or to improve the appeal processes.

External Review of Adverse Determination/Appeals

You are entitled to the external review process described below for all appeals of adverse determination (denials) concerning:

- Rescission of coverage;
- Medical judgment (including, based on the plans requirements, medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer.

Standard External Review Procedures

External appeals may be filed up to four (4) months after receipt of the notice from Independence Administrators of an adverse determination (denial) or final adverse determination (denial) for appeals involving the above stated issues.

You or your authorized representative can file an external appeal by calling the number listed on your ID card.

The Covered Person may be responsible for a nominal fee for the administrative duties performed in order to process the appeal for the external review.

Preliminary Review

Within five (5) business days following the date of receipt of the external review request, we will complete a preliminary review of the request to determine eligibility for the external review. Within one (1) business day after completion of this preliminary review, we will issue a written notification informing you if it is eligible for external review and if not, the reason why not and additional contact information. If your request is incomplete, we will inform you of the additional information needed to make the request for external review complete. If your request is eligible for external review you may submit, within ten (10) business days following the date of receipt of the notice, additional information that the Independent Review Organization (IRO) will consider when conducting the external review.

Referral to Independent Review Organization (IRO)

Eligible external review requests will be referred to a contracted, accredited independent review organization.

Final external review decisions are made by the external review organization within 45 days and will be forwarded in writing to the claimant and the Plan (Plan Administrator). The external decision is binding on Independence Administrators.

If you have any questions or concerns during the external review process or if you want to initiate an urgent care claim review, you (or your authorized representative) can call the toll-free number on your identification (ID) card.

Expedited External Review Process

If you (the claimant) have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your (claimant's) life or health or

would jeopardize the ability to regain maximum function or if the matter concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility then you or your authorized representative (including your healthcare provider with knowledge of your condition) may request an expedited external review.

You may make a written or oral request for the expedited (urgent) external review.

- Urgent care reviews may be initiated by calling the toll-free number on your identification (ID) card.

Preliminary Review

Immediately upon receipt, we (or the Plan) will determine whether the request meets the eligible review requirements for an expedited (urgent) external review and will notify you of the eligibility for expedited (urgent) review or standard external review.

Referral to Independent Review Organization (IRO)

Upon the determination that a request is eligible for expedited (urgent) external review following the preliminary review we (or the Plan) will assign an independent review organization and provide them all necessary documents and information considered in making the adverse determination or final adverse benefit determination.

If during the external review process, we (or the Plan) reconsiders and decides to provide coverage, we (or the Plan) will provide oral notice followed by written notice within 48 hours.

Notice of the Final External Review Decision

- The IRO/external examiner provides notice of the final external review decision.
- The decision is completed as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external review.
- If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to you (the claimant) and the Plan. within 48 hours after the date of providing that notice,

The external decision is binding on Independence Administrators.

If the Adverse Determination (denial) is Reversed

Upon our receipt of the notice of the external review decision, we immediately will authorize to provide the coverage or payment for the claim as required by federal rule set under the Patient Protection and Affordable Care Act.

NOTICE: Please see the subsection entitled "NOTICE OF CLAIMS" found under the *General Provisions* section of this booklet.

DEFINITIONS

ACCIDENTAL INJURY — A sudden, unforeseen, and identifiable event causing injury to a Covered Person, which is the direct result of the event and which occurs while coverage under the Plan for the Covered Person is in force.

ADMINISTRATIVE SERVICES AGREEMENT — The agreement between the Plan Sponsor and Independence Administrators, under which Independence Administrators provides administrative services to the Plan Sponsor in connection with the Plan.

AMBULANCE — A specially designed and medically equipped vehicle used solely for the transportation of the sick and/or injured.

AMBULATORY SURGICAL CENTER — A Facility that: (1) has permanent facilities and equipment for the primary purpose of performing Surgery on an Outpatient basis; and (2) provides such treatment by or under the supervision of an organized staff of Doctors; and (3) provides nursing services whenever the patient is in the Facility; and (4) does not provide Inpatient accommodations; and (5) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Medicare, or by Independence Administrators; and (6) is not, other than incidentally, a Facility used as an office or clinic for the private practice of a Professional Provider.

AMENDMENT — A supplement made a part of the Plan, which alters the benefits or terms of the Plan.

ANCILLARY PROVIDER — An individual or entity that provides services, supplies or equipment (such as, but not limited to, home infusion therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under the Plan.

ANESTHESIA — The administration of regional or local anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation, or loss of consciousness.

BIRTHING CENTER — A Facility that: (1) is primarily organized and staffed to provide maternity care by a Nurse Midwife; and (2) is licensed as a Birthing Center under the laws of the state where it is located; or (3) is approved by Independence Administrators.

BLUECARD PPO PROGRAM — A program that allows a Covered Person travelling or living outside of their plan's area to receive coverage for services at an in-network benefit level if the Covered Person receives services from Blue Cross Blue Shield providers that participate in the BlueCard PPO Program.

BLUECARD PPO PROVIDER — A Provider that participates in the BlueCard PPO Program as a Preferred Provider.

CERTIFIED REGISTERED NURSE — A Professional Provider who: (1) is a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist; and (2) is certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing.

CLAIM — A request for payment of benefits for services rendered or Supplies received, which is presented to Independence Administrators for payment. Such request must be submitted to Independence Administrators with all statements, questionnaires, certifications, instruments, documents, and affidavits requested by Independence Administrators that are necessary to properly process the request for benefits. Claim forms will be provided by Independence Administrators.

COINSURANCE — The specified percentage of Covered Expense the Covered Person is required to pay.

COMPANY — Clemens Family Corporation

CONDITIONS FOR DEPARTMENTS (for Qualifying Clinical Trials) — The conditions described in this paragraph, for a study or investigation conducted by the Department of Veteran Affairs, Defense or Energy, are that the study or investigation has been reviewed and approved through a system of peer review that the Government determines:

A. To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and

B. Assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.

COVERED EXPENSE — Refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

A. For Covered Services provided by a Facility Provider, "Covered Expense" means the following:

   i. For Covered Services provided by a Preferred Facility or BlueCard PPO Provider, "Covered Expense" for Outpatient services means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or the BlueCard PPO Provider.

   ii. For Covered Services provided by a Preferred Facility or BlueCard PPO Provider, "Covered Expense" for Inpatient services means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or the BlueCard PPO Provider.

   iii. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Outpatient services means the lesser of 1.5 times the Medicare Allowable Payment for Facilities or the Facility Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare

traditional program, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider's charges for Covered Services.

iv. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Inpatient services means the lesser of 1.5 times the Medicare Allowable Payment for Facilities or the Facility Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider's charges for Covered Services.

B. For Covered Services provided by a Professional Provider, "Covered Expense" means the following:

i. For Covered Services by a Preferred Professional Provider or BlueCard PPO Provider, "Covered Expense" means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with Independence Administrators, or the BlueCard PPO Provider.

ii. For a Non-Preferred Professional Provider, "Covered Expense" means the lesser of the Medicare Professional Allowable Payment or the Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent (50%) of the Professional Provider's charges for Covered Services.

C. For Covered Services provided by an Ancillary Provider, "Covered Expense" means the following:

i. For Covered Services provided by a Preferred Ancillary Provider or BlueCard PPO Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or BlueCard PPO Provider.

ii. For Covered Services provided by a Non-Preferred Ancillary Provider, "Covered Expense" means the lesser of the Medicare Ancillary Allowable Payment or the Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent (50%) of the Non-Preferred Ancillary Provider's charges for Covered Services.

D. Nothing in this section shall be construed to mean that Independence Administrators would provide coverage for services other than Covered Services.

COVERED PERSON — The Employee and/or his Dependent, if any, covered under the Plan.

COVERED SERVICE — A service, Supply, equipment, device, or drug specified in the Plan for which benefits will be provided when billed for by a Professional Provider, Facility, or Supplier.

CUSTODIAL CARE — Care that is provided primarily to assist the patient in meeting his activities of daily living. Such care is not provided primarily for its restorative or therapeutic value in the treatment of an Illness, injury, disease, or condition.

DEPENDENT — The Employee's: (1) spouse under a legally valid existing marriage; or (2) same sex domestic partner; (3) natural born or legally adopted child (including a child for whom adoption proceedings have been initiated), including a stepchild; or (4) unmarried child age 26 or older who is unable to earn his own living due to a physical or Mental Illness or handicap (subject to Eligibility — Continuation of Eligibility).

Dependent spouses may not be on active military service.

DOCTOR — A practitioner, other than a Covered Person, who is acting within the scope of his license as a Doctor of medicine; osteopathy; podiatry; dentistry; optometry; chiropractic; licensed speech pathologist; licensed audiologist; licensed teacher of the hearing impaired; or any other practitioner that the Plan must by law recognize as a Doctor legally entitled to render treatment.

DOMESTIC PARTNER — A member of a Domestic Partnership consisting of two partners of the same sex, each of whom: (a) is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time; (b) is not related to the other partner by adoption or blood; (c) is the sole Domestic Partner of the other partner, with whom he/she has a close committed and personal relationship, and has been a member of this Domestic Partnership for the last six (6) months; (d) agrees to be jointly responsible for the basic living expenses and welfare of the other partner;(e) meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships; and (f) demonstrates financial interdependence by submission of proof of three (3) or more of the following documents: (i) a domestic partner agreement; (ii) a joint mortgage or lease; (iii) a designation of one of the partners as beneficiary in the other partner's will; (iv) a durable property and health care power of attorney; (v) a joint title to an automobile, or joint bank account or credit account; or (vi) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case. Independence Administrators reserves the right to request documentation of any of the foregoing prior to commencing coverage for the Domestic Partner.

DURABLE MEDICAL EQUIPMENT — Charges for: (1) non-disposable equipment that is primarily medical in nature, such as wheelchairs and hospital beds; and (2) orthotics or medical devices that are applied to or around the body for care or treatment of an injury or Illness; and (3) assorted medical items necessary for the treatment of respiratory diseases, such as oxygen tanks, oxygen contents, and oxygen masks.

EMERGENCY ACCIDENT TREATMENT — Provider expenses charged for the initial treatment of an Accidental Injury. Such treatment must begin within 72 hours of the injury that is being treated and excludes Ambulance services.

EMERGENCY MEDICAL TREATMENT — Provider expenses charged for the initial treatment of a condition with acute symptoms that is life threatening or that could cause serious damage to a bodily function. Such treatment must begin within 72 hours of the onset of the condition that is being treated and excludes Ambulance services.

EMPLOYEE — A person employed by the Company.

EMPLOYMENT WAITING PERIOD — The period, beginning with the date of employment, that an Employee must serve continuously before he is eligible to receive benefits under the Plan.

EXPERIMENTAL/INVESTIGATIVE — A drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

A. Is the subject of ongoing clinical trials;

B. Is the research, experimental, study or investigational arm of an on-going clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

C. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;

D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Covered Person's particular condition; or

E. Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental/Investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market with a specific indication for the particular diagnosis or condition present. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the established referenced Compendia identified in the Company's policies recognize the usage as appropriate medical treatment.

Any biological product, device, medical treatment or procedure is not considered Experimental/Investigative if it meets all of the criteria listed below:

A. Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

B. Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure leads to measurable improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.

C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigatory settings.

E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

FACILITY — An institution or entity licensed, where required, to provide care. Such Facilities include:

- Alcoholism Treatment Facility
- Ambulatory Surgical Center
- Birthing Center
- Freestanding Dialysis Facility
- Freestanding Outpatient Facility
- Home Health Care Agency
- Hospital
- Psychiatric Hospital
- Rehabilitation Facility
- Skilled Nursing Facility
- Substance Abuse Treatment Facility

FAMILY UNIT — An Employee and his covered Dependents.

FULL-TIME EMPLOYEE — An Employee of the Company who works at least 40 hours per week for the Company for compensation in the form of salary, wages, or commission. In the case of a proprietorship or partnership, the individual proprietor or each of the partners whose principal occupation is the conduct of the Company's business, and whose duties for the Company normally require at least 40 hours per week, shall be deemed a Full-time Employee.

No member of the Board of Directors shall be deemed a Full-time Employee unless such person is otherwise eligible as a bona fide Employee of the Company.

HOME HEALTH AGENCY — An agency, association, or part of a Hospital that: (1) provides Skilled Nursing Care in the patient's home for the treatment of a physical Illness or injury that requires medical supervision and treatment; and (2) provides such care by or under the supervision of a Registered Nurse acting under the direction of a Doctor; and (3) is

approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

HOSPICE — A Facility that: (1) is primarily engaged in providing palliative care to terminally ill individuals; and (2) is licensed and operated according to the laws of the state in which it is located and approved by Independence Administrators.

HOSPITAL — A short-term, acute care Facility that: (1) is a duly licensed institution; and (2) is primarily engaged in providing Inpatient diagnostic and medical services for the care or treatment of sick and injured persons; and (3) provides such care by or under the supervision of an organized staff of Doctors; and (4) has organized departments of medicine; and (5) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (6) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Independence Administrators. A Hospital is not, other than incidentally, a:

- Nursing Home
- Place for Rest
- Place for the Aged
- Place for the Provision of Hospice care
- Place for the Provision of Rehabilitation Care
- Place for the Treatment of Alcoholism or other Drug Abuse
- Place for the Treatment of Mental Illness
- Skilled Nursing Facility
- Spa or Sanitarium

HOSPITAL-BASED PROVIDER - A physician who provides Medically Necessary services in a Hospital or Preferred Facility Provider supplemental to the primary care being provided in the Hospital or Preferred Facility Provider, for which the Covered Person has limited or no control of the selection of such physician. Hospital-based providers include physicians in the specialties of radiology, anesthesiology and pathology and/or other specialties as determined by Independence Administrators. When these physicians provide services other than in the Hospital or Preferred Facility, they are not considered Hospital-Based Providers.

ILLNESS — A condition marked by pronounced deviation from the normal, healthy state.

IMMEDIATE FAMILY — The Covered Person's spouse, parent, child, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, or son-in-law.

INCURRED — A charge is deemed Incurred as of the date of the service or purchase giving rise to the charge.

INPATIENT — A person who is treated as a registered overnight bed patient in a Facility.

LICENSED PRACTICAL OR VOCATIONAL NURSE (L.P.N. OR L.V.N.) — A nurse who has graduated from a formal practical or vocational nursing education program and is licensed by the appropriate state authority.

LIFE-THREATENING DISEASE OR CONDITION (for Qualifying Clinical Trials) — Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MAINTENANCE CARE — Care provided to maintain the patient's current level of functioning or to prevent deterioration. Such care is not primarily provided for its therapeutic value in the treatment of an Illness, disease, injury, or condition and does not require participation or administration by professional medical personnel.

MEDICALLY APPROPRIATE/MEDICALLY NECESSARY (or MEDICAL APPROPRIATENESS/MEDICAL NECESSITY) — An intervention will be covered if it is (a) a Covered Service, (b) not specifically excluded, and (c) Medically Appropriate/Medically Necessary. An intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by Independence Administrator's medical director or physician designee, it meets all of the following criteria:

A. It is a "Health Intervention". A Health Intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a "medical condition" or to maintain or restore functional ability. A medical condition is one of the following: disease; Illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

B. It is the most appropriate Supply or level of service, considering the potential benefit and harm to the Subscriber.

C. It is known to be "effective" in improving "health outcomes". Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a "new" or "existing" intervention.

i. New interventions: Effectiveness is determined by Scientific Evidence. An intervention is considered new if it is not yet in widespread use for (a) the medical condition, and (b) the patient indications being considered.

"Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

ii. **Existing interventions**: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion. For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for a determination of Medical Necessity. If no Scientific Evidence is available, professional standards of care should be considered. If professional standards of care do not exist, are outdated, or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence. Existing interventions can meet the contractual definition of Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

D. **It is cost-effective for this condition compared to alternative interventions, including no intervention.** "Cost effective" does not necessarily mean lowest price. An intervention is considered cost effective if the benefit and harm relative to costs represent an economically, efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this Medically Appropriate/Medically Necessary definition.

MEDICARE ALLOWABLE PAYMENT FOR FACILITIES — The payment amount, as determined by the Medicare program, for the Covered Service for a Facility Provider.

MEDICARE ANCILLARY ALLOWABLE PAYMENT — The payment amount, as determined by the Medicare program, for the Covered Service for an Ancillary Provider.

MEDICARE PARTS A AND B — "Hospital Insurance Benefits for the Aged and Disabled" under Title XVIII, Part A and/or Part B respectively, of the Social Security Act, as amended from time to time.

MEDICARE PROFESSIONAL ALLOWABLE PAYMENT — The payment amount, as determined by the Medicare program, for the Covered Service based on the Medicare Par Physician Fee Schedule.

MENTAL ILLNESS — An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances are the dominating feature.

Mental or nervous disorders that have a demonstrable organic origin will not be considered Mental Illness.

NON-PREFERRED ANCILLARY PROVIDER — An Ancillary Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED FACILITY PROVIDER — A Facility Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROFESSIONAL PROVIDER — A Professional Provider who is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROVIDER — A Facility Provider, Professional Provider or Ancillary Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NURSE MIDWIFE — A Professional Provider who: (a) is certified to practice as a Nurse Midwife; and (b) is licensed by the appropriate state authority as a Registered Nurse; and (c) has completed a program for the preparation of Nurse Midwife that is approved by the state in which the person is practicing.

OPEN ENROLLMENT PERIOD — The 31-day period immediately prior to the anniversary date of the Plan.

ORGANIC DISEASE — Includes any health condition in which there is an observable and measurable disease process (biomarker), e.g. inflammation or tissue damage: Non organic diseases or functional disorders, demonstrate no disease process which is visible or which can be established through standard diagnostic testing.

OUTPATIENT — A person who receives services or Supplies while not an Inpatient.

PLAN — Clemens Family Corporation Employee Benefit Plan.

PLAN SPONSOR — Clemens Family Corporation

PLAN YEAR DEDUCTIBLE — The amount of eligible expenses the Covered Person is required to pay each plan year before the Plan begins to pay benefits.

PREFERRED ANCILLARY PROVIDER — An Ancillary Provider that is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services and/or supplies to Covered Persons.

PREFERRED FACILITY PROVIDER — A Facility Provider that is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Covered Persons.

PREFERRED PROFESSIONAL PROVIDER — A Professional Provider who is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for "in-network" Covered Services rendered to a Covered Person.

PREFERRED PROVIDER — A Facility Provider, Professional Provider or Ancillary Provider that is a member of the PPO Network or is a BlueCard PPO Provider, authorized to perform specific "in-network" Covered Services at the Preferred level of benefits.

PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK — The network of Providers with whom Independence Administrators has contractual arrangements and BlueCard PPO Providers.

PRIOR AUTHORIZATION — Written approval by Independence Administrators for medical or surgical treatment given prior to such treatment that outlines the Plan's liability for such treatment. Such approval will be given only after Independence Administrators: (1) reviews the case; and (2) receives the Covered Person's medical history and an explanation of the condition and treatment to be given (including any Surgical Procedures to be performed) written by his Doctor, and any supporting documentation.

PRIVATE ROOM — Accommodations in a room designed as such by the Hospital, Rehabilitation Facility, or Skilled Nursing Facility and containing not more than one bed.

PROFESSIONAL PROVIDER — A licensed person or practitioner performing services within the scope of such licensure. The Professional Providers include:

- Certified Registered Nurse
- Chiropractor
- Dentist
- Doctor
- Independent Clinical Laboratory
- Licensed Practical Nurse (LPN)
- Licensed Vocational Nurse (LVN)
- Nurse Midwife
- Optometrist
- Physical Therapist
- Podiatrist
- Psychologist

PROVIDER — A Facility, Professional or Ancillary Provider, licensed where required.

PSYCHIATRIC HOSPITAL — A Facility that: (1) is primarily engaged in providing Inpatient diagnostic, medical, and psychiatric services for the care or treatment of Mental Illness; and (2) provides such services by or under the supervision of an organized staff of Doctors; and (3) provides continuous 24-hour nursing services by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Independence Administrators.

QUALIFIED INDIVIDUAL (for Clinical Trials) — A Covered Person who meets the following conditions:

A. The Covered Person is eligible to participate in an approved clinical trial

according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition; and

B. Either:

1. The referring health care professional is a health care provider participating in the clinical trial and has concluded that the Covered Person's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or

2. The Covered Person provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Covered Person meeting the conditions described above.

QUALIFYING CLINICAL TRIAL — A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is described in any of the following:

A. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

1. The National Institutes of Health (NIH);

2. The Centers for Disease Control and Prevention (CDC);

3. The Agency for Healthcare Research and Quality (AHRQ);

4. The Centers for Medicare and Medicaid Services (CMS);

5. Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);

6. Any of the following, if the Conditions For Departments are met:

a. The Department of Veterans Affairs (VA);

b. The Department of Defense (DOD); or

c. The Department of Energy (DOE).

B. The study of investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In the absence of meeting the criteria listed above, the clinical trial must be approved by the Plan as a Qualifying Clinical Trial.

REGIONAL NETWORK DISCOUNT — The percentage reduction from Facility charges for Covered Services that Independence Administrators passes on to its customers as a share of the savings Independence Administrators is expected to realize from its negotiated Hospital contracts. The balance of any savings not passed on to its

customers is for the sole benefit of Independence Administrators. The amount of the discount may be changed prospectively from time to time.

REGISTERED NURSE (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree program, or baccalaureate program) and is licensed by the appropriate state authority.

REHABILITATION FACILITY — An institution or part of an institution that: (1) specializes in providing restorative and therapeutic services on an Inpatient and Outpatient basis for the treatment of a physical Illness or injury, Mental Illness, drug addiction and alcoholism; and (2) provides such services by or under the supervision of a staff of Doctors; and (3) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

RELIABLE EVIDENCE — Only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS — Routine patient costs include all items and services consistent with the coverage provided under this Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

Routine patient costs do not include:

A. The investigational item, device, or service itself;

B. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

C. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SCHEDULE OF BENEFITS — The Schedule of Benefits, which describes benefits, maximums, and allowances of the coverage provided under the Plan for each Covered Person.

SECOND SURGICAL OPINION/CONSULTATION — A written evaluation by another surgeon/specialist, who is not associated in practice with the first surgeon, as to the Medical Necessity of the surgery recommended by the first surgeon.

SEMIPRIVATE ROOM — Accommodations in a room designated as such by the Hospital, Rehabilitation Facility, or Skilled Nursing Facility and containing no less than two nor more than four beds.

SKILLED NURSING CARE — All covered medical expenses charged for services that are primarily restorative and therapeutic in treatment of a physical Illness or injury that requires medical supervision of a Registered Nurse acting under the direction of a Doctor.

SKILLED NURSING FACILITY — An institution or part of an institution that: (1) specializes in providing Skilled Nursing Care on an Inpatient basis for the treatment of a physical Illness or injury that requires extended medical supervision and treatment; and (2) provides such care by or under the supervision of a staff of Doctors; and (3) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

SUBSTANCE ABUSE — Any use of alcohol or other drug that produces a pattern of pathological use causing impairment in social or occupational functions or that produces physiological dependency evidenced by physical tolerance or withdrawal.

SUBSTANCE ABUSE TREATMENT FACILITY — A Facility that: (1) is primarily engaged in providing detoxification and/or rehabilitation services for alcoholism and/or other drug abuse and (2) is approved by the Joint Commission on Accreditation of Healthcare Organizations, appropriate government agency, or by Independence Administrators.

SUPPLIES — Charges made by a Hospital or Doctor for nonprescription, nondurable, disposable medical and surgical items that are necessary for the care or treatment of an Illness or Accidental Injury.

SURGERY/SURGICAL PROCEDURE — Treatment of an Illness, injury, or deformity by manual and operative methods.

A. **Cosmetic Surgery** — A Surgical Procedure for the correction of superficial areas of the body to enhance appearance or to change contour. Such surgeries are performed without the expectation of restoring function to the body area.

B. **Elective Surgery** — A Surgical Procedure that is of a non-emergency nature and not required to be immediately carried out.

C. **Reconstructive Surgery** — A Surgical Procedure for the correction, restoration, or improvement of bodily functions, or the relief of pain.

THERAPY SERVICES — The following services and Supplies when prescribed by a Doctor for the treatment of an Illness or injury to promote the recovery of the Covered Person:

A. **Radiation Therapy** — Treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

B. **Chemotherapy** — Treatment of malignant disease by chemical or biological antineoplastic agents.

C. **Dialysis Treatment** — Treatment of acute renal failure or chronic irreversible renal

insufficiency for removal of waste materials from the body. This includes hemodialysis or peritoneal dialysis.

D. **Physical Therapy** — Treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain and restore maximum function following disease, injury, or loss of body part.

E. **Respiratory Therapy** — Introduction of dry or moist gases into the lungs for treatment purposes.

F. **Occupational Therapy** — Treatment of a disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

G. **Speech Therapy** — Treatment to restore speech lost or impaired through Illness or injury, or to correct an impairment due to a congenital defect for which corrective Surgery has been performed.

ADMINISTRATIVE INFORMATION

This booklet has been prepared to meet the Summary Plan Description Requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

PLAN NAME	Clemens Family Corporation Employee Benefit Plan
EMPLOYER AND PLAN SPONSOR	Clemens Family Corporation 2700 Clemens Road P.O. Box 902 Hatfield, PA 19440
EMPLOYER IDENTIFICATION NUMBER	75-2990486
TYPE OF PLAN	Health and Welfare
PLAN YEAR ENDS	4/30
PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS	Clemens Family Corporation 2700 Clemens Road P.O. Box 902 Hatfield, PA 19440
PLAN ADMINISTRATIVE SERVICES PROVIDED BY	Independence Administrators c/o Processing Center P.O. Box 21974 Eagan, MN 55121
PLAN'S INDEPENDENCE ADMINISTRATORS GROUP NUMBER(S)	003070
PLAN COSTS	See ***Eligibility***

Upon request, Covered Persons will be given a copy of this booklet which provides a description of each benefit. If misplaced, an additional copy can be obtained from the Plan Administrator, upon request.

ERISA STATEMENT OF RIGHTS

As a participant in this Plan, a Covered Individual is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan 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 participant 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 summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision

without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

Administered by Independence Administrators

To find a network doctor, get forms, or view your health benefits information, visit the website on your identification card.

c/o Processing Center • P.O. Box 21974 • Eagan, MN 55121

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

Independence

Independence Administrators

Your Group Health Plan

Clemens Family Corporation

Low Plan

Effective Date: May 1, 2021

This booklet describes your Clemens Family Corporation Employee Medical Plan (the "Plan"). All benefits becoming due under the Plan are funded directly by Clemens Family Corporation (the "Plan Sponsor"). The Plan Sponsor has the right to amend, modify, or discontinue the Plan at any time and for any reason.

The Plan Sponsor has entered into an agreement with QCC Insurance Company d/b/a Independence Administrators ("Independence Administrators") which provides for Independence Administrators to process benefit claims and provide certain other administrative services under the Plan.

Independence Administrators does not insure or guarantee the benefits described in this booklet.

Your health benefits are entirely funded by the Plan Sponsor. Independence Administrators provides administrative and claims payment services only. Independence Administrators has the authority to interpret claim policy on behalf of the Plan Sponsor. Independence Administrators is not the administrator of the Plan for the purposes of the Employee Retirement and Income Security Act ("ERISA").

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

Independence Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Administrators does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independence Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence Administrators has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

There are four ways to file a grievance directly with Independence Administrators:

- by mail: Independence Administrators,
  ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 888-356-7899 (TTY 711);
- by fax: 215-761-0920; or
- by email: **IACivilRightsCoordinator@ibxtpa.com**.

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Language Access Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en su tarjeta de identificación (TTY: 711).

注意：如果您使用简体中文，您可以免费获得语言协助服务。请致电您ID卡上的电话号码。

LƯU Ý: Nếu quý vị nói tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin gọi số điện thoại trên thẻ ID của quý vị.

ВНИМАНИЕ: Если вы говорите по-русски, вам предлагаются бесплатные услуги переводчика. Позвоните по телефону на вашем удостоверении.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf die Nummer uff dei ID-Card uff.

알림: 한국어 통역서비스가 필요한 분은 귀하의 ID 카드에 나와있는 번호로 전화하십시오. 통역서비스를 무료로 받으실 수 있습니다.

ATTENZIONE: se parla italiano, sono disponibili per lei servizi di assistenza linguistica gratuiti. Contatti il numero che vede sulla sua carta d'identità.

انتباه: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على الرقم الموجود على بطاقة التعريف الخاصة بك.

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le numéro indiqué sur votre carte d'identité.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen über Language Assistance Services ein Dolmetscher kostenlos zur Verfügung. Wenden Sie sich an die Nummer auf Ihrer ID-Karte.

ધ્યાન આપો : જો તમે ગુજરાતી બોલી શકતા હો, તો તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. તમારા ID કાર્ડ પરના નંબર પર કૉલ કરો.

UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer podany na Twojej karcie identyfikacyjnej.

ATANSYON: Si ou pale kreyòl ayisyen, gen asistans ak lang disponib pou ou gratis. Rele nimewo ki sou do kat idantifikasyon ou a.

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសា មន-ខ្មែរ ប្រទេសខ្មែរ សេវាជំនួយភាសាដែលឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខនៅលើកាតសំគាល់ខ្លួនរបស់អ្នក។

ATENÇÃO: se você fala português, serviços de assistência a idioma estão disponíveis gratuitamente para você. Ligue para o número no seu cartão de identificação.

BAA ÁKONÍNÍZIN: Diné bizaad bee yáníłti'go, ata' hane' bee áká i'iilyeed t'áá jíík'e bee ná ahóót'i'. Naaltsoos bee nééhózingo nanitinígíí bik'ehgo hane'í bikáá'ígíí bich'į' hólne'.

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tawagan ang numero sa ID card ninyo.

注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。IDカードの番号にお電話ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به رایگان در اختیار شما می باشد. با شماره نوشته شده روی کارت عضویت خود تماس بگیرید.

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SCHEDULE OF BENEFITS LOW PLAN

This Schedule of Benefits lists benefits, maximums, and allowances that your Plan provides for each enrolled person. The coinsurance rates shown in this table are based on your Plan's allowance for each service. *Read the section on* ***The Preferred Provider Network*** *carefully* to see how you can save money by receiving your care from Preferred Providers.

Remember…Your Plan has Clinical Services requirements for all inpatient admissions. It may also require pre-certification for certain outpatient procedures. If you do not comply with these provisions, your Plan may reduce the benefits for those services or may not cover them at all. *Read the sections on* ***Clinical Services*** *carefully*.

Service	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Plan Year Deductible		
• Individual	$500	$1,500
• Family Embedded	$1,000	$4,500
Out-of-pocket maximum expense you could pay in a Plan Year (includes deductible, coinsurance and copayments; Preferred Provider and Non-Preferred Provider expenses accumulate separately)		
• Individual	$1,750	$10,000
• Family Embedded	$5,000	$30,000
Coinsurance — This table shows the percentage of the Plan's allowance your Plan pays for different covered services. *All payments are based on your Plan's allowance* for the service performed. Your Plan begins to pay for eligible expenses, at the rate shown in the table, *after you meet your Plan Year Deductible*.		
Coinsurance rates for various services *(based on the Plan's allowance)*		
HOSPITAL BENEFITS		
Inpatient Hospital Facility *Maximum of 5 copays per admission*	$200 copay per day, up to 5 days, then 100%	50% after deductible
Inpatient Hospital Physician	100% after deductible	50% after deductible
Outpatient Surgery Facility	$100 copay then 100%	50% after deductible
Outpatient Surgery Physician	100% after deductible	50% after deductible
Inpatient Maternity *Includes delivery and inpatient services; Maximum of 5 copays per admission*	$200 copay per day, up to 5 days, then 100%	50% after deductible
EMERGENCY SERVICES		
Emergency Accident Treatment Facility – *Copay waived if admitted*	$500 copay then 100%	$500 copay then 100%
Non-Emergency Treatment in an Emergency Facility	Not Covered	Not Covered

Service	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Urgent Care Facility	$40/$80 copay then 100% $40 copay for non-emergency diagnosis/$80 copay applies to emergency diagnosis	50% after deductible
Ambulance	100% after deductible	100% after preferred deductible
OUTPATIENT SERVICES		
Physician Office Visit/Telehealth Visit	$20 copay then 100%	50% after deductible
Specialist Office Visit/Telehealth Visit	$40 copay then 100%	50% after deductible
Prenatal/Postnatal Office Visits *Copayment applies to first visit only*	$40 copay then 100%	50% after deductible
Chiropractic Office Visit *Benefit maximum of 20 visits per benefit period*	$40 copay then 100%	50% after deductible
Diagnostic Test (X-Ray, Ultrasound)	100% after deductible	50% after deductible
Diagnostic Test (Lab/Pathology) *Only In-Network blood work covered at 100%*	100%	50% after deductible
Diagnostic Imaging *MRI/MRA, CT/CTA Scan, PET Scan*	100% after deductible	50% after deductible
THERAPY SERVICES		
Physical & Occupational Therapy *Benefit maximum of 30 visits combined per benefit period*	$40 copay then 100%	50% after deductible
Speech Therapy *Benefit maximum of 20 visits per benefit period*	$40 copay then 100%	50% after deductible
MISCELLANEOUS SERVICES AND SUPPLIES		
Durable Medical Equipment	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible
Hospice Care	100% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	50% after deductible
Skilled Nursing Facility *Benefit maximum of 120 days per benefit period; Maximum of 5 copays per admission up to $250*	$50 copay per day, up to 5 days, then 100%	50% after deductible
Injectable Medications: Infusion Therapy Drugs & Bio-Tech Specialty Injectables	$20/$40 copay then 100% $20 copay PCP/$40 copay Specialist	50% after deductible

Service	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Injectable Medications: Medical Injectable Drugs & Therapeutic Injections	100% after deductible	50% after deductible
ADULT PREVENTIVE CARE-Age and Frequency limits may apply		
Adult Physical Examination	100% deductible waived	50% after deductible
Routine Gynecological Exams	100% deductible waived	50% after deductible
PAP Test	100% deductible waived	50% after deductible
Mammogram	100% deductible waived	50% after deductible
Colonoscopy *No age or time restriction for this benefit: Some generic prep included*	100% deductible waived	50% after deductible
Other Preventive Care	100% deductible waived	50% after deductible
CHILD PREVENTIVE CARE- Age and Frequency limits may apply		
Well-Child Care Examination	100% deductible waived	50% after deductible
Pediatric Immunizations	100% deductible waived	50% after deductible
MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT		
Inpatient Facility *Maximum of 5 copays per admission*	$200 copay per day, up to 5 days, then 100%	50% after deductible
Outpatient Facility	$40 copay then 100%	50% after deductible
Outpatient Visit	$40 copay then 100%	50% after deductible
PRESCRIPTION DRUGS *Administered by FutureScripts*		
Retail Pharmacy *30-day supply*		
Generic Drugs	90%	90%
Preferred-Brand Drugs	80%	80%
Non-Preferred Drugs	70%	70%
Specialty Drugs	$100 copay	$100 copay
Mail Order *90-day supply*		
Generic Drugs	90%	90%
Preferred-Brand Drugs	80%	80%
Non-Preferred Drugs	70%	70%
Generic High Blood Pressure and Diabetic medications are covered at 100%, deductible waived		

ELIGIBILITY

CLASS(ES) ELIGIBLE FOR COVERAGE

The following classes are eligible for coverage under the terms of the Plan:

All Active, Full-time Employees who work on average 30 hours or more per week per Affordable Care Act (ACA) requirements.

EMPLOYMENT WAITING PERIOD

Active, Full-time: First of the month coincident with or next following sixty (60) days from the date of hire with the company.

ELIGIBILITY DATE — EMPLOYEE COVERAGE

An Employee will be eligible for coverage upon completion of the Employment Waiting Period.

ELIGIBILITY DATE — DEPENDENT COVERAGE

Each eligible Employee will be eligible for Dependent coverage on the later of:

1. the date the Employee becomes eligible for coverage, if he has Dependents on that date; or
2. the date the Employee acquires a Dependent, if application is made within thirty-one (31) days.
3. Coverage of a newborn child will become effective immediately for routine nursery care, treatment for prematurity, birth abnormalities, congenital defects, or any other Illnesses. The newborn child will be entitled to receive all benefits, in accordance with the terms of the Plan, from birth for thirty-one (31) days. Upon application within the thirty-one (31) day period, the Employee may continue coverage beyond that period for a newborn child who qualifies as an eligible Dependent, subject to payment of any additional contribution if required by the Plan.

No Employee or Dependent may be covered simultaneously as an Employee and Dependent under the Plan. Also, a person may be covered under the Plan as the Dependent of only one Employee.

DEPENDENTS NOT ELIGIBLE FOR COVERAGE

The following Dependents are not eligible for coverage under the Plan in any case:

1. an eligible Employee's spouse if legally separated or divorced from the eligible Employee, unless a court decree directs otherwise, and then only until either the Employee or ex-spouse remarries;

2. an eligible Employee's child 26 or more years of age, with the exception of (a) an unmarried child, 26 or more years of age, who is unable to earn his own living due to physical or Mental Illness or handicap;

3. a foster child;

4. a grandchild; unless legal guardianship is granted.

CONTINUATION OF ELIGIBILITY

Mental or Physical Handicap

An unmarried child who is unable to earn his own living due to physical or Mental Illness or handicap, and is at or reaches a terminating age under the terms of the Plan, will be eligible for coverage if Independence Administrators receives proof, satisfactory to Independence Administrators, that he is unable to earn his own living.

If the dependent wants to be considered for handicap status, they must work with their physician to complete a handicap application/questionnaire. Once the application for handicap status is received, AmeriHealth Medical Management will make a determination whether the child should be approved or denied. Approved dependents can receive a lifetime approval or renewable (non-lifetime). Dependents with non-lifetime approvals (e.g., one year, two year) must complete another questionnaire when the approval term is complete.

Such proof must be received:

a. within thirty (30) days of such Dependent's eligibility date; or

b. within thirty (30) days of the date such Dependent reaches a terminating age under the terms of the Plan.

The Plan reserves the right to require subsequent proof of incapability during the time such Dependent coverage is in effect. Such proof will not be required more than once per year.

COST OF THE COVERAGE

You will be informed of the amount of your contribution when you are invited to enroll.

EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT PERIOD

Once in each Plan Year, the Company will hold an open enrollment period. During this period, an Employee may enroll for coverage, if he or she elected not to enroll when first eligible.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within thirty (30) days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because you or your dependents were enrolled in Medicaid or your state's State Children's Health Insurance Program and you or your dependent cease to be enrolled in such program as a result of no longer being eligible for the program, you may be able to enroll yourself or your dependents in this Plan in the future, provided that you request enrollment within sixty (60) days after coverage ends. If you or your dependents become eligible for premium assistance for this Plan from Medicaid or your state's State Children's Health Insurance Program and choose to enroll in this Plan, you must request coverage under this Plan within sixty (60) days after the date you or your dependent become eligible for premium assistance.

EFFECTIVE DATE

Employee and/or Dependent coverage shall become effective on the applicable date set forth below.

1. **Non-contributory Funding**

   If contribution from an Employee toward the cost of Employee and Dependent coverage is not required under the Plan, coverage will become effective on the date of eligibility.

2. **Contributory Funding**

   If contribution from an Employee toward the cost of Employee or Dependent coverage is required, and the Employee agrees to make the required contribution, coverage will become effective, upon the payment of such contribution, on the date shown below:

a. the date of eligibility if the application is made and is received by Independence Administrators on or before that date; or

b. the date Independence Administrators receives application, if the application is made within thirty (30) days after the date of eligibility.

3. Dependent(s)

No Dependents' coverage will become effective for an Employee unless the eligible Employee is, or simultaneously becomes, covered.

Coverage of a newborn child will become effective immediately for routine nursery care, treatment for prematurity, birth abnormalities, congenital defects, or any other Illnesses. The newborn child will be entitled to receive all benefits, in accordance with the terms of the Plan, from birth for thirty-one (31) days. Upon application within the thirty-one (31) day period, the Employee may continue coverage beyond that period for a newborn child who qualifies as an eligible Dependent, subject to payment of any additional contribution if required by the Plan.

THE PREFERRED PROVIDER NETWORK

Your PPO Network Plan is a program, which allows you to maximize your health care benefits by utilizing the PPO Network, which is comprised of Providers that have a contractual arrangement with Independence Administrators and BlueCard PPO providers. These Providers are called "Preferred Providers." You may think of them as "in-network" providers. Preferred Providers are doctors, hospitals and other health care professionals and institutions that are part of the PPO Network, which is designed to provide access to care through a selected managed network of providers. Services by Preferred Providers are delivered through a selected, managed network of providers designed to provide quality care. The PPO Network includes hospitals, primary care physicians and specialists, and a wide range of ancillary providers, including suppliers of Durable Medical Equipment, Hospice and Home Health agencies, Skilled Nursing Facilities, free standing dialysis facilities and Ambulatory Surgical Centers.

When you receive health care through a Provider that is a member of the PPO Network, you incur lower out-of-pocket expenses and there are no claim forms to fill out. Benefits are also provided if you choose to receive health care through a Provider that is not a Preferred Provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses, and the amount of your expenses could be substantial. You may have to reach a deductible before receiving benefits, and you may be required to file a claim form.

To locate a BlueCard PPO network provider, go to www.IBXTPA.com or call 1-800-810-BLUE (2583). Independence Administrators covers only care that is Medically Necessary. Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in short procedure units and care in a hospital outpatient department.

Some of the services you receive through this Plan must be pre-certified before you receive them, to determine whether they are Medically Necessary. Failure to pre-certify services to be provided by a Non-Preferred Provider, when required, may result in a reduction of benefits. Pre-certification of services is a vital program feature that reviews the Medical Necessity of certain procedures/admissions. In certain cases, Pre-certification helps determine whether a different treatment may be available that is equally effective. Pre-certification also helps determine the most appropriate setting for certain services. Innovations in health care enable doctors to provide services, once provided exclusively in an inpatient setting, in many different settings – such as an outpatient department of a hospital or a doctor's office.

If the request for Pre-certification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

1. Acknowledge this in writing.
2. Request to have services provided.
3. State your willingness to assume financial liability.

When you seek treatment from a Non-Preferred Provider or a BlueCard Provider, you are responsible for initiating the Pre-certification process. You or your provider should call the Pre-certification number listed on the back of your Identification Card, and give your name, facility's name, diagnosis, and procedure or reason for admission. Failure to pre-certify required services will result in a reduction of benefits payable to you.

For more Information regarding pre-certification please see the ***Clinical Services*** section of this Booklet.

REGARDING USE OF NON-PREFERRED PROVIDERS

While the PPO has an extensive network, it may not contain every Provider that you elect to see. To receive the maximum benefits available under this program, you must obtain Covered Services from Preferred Providers that participate in the PPO Network or is a Blue Card PPO Provider.

In addition, your PPO program allows you to obtain Covered Services from Non-Preferred Providers. If you use a Non-Preferred Provider you will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles and Coinsurance. The Non-Preferred Provider may charge you for the balance of the Provider's bill. This is true whether you use a Non-Preferred Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a Provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense.

For specific terms regarding Non-Preferred Providers, please refer to the following sections: ***Definitions***, including but not limited to the definition of Covered Expense and Non-Preferred Provider, and the Payment of Providers subsection under ***General Provisions***.

BLUECARD PPO PROGRAM

Out-of-Area Services

Overview

Independence Administrators has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside of the geographic area Independence Administrators serves, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Independence Administrators' service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. Independence Administrators explains below how it pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Independence Administrators to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Independence Administrators will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside Independence Administrator' service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Independence Administrators.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider.

Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Independence Administrators has used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Independence Administrators through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If Independence Administrators has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on the Member's behalf, Independence Administrators will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

Nonparticipating Providers Outside Independence Administrators' Service Area

Please refer to the Covered Expense definition in the Defined Terms section of the Benefit Booklet for a description of Independence Administrator's reimbursement for Nonparticipating/Non-Preferred Providers.

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue.

As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) (TTY: 711) or call collect at 1.804.673.1177 (TTY: 711), 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact Independence Administrators to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

PAYMENT OF COVERED MEDICAL CHARGES

1. The Plan Year Deductible is as shown in the ***Schedule of Benefits***. A Covered Person must Incur covered medical charges of at least this amount within a plan year before any benefits are payable during that year, unless otherwise stated in the ***Schedule of Benefits***.

   A Covered Person must satisfy the individual deductible amount only once during a plan year. However, after the Covered Persons in a family unit have satisfied the family deductible amount during a plan year, benefits will be payable for covered medical charges incurred for all Covered Persons in a family unit for the remainder of that plan year. Please refer to the ***Schedule of Benefits*** for individual and family deductible information.

2. When a Covered Person is confined in a Hospital, Rehabilitation Facility, or Skilled Nursing Facility, benefits payable will be determined by the condition primarily being treated. Determination will be made by Independence Administrators based on the Covered Person's medical history and will be conclusive.

3. In counting the number of days of medical care furnished to a Covered Person while confined in a Hospital, Rehabilitation Facility, or Skilled Nursing Facility, either the day of admission or the day of discharge will be counted, but not both.

4. No benefits will be payable under the Plan for charges Incurred after the Hospital's regular discharge hour, provided the Covered Person has been advised by his attending Doctor prior to such discharge that further confinement is not required.

5. Pregnancy benefits will be provided under the same conditions and limitations as any other Illness.

   This Plan does not restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than the following:

   a. 48 hours following a normal vaginal delivery; or
   b. 96 hours following a caesarean section.

   This Plan does not require that a Provider obtain authorization from the Plan for prescribing a length of stay that does not exceed these periods.

COVERED MEDICAL CHARGES

Subject to "Exceptions and Exclusions" which follows, covered medical charges include the charges described below that are Medically Necessary and Incurred while covered under the Plan. (A charge is deemed Incurred as of the date of the service, treatment, or purchase giving rise to the charge.)

FACILITY SERVICES

1. Room and Board

   a. Semiprivate Room — Includes special diets and general nursing care.

   b. Private Room — In a Facility having primarily private accommodations, the Covered Person is entitled to either the Facility's most common semiprivate room charge, if any, or an allowance agreed upon by Independence Administrators and the Facility. The difference between the Plan's allowance and the Facility's charge is the Covered Person's responsibility.

      Private Room accommodations will be covered in full if Medically Necessary.

   c. Special care accommodations — Special care accommodations include intensive care, cardiac care, and burn treatment or such other special care accommodations approved by Independence Administrators.

2. Ancillary Services — Includes those services and Supplies that are regularly provided and billed by a Facility, such as:

   a. use of operating, delivery, and treatment rooms and equipment;

   b. administration of blood and blood processing including blood and blood plasma to the extent that it is not donated or otherwise replaced;

   c. oxygen and other gases and their administration;

   d. prescribed drugs and medications that are dispensed for use in the Facility;

   e. anesthesia and the administration of anesthetics when performed by an employee of the Facility;

   f. medical and surgical dressings, Supplies, casts, and splints; and

   g. diagnostic services.

   When counting the number of days of care furnished to an Inpatient, either the day of admission or the day of discharge will be counted, but not both.

Charges Incurred after a Facility's regular discharge hour are not covered provided the Covered Person has been advised by his attending Professional Provider prior to such discharge that further confinement is not required.

MEDICAL CARE

Medical care and Facility services rendered to an Inpatient by the Doctor in charge of the case for a condition not related to Surgery or pregnancy, except as specifically provided. Such care includes Inpatient intensive medical care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period.

1. Concurrent Care

   Medical care rendered to an Inpatient by a Professional Provider who is not in charge of the case, but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations, or medical care routinely performed in the preoperative or postoperative or prenatal or postnatal periods, or medical visits required by a Facility's rules and regulations.

2. Consultation Services

   Consultation services rendered to an Inpatient by a Professional Provider at the request of the attending Professional Provider. Consultation services do not include staff consultations that are required by a Facility's rules and regulations.

   Benefits are provided for one consultation per consultant during each period of confinement.

REHABILITATION HOSPITAL CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Rehabilitation Hospital.

No benefits are provided for services in a Rehabilitation Facility:

1. once the Covered Person reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment; or

2. when the services are primarily provided to maintain the Covered Person's level of functioning; or to assist the Covered Person with the activities of daily living; or to provide an institutional environment for the convenience of the Covered Person.

SKILLED NURSING FACILITY CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Skilled Nursing Facility as described in the ***Schedule of Benefits***.

Benefits for medical care in a Skilled Nursing Facility are provided for up to two visits during the first week of confinement and one visit a week for each consecutive week of confinement thereafter.

No benefits are provided for services in a Skilled Nursing Facility:

1. once the Covered Person reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment;

2. when the services are primarily provided to maintain the Covered Person's level of functioning; or to assist the Covered Person with the activities of daily living; or to provide an institutional environment for the convenience of the Covered Person.

SURGICAL SERVICES

Surgery for the treatment of Illness or Accidental Injury.

Covered Surgery includes sterilization procedures regardless of their Medical Necessity.

If more than one surgical procedure is performed by the same Professional Provider during the same operative session, benefits will be provided for the highest paying procedure plus an allowance of 50% of eligible charges for the additional procedure(s), plus any additional payment beyond the 50% that is deemed appropriate due to the nature or circumstances of the procedure. No additional allowance will be provided for those surgical procedures determined by Independence Administrators to be incidental to or an integral part of another surgical procedure performed during the same operative session.

1. Preoperative and Postoperative Medical Care

   The payment allowance for Surgery includes related preoperative and postoperative care rendered by the surgeon within the timeframe based on the surgical procedure.

2. Maternity Delivery

   The payment for maternity delivery includes prenatal and postpartum care normally provided by a Doctor for the care and management of pregnancy.

3. Surgical Assistance

   Services rendered by an assistant surgeon who actively assists the operating surgeons in the performance of Surgery.

   The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

4. Anesthesia

   Anesthesia and the administration of anesthetics in connection with the performance of covered medical services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon, or attending Professional Provider.

5. Second Surgical Opinion Consultation

   Consultation services rendered by a surgeon or specialist to determine the Medical Necessity of an Elective Surgery. Such services must be performed and billed by a surgeon or specialist who is not in association with the one who initially recommended the Surgery.

   Benefits are provided for one additional consultation, as a third opinion, in cases where the second opinion disagrees with the first recommendation. In such instances, benefits will be provided for a maximum of two consultations, but limited to one consultation per consultant.

6. Transplant Services

   If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

   a. When both the donor and recipient are covered by the Plan, each is entitled to the benefits of the Plan.

   b. When only the recipient is covered by the Plan, both the donor and recipient are entitled to the benefits of the Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be charged against the recipient's coverage under the Plan.

   c. When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program available to the recipient. No benefits are provided under the Plan to the non-Covered Person transplant recipient.

   d. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue. However, other costs related to evaluation and procurement are covered up to the Covered Person recipient's Plan limit.

PREADMISSION TESTING

Diagnostic tests and studies performed on an Outpatient basis prior to Elective Surgery. Benefits are provided for preadmission testing if:

1. the Covered Person was scheduled for Surgery prior to the testing;
2. the Surgery is not delayed beyond the 14 day period immediately following the testing; and
3. the Surgery to which the testing is related is covered by the Plan.

EMERGENCY ACCIDENT TREATMENT

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of an Emergency Accident, as defined.

Benefits are provided for emergency treatment that commences within 72 hours following the accident.

EMERGENCY MEDICAL TREATMENT

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of a condition with acute symptoms of sufficient severity that the absence of immediate medical attention could:

1. permanently place the Covered Person's health in jeopardy;
2. cause other serious medical consequences;
3. cause serious impairment to bodily functions; or
4. cause serious and permanent dysfunction of any bodily organ or part.

Benefits are provided for emergency treatment that commences within 72 hours following the onset of the medical emergency.

Should any dispute arise as to whether an emergency condition existed, the determination by Independence Administrators will be final.

HOME VISITS, OFFICE VISITS, AND OTHER OUTPATIENT VISITS

Medical visits and consultation services for the examination, diagnosis, and treatment of a condition not related to Surgery, or pregnancy, except as specifically provided.

1. Well-child care and immunizations

Well-child care including routine physical examinations and immunizations. Benefits are provided for these services as prescribed by the American Pediatric Association. Immunizations as recommended by the Department of Health.

Well-child care and immunizations are subject to a maximum described in the ***Schedule of Benefits***.

2. Routine physical examinations

   Examinations including a complete medical history.

   Benefits are provided for these services as prescribed by the American Medical Association. Services provided under a Vision Care program or plan are not covered.

   Routine physical examinations are subject to a maximum described in the ***Schedule of Benefits***.

3. Preventive care services

   100% coverage for certain designated preventive care services. There will be no cost sharing (copayments, coinsurance, deductibles) for the following preventive care services if provided by a Participating Provider:

   a. Evidence-based items/services with a rating of "A" or "B" in the current recommendations of the U.S. Preventative Services Task Force.
   b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
   c. Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents.
   d. With respect to women, additional preventive care and screenings provided for in guidelines supported by HRSA.

   You can find online links to these lists of services at www.Healthcare.gov. Click the *Learn About Prevention* tab.

   Be aware that you may be required to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

DIAGNOSTIC SERVICES

The following procedures when ordered by a Professional Provider to determine a definite condition because of specific symptoms:

1. diagnostic X-ray consisting of radiology, ultrasound, and other diagnostic X-ray procedures.

2. diagnostic laboratory and pathology tests;

3. diagnostic medical procedures consisting of EKG, EEG, and other diagnostic medical procedures; and

4. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

THERAPY SERVICES

The following Therapy Services:

1. Radiation Therapy, including the cost of radioactive materials;

2. Chemotherapy by intravenous, intra-arterial, or intracavity injection infusion or perfusion, subcutaneous and intramuscular routes. Oral chemotherapy, including its administration, is also covered. The cost if listed as approved or indicated for the diagnosis under treatment by one or more of the following: FDA, NCCN, NIH, NCI. Notwithstanding experimental and investigational use of chemotherapy agents is not covered. All chemotherapy is subject to medical necessity review as antineoplastic agents is covered, provided they are administered as described in this paragraph;

3. Dialysis Treatment;

4. Physical Therapy;

5. Cardiac Rehabilitation;

6. Any other therapy services Independence Administrators determines necessary to treat Accidental Injury or Illness.

HOME HEALTH CARE SERVICES

The following services, as described in the ***Schedule of Benefits***, when provided to an essentially homebound Covered Person by a Home Health Care Agency:

1. Skilled Nursing Care; and

2. Therapy Services;

3. Medical Social Work;

4. Nutritional Services

5. Health services furnished by a home health aide;

6. Medical appliances;

7. Medical equipment;

8. Special meals;

9. Diagnostic or therapeutic services, including surgical services furnished;

    a. In an outpatient department of a Hospital;

    b. In a Physician's office; or

    c. At any other licensed health care facility.

Benefits are also provided for certain other medical services when furnished along with a primary service. Such other services include prescription drugs, diagnostic services, Supplies, and other Medically Necessary services.

No benefits are provided for services in connection with:

1. Custodial Care, food, housing, homemaker services, home delivered meals, and supplementary dietary assistance;

2. services provided by a member of the Covered Person's Immediate Family;

3. patient transportation, including Ambulance services;

4. visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational therapy or social services;

5. services provided to Covered Persons who are not essentially home bound for medical reasons; or

6. visits solely for the purpose of assessing the Covered Person's condition and determining whether or not the Covered Person requires and qualifies for home health care services.

HOSPICE SERVICES

Hospice benefits, as described in the ***Schedule of Benefits***, are provided when the Covered Person's attending Doctor certifies that the Covered Person has a terminal Illness with a medical prognosis of six months or less to live.

Hospice benefits are provided for the following services when rendered by a Hospice or under arrangements made by a Hospice in accordance with a Hospice care program and approved by Independence Administrators.

1. Medical care by a Doctor affiliated with the Hospice care program;

2. Nursing care by an R.N., or L.P.N., or home health aide;

3. Medical social services;

4. Therapy services except for dialysis treatments;

5. Dietary services;

6. Laboratory services;
7. Prescribed drugs and medicines;
8. Family counseling services;
9. Ambulance services when Medically Necessary to transport the Covered Person to and from the nearest Inpatient Hospice Facility;
10. The following medical services, Supplies, and equipment:
    a. oxygen, including the rental of oxygen equipment;
    b. artificial limbs or other prosthetic devices, but not including replacement;
    c. rental of Durable Medical Equipment;
11. Inpatient Hospice care when needed to control pain and other symptoms associated with the terminal Illness, but only if the Covered Person's attending Doctor certifies that it is Medically Necessary for the care to be provided on an Inpatient basis rather than in a home setting or on an Outpatient basis;
12. Inpatient respite care in a Hospice, which may be subject to a benefit maximum.

Special Exclusions and Limitations

1. The Hospice care program must deliver Hospice care in accordance with a treatment plan approved by and periodically reviewed by Independence Administrators.
2. No Hospice care benefits will be provided for:
    a. Medical care rendered by the Covered Person's private Doctor;
    b. Volunteers who do not regularly charge for services;
    c. Pastoral services;
    d. Homemaker services;
    e. Food or home delivered meals;
    f. Legal or financial services or counseling;
    g. Curative treatment or services;
    h. Bereavement counseling.

PRIVATE DUTY NURSING SERVICES

The following services, as described in the ***Schedule of Benefits***, when provided by an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) and ordered by a Doctor. **Prior authorization of services is required.**

1. Home Services

   Nursing services that Independence Administrators determines require the skills of an R.N. or L.P.N. No benefits are provided for the services of a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Immediate Family.

AMBULANCE SERVICES

Ambulance service by an authorized agency or a Facility providing local transportation of a sick or injured Covered Person:

1. from the site of injury or medical emergency to the nearest Facility; or
2. from the first Facility to the nearest Facility that can provide services Medically Necessary for the treatment of the Covered Person's condition, but only if the services necessary to treat the condition are not available at the first Facility.

Benefits are provided for air Ambulance transportation only if Independence Administrators determines that the Covered Person's condition, and the type of service required for the treatment of the Covered Person's condition, and the type of Facility required to treat the Covered Person's condition justify the use of air Ambulance instead of another means of transport.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC APPLIANCES

1. Durable Medical Equipment

   The rental or purchase of Durable Medical Equipment when prescribed by a Doctor and required for therapeutic use.

   a. Rental — Benefits are provided for rental fees up to an amount that equals, but does not exceed, the purchase price of the equipment.

   b. Purchase — Benefits may be provided for the purchase of Durable Medical Equipment at the option of the Plan.

   If a Claim is filed for equipment containing features of an aesthetic nature or features of a medical nature that are not required by the Covered Person's condition or if there exists a reasonable or feasible and medically appropriate alternative piece of equipment that is less costly than the equipment furnished, the benefit provided is based on the charge for the equipment that meets the Covered Person's medical needs. **Payment for the purchase or rental of Durable Medical Equipment may**

require preauthorization. Preauthorization may be obtained by calling Independence Administrators' Clinical Services Department at the number listed on your identification (ID) card.

2. Prosthetic Appliances

   The first purchase and fitting of artificial limbs, eyes, and other prosthetic appliances that replace all or part of an absent or inoperative or malfunctioning body organ but only if required for the replacement of natural parts of the body lost or becoming inoperative while covered by the Plan (excluding dental appliances).

3. Replacement and Modification

   Benefits are provided for the replacement or modification of Durable Medical Equipment, orthotics, and prosthetic appliances when Medically Necessary due to a change in the Covered Person's physical condition. Benefits for the replacement of such items are provided to the extent that the cost of the purchase is less expensive than the modification. In no event will the Plan pay for contact lenses other than the initial pair of contact lenses following cataract surgery.

4. Diabetic Education

5. Orthotics

   Benefits are provided if orthotics are an integral part of a leg brace and the cost is included in the orthotist's charges, including the initial purchase, fitting and repair of orthotic appliance that are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or illness.

6. Cranial prosthesis (wigs) are covered only in relation to baldness as a result of burns, chemotherapy, radiation therapy, or surgery.

DENTAL SERVICES

1. Dental treatment performed within six months following Accidental Injury to sound natural teeth, but only if such injury occurs while covered by the Plan. Accidental Injury does not include injuries that result from biting or chewing.

2. Oral Surgery performed for the removal of impacted teeth partially or totally covered by bone.

ROUTINE NEWBORN CARE

Professional visits to examine the newborn while an Inpatient in a Hospital or Birthing Center. Facility charges for ordinary nursery care of the newborn as well as routine newborn circumcisions are also covered.

MENTAL ILLNESS BENEFITS

Treatment of Mental Illness is eligible anywhere when performed by a Professional Provider as follows:

1. Psychiatric Visits
2. Electro-Convulsive Therapy
3. Individual Psychotherapy
4. Group Psychotherapy
5. Psychological Testing
6. Family Counseling

   Counseling with family members to assist in the Covered Person's diagnosis and treatment.

Facility Services for Mental Illness

1. Inpatient Facility Services

   Facility services provided for Inpatient treatment of Mental Illness by a Facility.

2. Partial Hospitalization

   Treatment of Mental Illness in a planned therapeutic program when such services are rendered during the day only or during the night only.

3. Outpatient Mental Illness Services

   Facility services and supplies provided to an Outpatient by a Facility.

SUBSTANCE ABUSE BENEFITS

1. Inpatient Detoxification Services

   Benefits are payable for a detoxification program provided either in a Hospital or in a licensed Substance Abuse Treatment Facility.

   a. Room and board
   b. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services
   c. Diagnostic X-ray
   d. Psychiatric, psychological, and medical laboratory testing
   e. Drugs, medicine, equipment, and Supplies

2. Inpatient Rehabilitation Services

   Benefits are payable for Inpatient services provided in a licensed Substance Abuse Treatment Facility provided the Covered Person: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

   a. Room and board
   b. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services
   c. Rehabilitation therapy and counseling
   d. Family counseling and intervention
   e. Psychiatric, psychological, and medical laboratory testing
   f. Drugs, medicine, equipment, and Supplies

3. Outpatient Rehabilitation Services

   Benefits are payable for Outpatient services provided in a licensed Substance Abuse Treatment Facility provided the Covered Person: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

   a. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services;
   b. rehabilitation therapy and counseling;
   c. family counseling and intervention;
   d. psychiatric, psychological, and medical laboratory testing; and
   e. drugs, medicine, equipment, and Supplies.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS

Benefits are provided for Routine Patient Costs Associated with Participation in a Qualifying Clinical Trial (see ***Definitions*** section). To ensure coverage and appropriate claims processing, the Plan must be notified in advance of the Covered Person's participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by a Preferred Professional Provider and conducted in a Preferred Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by a Preferred Professional Provider, and in a Preferred Facility Provider, then the Plan will consider the services by a Non-Preferred Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial (see ***Definitions*** section) by the Plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In accordance with this law, the required mastectomy coverage includes:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications of all stages of a mastectomy, including lymphedemas.

The benefits for these services must be provided in a manner determined in consultation with the attending doctor and the patient. These services may be subject to the deductibles and coinsurance amounts applicable to your group health plan.

CHILD IMMUNIZATION COVERAGE

Coverage will be provided for those child immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with standards of the Advisory Committee on Immunization Practices of the Center of Disease Control, U.S. Department of Health and Human Services. Benefits will be exempt from deductibles or dollar limits.

ANNUAL GYNECOLOGICAL EXAMINATION AND ROUTINE PAP SMEARS

- Annual gynecological examination, including a pelvic examination and clinical breast examination; and
- Routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

These gynecological examination/pap smear benefits are exempt from any deductible or dollar limit provisions in the contract. However, they may be subject to any copayment or coinsurance amounts applicable to your group health plan.

COLORECTAL CANCER SCREENING COVERAGE

Coverage for colorectal cancer screening may be subject to annual deductibles, coinsurance, and copayment requirements applicable to your group health plan.

Benefits for preventive care colorectal cancer screening are subject to the requirements as established by the U.S. Preventive Services Task Force Recommendations and may be different from the benefits detailed below. For more information on preventive care colorectal cancer screening, please visit www.healthcare.gov.

Symptomatic individuals;

Colonoscopy
Sigmoidoscopy
Colorectal Screening Tests (any combination thereof as determined by the treating Physician)

Non-symptomatic individuals covered over age 50;

Annual Fecal Occult Blood Test
Sigmoidoscopy – a screening barium enema test once every five years
Colonoscopy – no age or time restriction for this benefit
Colon Cancer test at least once every 5 years

Non-symptomatic coverage for individuals at high or increased risk of colorectal cancer under age 50;

Colonoscopy
Any combination of colorectal cancer screening tests.

PRESCRIPTION DRUG COVERAGE

Your prescription drug coverage is administered by FutureScripts. One (1) ID card is used for access to both Medical and Prescription drug benefits.

You are responsible for a copayment for each prescription drug or refill. You may also be responsible for a prescription drug OR plan deductible that must first be met before any benefits are payable. This amount is shown in the ***Schedule of Benefits***.]

If you purchase your prescription at a pharmacy that accepts FutureScripts, simply present your ID card and pay the copayment and/or deductible.

If you purchase your prescription at a Doctor's office or pharmacy that does not accept FutureScripts, pay the full cost of the prescription and have the Doctor or pharmacist complete their portion of a "Direct Reimbursement" form. Submit this form to FutureScripts and they will reimburse you for the cost of the prescription minus your copayment and/or deductible.

PRIOR AUTHORIZATION

Your prescription drug coverage requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing physicians and pharmacists.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on: clinical data; information submitted by the plan member's prescribing physician; and the plan member's available prescription drug therapy history. Their review includes a determination that: there are no drug interactions or contra indications; that dosing and length of therapy are appropriate; and that other drug therapies, if necessary, were used.

Without prior authorization, the plan member's prescription will not be covered at your health benefits program's retail or mail order pharmacy.

The prior authorization process may take up to two working days once FutureScripts receives complete information from the prescribing physician. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, the approval will include an expiration date. If the physician wants a plan member to continue the drug therapy after the expiration date, he or she will need to get approval for a new prior authorization request in order for coverage to continue.

DRUGS THAT REQUIRE PRIOR AUTHORIZATION

You can see what drugs require prior authorization online. Visit the website listed on your identification (ID) card and click Prescription Drug Program > More information.

If you prefer to talk with a FutureScripts representative, please call 1-888-678-7013.

APPEALING A DECISION

If a request for prior authorization/preapproval or override results in a denial, the plan member or physician, on the plan member's behalf, may file an appeal. Both the plan member and the physician will receive written notification of a denial, which will include the telephone number and address to which they can direct an appeal. In all cases, the physician must be involved in the appeals process to provide the required medical information for the basis of the appeal.

REQUEST PRIOR AUTHORIZATION/PREAPPROVAL OR OVERRIDE

The physician prescribing the medication completes a prior authorization form or writes a letter of medical necessity and faxes it to FutureScripts at 215-241-3073 or 1-888-671-5285. Or the physician may request the form by calling 1-888-678-7013. Plan members may request the form through FutureScripts Customer Service on the physician's behalf, but the physician must complete and submit it.

FutureScripts will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review it.

CLINICAL SERVICES

You MUST CALL the number for Clinical Services listed on your identification (ID) card to fulfill the requirements of Clinical Services.

The pre-certification process reviews the Medical Appropriateness/Medical Necessity of the requested services only. Pre-certification is not a guarantee of eligibility for the coverage or payment of a Claim. Coverage and payment are dependent upon, among other things, the Covered Person being eligible, i.e., actively enrolled in the health benefits plan when the services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

A. UTILIZATION REVIEW PROCESS

A basic condition of the Plan's benefit plan coverage is that in order for a health care service to be covered or payable, the service must be Medically Appropriate/Medically Necessary. Medically Appropriate/Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and care in a Hospital Outpatient Department. To assist Independence Administrators' delegate in making coverage determinations for requested health care services, Independence Administrators uses established medical policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Covered Person's benefit plan is called utilization review.

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by Independence Administrators to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/Medical Necessity of the procedure itself, the diagnosis reported, or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an emergency room which has been approved by Independence Administrators' delegate based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g. rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed, it is called a pre-certification review. Reviews occurring during a Hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. Independence Administrators' delegate follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Appropriateness/Medical Necessity review, nurses perform the initial case review using medical policies, established guidelines and evidence-based clinical criteria and protocols; however, only a medical director employed by Independence Administrators or its delegate may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable guidelines and evidence-based clinical criteria and protocols, taking into consideration the Covered Person's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a medical director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and the Covered Person in accordance with applicable law.

Independence Administrators' utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to Independence Administrators' or its delegate's medical directors to discuss coverage of a case. Medical directors and nurses receive salaries. Contracted external physicians and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. Neither Independence Administrators nor its delegates specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

B. CLINICAL CRITERIA, GUIDELINES AND RESOURCES

The following guidelines, clinical criteria and other resources are used to help make Medically Appropriate/Medically Necessary coverage decisions.

Clinical Decision Support Criteria — Clinical Decision Support Criteria is an externally validated and computer-based system used to assist Independence Administrators or its delegate in determining Medical Appropriateness/Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of Illness, these criteria assist clinical staff in evaluating the Medical Appropriateness/Medical Necessity of services based on a Covered Person's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in plan determinations for similar medical issues and requests; and, reduces practice variation among Independence Administrators' or its delegate's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following: some elective Surgeries - settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery), Inpatient hospitalizations, Inpatient and Outpatient rehabilitation, diagnostic procedures, Home Health Care, Durable Medical Equipment, and Skilled Nursing Facility.

Medical Policies — Independence Administrators and its delegates maintain an internally developed set of policies, which document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which Medical Polices are applied include, but are not limited to: Ambulance, Infusion, Speech Therapy, Occupational Therapy, Durable Medical Equipment, and review of potential cosmetic procedures.

Internally Developed Guidelines — A set of guidelines developed with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting medical policies for coverage.

C. DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

Independence Administrators has agreements with state licensed utilization review entities, where required, and a NCQA (National Committee for Quality Assurance) accredited utilization management program. Independence Administrators has delegated certain utilization review activities, including pre-certification review, concurrent review, and case management, to entities with an expertise in medical management of certain conditions and services (such as, mental illness/substance abuse), or certain membership populations (such as, neonates/premature infants), or after-hours pre-certification services. In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with Independence Administrators' approval.

D. PRE-CERTIFICATION REVIEW

When required, Pre-certification review evaluates the Medical Necessity, including the appropriateness of the setting, of proposed services for coverage under the Covered Persons benefit plan. Examples of these services include planned or elective Inpatient admissions and selected Outpatient procedures. For Covered Persons located in the PPO Network service area, Pre-certification review may be initiated by the Provider or the Covered Person depending on whether the Provider is a PPO Network Provider. For Covered Person's located outside Independence Administrators PPO Network who are accessing BlueCard PPO Providers, the Covered Person is responsible for initiating or requesting the Provider to initiate the Pre-certification review. Where Pre-certification review is required, Independence Administrators' coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Pre-certification review is required for a procedure but is not obtained.

1. INPATIENT PRE-ADMISSION REVIEW

Inpatient Admissions

In accordance with the criteria and procedures described above, Inpatient admissions, other than an emergency admission, must be pre-certified in accordance with the standards of Independence Administrators as to the Medical Appropriateness/Medical Necessity of the admission. The pre-certification requirements for emergency admissions are set forth in the "Emergency Admission Review" subsection immediately following below. The Covered Person is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.

a. To obtain Pre-certification, the Covered Person is responsible to contact or have the admitting Physician or other Facility Provider contact Independence Administrators prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. Independence Administrators will notify the Covered Person, admitting Physician and the Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits at the Preferred or Non-Preferred level shown in the ***Schedule of Benefits*** if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this booklet.

b. If such prior approval for a Medically Appropriate/Medically Necessary Inpatient Admission has not been certified as required, there will be a penalty for non-compliance and benefits for Covered Services will be reduced 100%, up to a maximum benefit reduction of $200, per hospitalization to the Covered Person. Such penalty, and any difference in what is covered by the Plan and

the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

c. If a Covered Person elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Covered Person will be financially liable for non-covered Inpatient charges.

d. If Pre-certification is denied, the Covered Person, the Physician or the Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Covered Person, Physician, or Facility Provider will be so notified.

2. EMERGENCY ADMISSION REVIEW

Emergency Admissions

a. Covered Persons are responsible for notifying Independence Administrators of an emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by Independence Administrators.

b. Failure to initiate Emergency admission review will result in a penalty for non-compliance and benefits for Covered Services will be reduced 100%, up to a maximum benefit reduction of $200, per hospitalization to the Covered Person. Such penalty will be the sole responsibility of, and payable by, the Covered Person.

c. If the Covered Person elects to remain hospitalized after Independence Administrators and the attending Doctor have determined that an Inpatient level of care is not Medically Appropriate/Medically Necessary, the Covered Person will be financially liable for non-covered Inpatient charges from the date of notification.

3. CONCURRENT AND RETROSPECTIVE/POST-SERVICE REVIEW, PRE-NOTIFICATION AND DISCHARGE PLANNING

Concurrent review may be performed while services are being performed. If concurrent review is performed during an Inpatient stay, the expected and current length of stay is evaluated to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Covered Person and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent review may not be performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with a Facility does not require such review.

Retrospective/post-service review occurs after services have been provided. This may be for a variety of reasons, including when Independence Administrators has not been notified of a Covered Person's admission until after discharge, or where medical charts are unavailable at the time of a concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, Independence Administrators may determine coverage of certain procedures and other benefits available to Covered Persons through pre-notification as required by the Covered Person's benefit plan and discharge planning.

Pre-notification is advance notification to Independence Administrators of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Covered Persons for concurrent review needs, to ascertain discharge planning needs proactively, and to identify Covered Persons who may benefit from case management programs.

Discharge planning is performed during an Inpatient admission and is used to identify and coordinate a Covered Person's needs and benefit coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge planning involves Independence Administrators' authorization of covered post-Hospital services along with identifying and referring Covered Persons for disease management or case management services.

E. TRANSPLANT SERVICES

Independence Administrators requests notification of transplant services as soon as the need for an organ or tissue transplant is known. For a complete list of services requiring Pre-certification please call the number for Clinical Services or visit the website listed on your identification (ID) card. This list may be subject to change.

F. MATERNITY SERVICES

Independence Administrators requests maternity care notification as soon as the pregnancy is confirmed by a Doctor.

Pre-certification requirements apply when:

1. a Covered Person is admitted for any condition or procedure other than delivery of the baby;
2. the type of delivery anticipated or place of service changes before admission for delivery;

3. the Covered Person's medical condition requires a stay longer than 48 hours after a vaginal delivery or 96 hours after an approved cesarean section. Independence Administrators must pre-certify additional Inpatient days;

4. the baby is required to stay after the mother is discharged. Independence Administrators must pre-certify additional Inpatient days.

A Covered Person is encouraged to call Independence Administrators if medical problems develop during the pregnancy.

G. OTHER PRE-CERTIFICATION REQUIREMENTS

Pre-certification is required by Independence Administrators in advance for Home Health Care, Hospice Care, certain surgical and diagnostic procedures, Inpatient and Partial Hospitalization services for Substance Abuse, Mental Illness and Serious Mental Illness. For a complete list of Pre-certification requirements please call the number for Clinical Services listed on your identification (ID) card or visit the website listed on your identification (ID) card. This list may be subject to change. When a Covered Person plans to receive any of these listed procedures, Independence Administrators will review the Medical Appropriateness/Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures that are performed during an emergency, as determined by Independence Administrators, do not require pre-certification. However, Independence Administrators should be notified within two (2) business days of emergency services for such procedures, or as soon as reasonably possible, as determined by Independence Administrators. A complete list of Pre-certification requirements is available by calling the number for Clinical Services listed on your identification (ID) card or by visiting the website listed on your identification (ID)card. This list may be subject to change.

The Covered Person is responsible to have the Provider performing the service contact Independence Administrators to initiate pre-certification. Independence Administrators will notify the Covered Person, the Doctor and the Facility, if applicable, of the determination.

If such prior approval is not obtained and the Covered Person undergoes the Surgical Procedure, diagnostic or other procedure, or treatment then benefits will be provided for Medically Appropriate/Medically Necessary treatment, but there will be a penalty for non-compliance. Benefits for Covered Services will be reduced 100%, up to a maximum benefit reduction of $200, per service to the Covered Person. Such penalty, and any difference in what is covered by Independence Administrators and the Covered Person's obligation to the Provider, may be the sole responsibility of, and payable by, the Covered Person.

H. SERVICES REQUIRING PRE-CERTIFICATION

For a complete list of services requiring Pre-certification please call the number for Clinical Services listed on your identification (ID) card or visit the website listed on your identification (ID) card. This list may be subject to change.

I. CASE MANAGEMENT

Case management serves individuals who have been diagnosed with a complex, catastrophic, or chronic Illness or injury. The objectives of case management are to facilitate access by the patient to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve outcomes of Covered Persons. Case management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic Illness and/or injury across various levels and sites of care.

Independence Administrators will provide case management services for those identified Covered Persons that would benefit from:

- Support during the continuum of care;
- Improved self-management skills;
- Improved transition and coordination among multiple Providers and/or levels of care;
- Assistance to maximize the effective use of health plan benefits;
- Reduction of acute exacerbation of a chronic Illness; and,
- Reduction of preventable complications.

Covered Persons may be identified for case management through the pre-certification process or through claims review. External referrals are also accepted from Covered Persons' Providers or family members. Covered Persons referred to case management are screened and accessed prior to acceptance into the program. Only those Covered Persons likely to benefit from case management are accepted into case management.

A case manager will consult with the patient, the patient's authorized representative, the caregiver and the attending Doctor in order to develop a plan of care for approval by the patient's attending Doctor and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the care giver to offer assistance and support;

- monitoring Inpatient care;
- identifying available resources for appropriate care;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The attending Doctor, the patient and the patient's caregiver must all agree to the alternate treatment plan. Once agreement has been reached, Independence Administrators may reimburse necessary expenses in the treatment plan, even if some expenses normally would not be paid by the benefit plan.

Case management is a voluntary service. Covered Persons must provide their consent for enrollment into case management. There is no reduction in benefits if the patient and the patient's family choose not to participate.

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

J. DISEASE MANAGEMENT AND DECISION SUPPORT PROGRAMS

Disease Management and Decision Support programs help Covered Persons to be effective partners in their health care by providing information and support to Covered Persons with certain chronic conditions as well as those with everyday health concerns. Disease Management is a systematic, population-based approach that involves identifying Covered Persons with certain chronic conditions, intervening with specific information or support to follow a Provider's treatment plan, and measuring clinical and other outcomes. Decision Support involves identifying Covered Persons who may be facing certain treatment option decisions and offering them information to assist in informed, collaborative decisions with their Doctors. Decision Support also includes the availability of general health information, personal health coaching, Provider information, or other programs to assist in health care decisions.

Disease Management interventions are designed to help Covered Persons manage their chronic conditions in partnership with their Doctors. Disease Management programs, when successful, can help such Covered Persons avoid long term complications, as well as relapses that would otherwise result in Hospital or emergency room care. Disease Management programs also include outreach to Covered Persons to obtain needed preventive services, or other services recommended for chronic conditions. Information and support may occur in the

form of telephonic health coaching, print, audio library or videotape, or Internet formats.

AmeriHealth Administrators will utilize medical information such as claims data to operate the Disease Management or Decision Support program, e.g. to identify Covered Persons with chronic conditions, to predict which Covered Persons would most likely benefit from these services, and to communicate results to Covered Persons' treating Doctors. AmeriHealth Administrators will decide what chronic conditions are included in the Disease Management or Decision Support program.

Participation by a Covered Person in the Disease Management or Decision Support program is voluntary. A Covered Person may continue in the Disease Management or Decision Support program until either of the following occurs:

1. the Covered Person declines participation; or
2. AmeriHealth Administrators determines that the program, or aspects of the program, will not continue.

EXCEPTIONS AND EXCLUSIONS

Except as specifically provided in this booklet, no benefits will be provided for services, supplies or charges:

1. Which are not Medically Necessary as determined by the Plan for the diagnosis or treatment of illness or injury;
2. Which are Experimental/Investigative in nature, except, a) as approved by the Plan, or b) Routine Patient Costs Associated with Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under the Plan;
3. Which were Incurred prior to the Covered Person's effective date of coverage;
4. Which are in excess of the Covered Expense, as defined herein;
5. Which were or are Incurred after the date of termination of the Covered Person's coverage;
6. For any loss sustained or expenses Incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared;
7. For which a Covered Person would have no legal obligation to pay, or another party has primary responsibility;
8. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
9. Paid or payable by Medicare when Medicare is primary. For purposes of this plan, a service, supply or charge is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;
10. For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation;
11. To the extent a Covered Person is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Covered Person;
12. For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the state's Motor Vehicle Financial Responsibility Law or similar law;
13. Which are not billed and performed by a Provider as defined under this coverage as a "Professional Provider", "Facility Provider" or "Ancillary Provider" except as otherwise indicated under the subsections entitled: (a) Therapy Services" (that identifies covered therapy services as provided by licensed therapists) and (b) "Ambulance Services" in the ***Covered Medical Charges*** section;
14. Rendered by a member of the Covered Person's Immediate Family;

15. Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a Hospital or university;
16. For ambulance services except as specifically provided under this Plan;
17. For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, injury or congenital birth defect. This exclusion does not apply to mastectomy related charges as provided for in this booklet;
18. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
19. For alternative therapies/complementary medicine, including but not limited to, acupuncture (covered only as a form of anesthesia in connection with a covered surgical procedure), music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;
20. For marriage counseling;
21. For Custodial Care, domiciliary care or rest cures;
22. For equipment costs related to services performed on high cost technological equipment as defined by the Plan, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the pre-certification process and/or by the Plan;
23. For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this booklet/certificate. Services not covered include, but are not limited to, apicoectomy (dental root resection), prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated;
24. For dental implants for any reason;
25. For dentures, unless for the initial treatment of an Accidental Injury/trauma;
26. For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;
27. For injury as a result of chewing or biting (neither is considered an Accidental Injury);
28. For palliative or cosmetic foot care including treatment of bunions (except for capsular or bone surgery), toenails (except surgery for ingrown nails), the treatment of subluxations of the foot, care of corns, calluses, fallen arches, pes planus (flat

feet), weak feet, chronic foot strain, and other routine podiatry care, unless associated with the Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes;

29. For supportive devices for the foot (orthotics), such as, but not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes. This exclusion does not apply to orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
30. For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such Surgery;
31. For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury;
32. For treatment of obesity, except for surgical treatment of obesity when the Plan (a) determines the surgery is Medically Necessary; and (b) the surgery is limited to one surgical procedure per lifetime regardless of whether such procedure was covered by the Plan or another Plan. Any new or different obesity surgery, revisions, repeat, or reversal of any previous surgery are not covered. The exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure results in technical failure or when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person;
33. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
34. For diagnostic screening examinations, except for mammograms and preventive care as provided in the ***Covered Medical Charges*** section;
35. For routine physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for college, camp or travel, and examinations for insurance, licensing and employment;
36. For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;
37. For immunizations required for employment purposes, or for travel except for those immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee for Immunization Practices;
38. For care in a nursing home, home for the aged, convalescent home, school, camp, institution for intellectually disabled children, Custodial Care in a Skilled Nursing Facility;
39. For counseling or consultation with a Covered Person's relatives, or Hospital charges for a Covered Person's relatives or guests, except as may be specifically provided;
40. For home blood pressure machines, except for Covered Persons: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, or (c) with end-stage renal disease receiving home dialysis;
41. As described in the "Durable Medical Equipment" section in the ***Covered Medical Charges*** section for personal hygiene, comfort and convenience items; equipment and devices of a primarily nonmedical nature; equipment inappropriate for home use; equipment containing features of a medical nature that are not required by

the Covered Person's condition; non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicate equipment, whether or not rented or purchased as a convenience; devices and equipment used for environmental control; and customized wheelchairs;

42. For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits;
43. For prescription drugs, except as may be provided in the ***Prescription Drug Coverage*** section of this booklet. This exclusion does not apply to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels as provided for the treatment of diabetes;
44. For over-the-counter drugs and any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient admission;
45. For amino acid supplements, non-elementals formulas, appetite suppressants or nutritional supplements. This exclusion includes basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy;
46. For Inpatient Private Duty Nursing services;
47. For maintenance of chronic conditions;
48. For charges Incurred for expenses in excess of Benefit limits as specified in the ***Schedule of Benefits***;
49. For any therapy service provided for: the ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond this Plan's limits, if any, shown on the ***Schedule of Benefits***; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;
50. For cognitive rehabilitative therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (e.g. stroke, acute brain insult, encephalopathy);
51. For self-injectable Prescription Drugs, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered self-injectable Prescription Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration. This exclusion does not apply to self-injectable Prescription Drugs that are: (a) mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes, unless these drugs are covered by Prescription Drug coverage under the Plan or free-standing Prescription Drug Contract issued to the Group by the Plan; or (b) required for treatment of an emergency condition that requires a self-injectable drug;
52. For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension;

53. For hearing aids, including cochlear electromagnetic hearing devices, and hearing examinations or tests for the prescription or fitting of hearing aids unless otherwise indicated. Services and supplies related to these items are not covered;
54. For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);
55. For any Surgery performed for the reversal of a sterilization procedure;
56. For abortion services except when abortion is necessary to avert the death of the mother, and in cases when pregnancy is the result of rape or incest;
57. For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated;

For any other service or treatment except as provided under this Plan.

COORDINATION OF BENEFITS

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS

The following special coordination rule applies regarding automobile insurance. If a covered person has automobile insurance (including, but not limited to no-fault) that provides health insurance benefits, the automobile insurance shall be the primary plan and this Plan shall be secondary for the purposes of paying benefits.

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF MOTORCYCLE ACCIDENTS

The following special coordination rule applies regarding motorcycle accidents. If a covered person is injured in an accident that involves a motor vehicle, claims will be processed in accordance with the Plan's position on motor vehicle accidents.

IF A COVERED PERSON IS OPERATING A MOTORCYCLE AND IS INJURED IN AN ACCIDENT THAT DOES NOT INVOLVE A MOTOR VEHICLE, THIS PLAN WILL EXCLUDE COVERAGE FOR THE FIRST $20,000 IN ELIGIBLE CHARGES OR, IF GREATER, THE AMOUNT OF HEALTH BENEFITS PAYABLE BY THE MOTORCYCLE INSURANCE POLICY.

It is the responsibility of any covered person who operates a motorcycle to ensure that he or she is covered under a motorcycle insurance policy that will pay at least $20,000 in health benefits for him or her per accident. This requirement applies even if the covered person is not legally required to have such health benefit coverage. If the covered person fails to maintain $20,000 of coverage through a motorcycle insurance policy, the difference between the policy's maximum payout per accident (if any) and $20,000 will be the covered person's responsibility.

A covered person who is riding a motorcycle as a passenger and is injured in an accident that does not involve a motor vehicle will not be subject to this provision and will not have his or her otherwise eligible claims excluded from Plan coverage as described.

APPLICABILITY

1. This Coordination of Benefits ("COB") provision applies to This Plan when an Employee or the Employee's covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the Order Of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

    a. shall not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but

b. may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in "Effect on the Benefits of This Plan."

DEFINITIONS

1. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It does not include school accident-type coverage, group or group-type hospital indemnity benefits of $100 per day or less.

   b. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid. It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

   Each contract or other arrangement for coverage under (a) or (b) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **"This Plan"** is the part of the group contract that provides benefits for health care expenses.

3. **"Primary Plan/Secondary Plan."** The Order Of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **"Allowable Expense"** means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

   The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary

either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. **"Claim Determination Period"** means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES

1. **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

   a. the other Plan has rules coordinating its benefits with those of This Plan; and

   b. both those rules and This Plan's rules, in subparagraph 2 below, require that This Plan's benefits be determined before those of the other Plan.

2. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

   a. **Non-dependent/Dependent.** The benefits of the Plan which covers the person as other than a dependent are determined before those of the Plan which covers the person as a dependent.

   b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph 2 (c) below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

      (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

      (2) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period.

      However, if the other Plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. **Dependent Child/Parents Separated or Divorced**. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;

(2) then, the Plan of the spouse of the parent with custody of the child; and

(3) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. **Active/Inactive Employee.** The benefits of a Plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

e. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee longer are determined before those of the Plan that covered that person for the shorter time.

EFFECT ON THE BENEFITS OF THIS PLAN

1. **When this Section Applies.** This section applies when, in accordance with "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2 immediately below.

2. **Reduction in This Plan's Benefits.** The benefits of This Plan will be reduced when the sum of:

   a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

   b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that

they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Independence Administrators has the right to release or obtain benefit information in order to implement this provision.

FACILITY OF PAYMENT

If payments should have been made under this Plan but were made under any other Plan(s), Independence Administrators may make payments to such other Plan(s) to satisfy the intent of the provision. Benefits under this Plan will then be deemed paid. The Plan will no longer be liable for such payments.

RIGHT OF RECOVERY

Independence Administrators has the right to recover any excess payments made to satisfy the intent of this provision.

TERMINATION OF COVERAGE

EMPLOYEE

Coverage for an Employee will end on the earliest of:

1. the date the Plan terminates;
2. the end of the month in which coverage terminates under the Plan for the class of Employees to which the Employee belongs;
3. the end of the month in which the Employee transfers to an ineligible class of Employees;
4. the end of the period covered by the last contribution made by the Employee for coverage under the Plan;
5. the date in which the Employee's employment is terminated;
6. the date the Employee begins full-time active duty as a member of any military organization;
7. the date the Employee becomes involved in a labor dispute, strike, or work stoppage. Coverage will be reinstated only upon the return of such Employee to the Plan.

DEPENDENTS

Coverage for a Dependent will end on the earliest of:

1. the date an Employee's coverage terminates under the Plan;
2. the end of the month in which the Dependent no longer satisfies the eligibility requirements for coverage as a Dependent under the Plan;
3. the end of the period covered by the last contribution made by the Employee for Dependent coverage.

CONTINUATION OF COVERAGE DURING CERTAIN LEAVES OF ABSENCE

In certain instances, the Company may allow you to continue your coverage while you are on an approved leave of absence. Please refer to the Company's leave of absence policies outlined in a separate document.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA affects employers who have employed 20 or more Employees on more than 50% of the typical business days during the previous calendar year. The employer is responsible for notifying each qualified beneficiary of their rights under COBRA.

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee. In order to be a qualified beneficiary an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment, or a divorce from or death of the covered employee). A child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage is also a qualified beneficiary.

Each qualified beneficiary, as defined under the Consolidated Omnibus Budget Reconciliation Act of 1985, whose coverage would end under the Contract as a result of a qualifying event (listed below) will have an opportunity to elect continuation coverage under the Contract as required by law.

The employer retains full responsibility for notifying Employees of the rights of continuation coverage and for administering the exercise of continuation rights, as required by COBRA.

Each Employee has a right to continue coverage if:

1. employment with the employer ends for a reason other than gross misconduct;
2. work hours are reduced.

Each Dependent has a right to continue coverage if:

1. the Employee's employment with the employer ends for a reason other than gross misconduct;
2. the Employee's work hours are reduced;
3. the Employee dies;
4. in the case of the Employee's spouse, such spouse ceases to be an eligible Dependent as a result of divorce or legal separation;
5. the Employee is entitled to Medicare benefits, or
6. in the case of a Dependent child, such child ceases to be an eligible Dependent according to the terms of the Contract.

If any of the qualifying events occur, each qualified beneficiary, as reported to Independence Administrators by the employer, will receive a form from the employer to decide whether or not to elect COBRA continuation. Each qualified beneficiary will then have 45 days to pay the premium due. Premiums are payable from the date of the qualifying event.

In the case of the Employee's termination of employment or reduction in work hours, the coverage may be continued for up to 18 months, or 29 months if the individual is disabled either at the time of his qualifying event or during the first 60 days of COBRA coverage and has received notification of disability eligibility from the Social Security Administration and notifies the employer within 60 days after receiving such notification.

If the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29-month disabilities extension. With respect to all other events, coverage may be continued for up to 36 months.

However, coverage will cease earlier if one of the following events occurs:

1. the employer ceases to provide group health coverage to any Employee; or
2. the qualified beneficiary fails to make timely payments of any premium required; or
3. the qualified beneficiary is covered under another group health plan; or
4. the qualified beneficiary is entitled to benefits under Title XVIII of the Social Security Act (Medicare); or
5. the spouse remarries and becomes covered under another group health insurance plan.

Independence Administrators will have no obligation to ensure that any termination instructions received by it from the employer comply with the requirement of COBRA.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

THIRD PARTY RECOVERY PROVISION

To the extent payment for the Illness or injury is made, or may be made in the future, by or for the party or parties legally responsible (as a settlement, judgment or in any other way), charges arising from that Illness or injury are not considered to be eligible charges under the terms of the Plan. If, however, payment by or for the party or parties legally responsible has not yet been made and the Covered Person(s) involved (or if incapable, that person's legal representative) agrees in writing to pay back promptly the benefits paid as a result of the Illness or injury to the extent of any future payments made by or for the party or parties legally responsible for the Illness or injury, the Plan will consider charges arising from that Illness or injury as eligible charges and benefits will be paid under the terms of the Plan. The agreement is to apply whether or not: (a) liability for the payments is admitted by the party or parties legally responsible; and (b) such payments are itemized.

When a Covered Person incurs medical expenses which are payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or if medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Covered Person shall reimburse the Plan for the cost of any and all medical expenses out of any funds or monies that he recovers from any third party, whether by coverage under another program, statute, insurance policy, lawsuit, settlement, judgment or otherwise.

Because the Plan is entitled to reimbursement for any payment which a Covered Person may receive from a third party if the Plan has paid medical benefits for expenses that arose from the same circumstances that were the basis for the payment received from the third party, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Covered Person may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount and/or recovery from a third party. This right to reimbursement comes first regardless of the manner in which the recovery is structured or worded, and/or even if the Covered Person has not been paid fully or reimbursed for all of his/her damages or expenses. Therefore, the Plan's share of the recovery shall not be reduced because the Covered Person has not received the full damages or expenses claimed unless the Plan agrees in writing to such reduction.

Each Covered Person hereby consents and agrees that a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan exists with regard to any payment, amount and/or recovery from a third party; and in accordance with that constructive trust, lien and/or equitable lien by agreement, each Covered Person agrees to cooperate with the Plan in reimbursing it for the Plan's costs and expenses.

To that end, once a Covered Person has any reason to believe that he may be entitled to recovery from any third party, he must notify the Plan. And, at that time, the Covered Person (and his attorney, if applicable) must sign a subrogation/reimbursement agreement that acknowledges the Plan's subrogation rights and its right to be reimbursed for expenses arising from circumstances that entitle the Covered Person to any payment, amount and/or recovery from a third party.

If a Covered Person fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to the Covered Person and/or any of his dependents until the agreement is signed. Alternatively, if a Covered Person fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Covered Person, the Covered Person's acceptance of such benefits shall constitute his or her agreement to the Plan's right to subrogation or reimbursement from any recovery by the Covered Person from any third party that is based on the circumstances from which the expenses or benefits paid by the Plan arose, and the Covered Person's agreement to a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan on any payment, amount or recovery that the Covered Person recovers from any third party.

The Plan also may enforce its subrogation or reimbursement rights by requiring the Covered Person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorneys' fees or costs associated with the Covered Person's claim or lawsuit without express written authorization from the Plan Sponsor.

Each Covered Person consents and agrees that he/she shall not assign his/her rights to any payment, amount or recovery against a third party to any other party, including his/her attorneys without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

The Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorneys fund" doctrine, regulatory diligence or any other equitable defense that may affect the Plan's right to subrogation or reimbursement.

If the Plan shall become aware that a Covered Person has received a third party payment amount and/or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further payments related to the Covered Person and/or his or her dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to the Covered Person.

GENERAL PROVISIONS

REGARDING TREATMENT WHICH IS NOT MEDICALLY NECESSARY

Independence Administrators only covers treatment which it determines Medically Necessary. A Preferred Provider accepts Independence Administrators decision and contractually is not permitted to bill the Covered Person for treatment which Independence Administrators determines is not Medically Necessary unless the Preferred Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by Independence Administrators, and that the Covered Person will be financially responsible for such services. A Non-Preferred Provider, however, is not obligated to accept Independence Administrators determination and the Covered Person may not be reimbursed for treatment which Independence Administrators determines is not Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Preferred Provider. You can avoid these charges simply by choosing a Preferred Provider for your care. The term "Medically Necessary" is defined in the ***Definitions*** section.

LIMITATION OF LIABILITY

Independence Administrators will not be liable for any injury(ies) or damage(s) resulting from acts or omissions of any person, institution or other Provider furnishing services or supplies to the Covered Person.

No legal action may be taken to recover benefits provided by the Plan until 30 days after Independence Administrators has received a properly completed claim. In no event may such action be taken later than one year after services or Supplies were performed or provided.

NOTICE OF CLAIMS

Payments of benefits will not be made under the Plan unless proper notice is furnished to Independence Administrators that covered expenses have been provided to a Covered Person. **Written notice must be given within 60 days after expenses are Incurred for covered expenses.**

Failure to give notice to Independence Administrators within the specified time will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but **in no event will Independence Administrators be required to accept notice more than one year after covered expenses are Incurred.**

PAYMENT OF BENEFITS

Independence Administrators is authorized by the Plan to make payment directly to Facilities and Preferred Providers furnishing Covered Services for which benefits are provided under the Plan.

However, Independence Administrators reserves the right to make the payments directly to the Covered Person. The right of the Covered Person to receive payment is not otherwise assignable unless required by State law.

If any benefit remains unpaid at the death of the Employee, payment will be made to the Employee's estate. If no estate is probated or expected to be probated, Independence Administrators will have the right to make payment to a third party who has paid covered expenses for the Employee, upon receipt of proper documentation of such payment. Independence Administrators will incur no liability due to such payment made pursuant to this provision.

A request for payment of benefits will be deemed to authorize Independence Administrators to institute an investigation and to have access to all pertinent data, including all records of a Hospital and/or Doctor pertaining to the Covered Person.

COVERED PERSON/PROVIDER RELATIONSHIP

1. The choice of a Provider or choice of treatment by a Provider is solely that of the Covered Person.

2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by a Covered Person. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's rendering of, failure or refusal to render Covered Services to a Covered Person.

PAYMENT OF PROVIDERS

1. PREFERRED PROVIDER REIMBURSEMENT

Reimbursement of health care providers who participate in the Preferred Provider Network is intended to encourage the provision of quality, cost-effective care. Set forth below is a general description of the reimbursement programs, by type of Network health care provider.

Please note that these reimbursement programs may change from time to time, and the arrangements with particular Providers may be modified as new contracts are negotiated. If you have any questions about how your health care provider is compensated, please speak with your healthcare provider directly or contact Customer Service.

PHYSICIANS

Network physicians, including primary care physicians (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to the Network fee schedule for the specific medical services that the Physician performs.

INSTITUTIONAL PROVIDERS

Hospitals

For most Inpatient medical and surgical services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Hospital. These rates usually vary according to the intensity of the Covered Services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various services.

Independence Administrators is implementing a quality incentive program with a few of the Hospitals in the Network. This program will provide increased reimbursement to these Hospitals based on them meeting specific quality criteria, including "Patient Safety Measures". Such patient safety measures are consistent with recommendations by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes, higher nursing staff ratios, and electronic submissions. This is a new incentive program that is expected to evolve over time.

Skilled Nursing Facilities, Rehabilitation Hospitals, and other care facilities

Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Facility. These amounts may vary according to the intensity of the Covered Services provided.

Ambulatory Surgical Centers ("ASCs")

Most ASCs are paid specific rates based on the type of Covered Service performed. For a few services, some ASCs are paid based on a percentage of billed charges.

Physician Group Practices, Physician Associations and Integrated Delivery Systems

Certain physician group practices, independent physician associations ("IPAs") and integrated hospital/physician organizations called Integrated Delivery Systems ("IDS") employ or contract with individual physicians to provide medical services. These groups are paid as described in the Physicians reimbursement subsection outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

Ancillary Service Providers, certain Facility Providers and Mental Health/Substance Abuse Providers

Ancillary service providers, such as Durable Medical Equipment providers, laboratory providers, Home Health Care agencies, and Mental Health and Substance Abuse providers are paid on the basis of fee-for-service payments according to the Network fee schedule for the specific Covered Services performed. In some cases, such as for mental health and substance abuse benefits, one vendor arranges for all such services through a contracted set of Providers. Independence Administrators reimburses the contracted Providers of these vendors on a fee-for-service basis. An affiliate of Independence Administrators has less than a three percent ownership interest in this mental health/substance abuse vendor.

Hospitalists

Independence Administrators currently does not have a hospitalist program in place but is considering implementing such a program in the future. However, Independence Administrators continues to maintain interest in encouraging Hospitals to contract with Physicians who specialize in providing emergency room consultation and inpatient management services.

2. PAYMENT METHODS

The Covered Person or the Provider may submit bills directly to Independence Administrators and, to the extent that benefits are payable within the terms and conditions of this booklet, reimbursement will be furnished as detailed below. The Covered Person's benefits for Covered Services are based on the rate of reimbursement as set forth under "Covered Expense" in the ***Definitions*** section of this Booklet.

FACILITY PROVIDERS

Preferred Facility Providers

Preferred Facility Providers are members of the PPO Network and have a contractual arrangement with Independence Administrators for the provision of services to Covered Persons. Benefits will be provided as specified in the ***Schedule of Benefits*** for Covered Services which have been performed by a Preferred Facility Provider. Independence Administrators will compensate the Preferred Facility Providers in accordance with the contracts entered into between such Providers and Independence Administrators. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Facility Provider.

Non-Preferred Facility Providers

Non-Preferred Facility Providers include facilities that are not part of the PPO Network.

When a Covered Person seeks care from a Non-Preferred Facility Provider, benefits will be provided to the Covered Person at the Non-Preferred cost sharing level specified in the ***Schedule of Benefits***. The reimbursement rate is specified under "Covered Expense" in the ***Definitions*** section of this Booklet.

If Independence Administrators determines that Covered Services were for Emergency treatment as defined herein, the Covered Person normally will not be subject to the cost sharing penalties that would ordinarily be applicable to Non-Preferred services. Emergency admissions must be certified within two (2) business days of admission, or as soon as reasonably possible, as determined by Independence Administrators. Payment for emergency services provided by Non-Preferred Provider will be the greater of (1) the median of the amounts paid to Preferred Providers for emergency services; (2) the amount paid to non-Preferred Providers; or (3) the amount paid by Medicare.

Once Covered Services are rendered by a Facility Provider, the Plan will not honor a Covered Person's request not to pay for claims submitted by the Facility Provider. The Covered Person will have no liability to any person because of its rejection of the request.

PROFESSIONAL PROVIDERS

Preferred Professional Providers

Independence Administrators is authorized by the Covered Person to make payment directly to the Preferred Professional Providers furnishing Covered Services for which benefits are provided under this coverage. Preferred Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. Preferred Professional Providers will make no additional charge to Covered Persons for Covered Services except in the case of certain Copayments, Coinsurance or other cost sharing features as specified under this program. The Covered Person is responsible, within 60 days of the date in which Independence Administrators finalizes such services, to pay, or make arrangements to pay, such amounts to the Preferred Professional Provider.

Benefit amounts, as specified in the ***Schedule of Benefits*** of this coverage, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the Preferred Professional Provider and a Covered Person with respect to balance billing shall be submitted to Independence Administrators for determination. The decision of Independence Administrators shall be final.

Once Covered Services are rendered by a Professional Provider, Independence Administrators will not honor a Covered Person's request not to pay for claims submitted by the Professional Provider. Independence Administrators will have no liability to any person because of its rejection of the request.

Emergency Care by Non-Preferred Providers

Payment for emergency services provided by Non-Preferred Provider will be the greater of (1) the median of the amounts paid to Preferred Providers for emergency services; (2) the amount paid to non-Preferred Providers; or (3) the amount paid by Medicare. Any Non-Preferred Provider emergency care cost sharing (copayments, coinsurance) requirement will be the same as any Preferred Provider emergency care cost sharing requirement.

If Independence Administrators determines that Covered Services provided by a Non-Preferred Provider were for Emergency Care, the Covered Person will be subject to the Preferred cost-sharing levels. Penalties that ordinarily would be applicable to Non-Preferred Covered Services will not be applied. For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by Independence Administrators.

A Non-Preferred Provider who provided Emergency Care can bill you directly for their services, for either the Provider's charges or amounts in excess of Independence Administrators payment for the Emergency Care, i.e., "balance billing." In such situations, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance-billing.

Non-Preferred Hospital-Based Provider

When you receive Covered Services from a Non-Preferred Hospital-Based Provider while you are an Inpatient at a Preferred Hospital or other Preferred Facility Provider and are being treated by a Preferred Professional Provider, you will receive the Preferred cost-sharing level of benefits for the Covered Services provided by the Non-Preferred Hospital-Based Provider. For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

A Non-Preferred Hospital–Based Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of Independence Administrators payment to the Non-Preferred Hospital-Based Providers, i.e., "balance billing." In such situations, you will need to contact Independence Administrators at the

Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance billing.

Note that when you elect to see a Non-Preferred Hospital-Based Provider for follow-up care or any other service where you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Treatment, if a Non-Preferred Provider admits you to a Hospital or other Facility Provider, Covered Services provided by a Non-Preferred Hospital-Based Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Provider. The Covered Person will be responsible to reimburse the Provider for the difference between Independence Administrators payment and the Provider's charge.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

Inpatient Hospital Consultations by a Non-Preferred Professional Provider

When you receive Covered Services for an Inpatient hospital consultation from a Non-Preferred Professional Provider while you are Inpatient at a Preferred Facility Provider, and the Covered Services are referred by a Preferred Professional Provider, you will receive the Preferred cost-sharing level of benefits for the Inpatient hospital consultation.

For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

A Non-Preferred Professional Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of Independence Administrators payment to the Non-Preferred Professional Providers, i.e., "balance billing." In such situations, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance billing.

Note that when you elect to see a Non-Preferred Professional Provider for follow-up care or any other service when you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Care, if a Non-Preferred Professional Provider admits you to a Hospital or other Facility Provider, services provided by Non-Preferred Professional Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Provider. The Covered Person will be responsible to reimburse the Provider for the difference between Independence Administrators' payment and the Provider's charge.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

Non-Preferred Professional Provider

Except as set forth above, when a Covered Person seeks care from a Non-Preferred Professional Provider, benefits will be provided to the Covered Person at the Non-Preferred cost sharing level specified in the ***Schedule of Benefits***. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Professional Provider, the Covered Person will be responsible to reimburse the Non-Preferred Professional Provider for the difference between Independence Administrators payment and the Non-Preferred Professional Provider's charge. Payment for emergency services provided by Non-Preferred Provider will be the greater of (1) the median of the amounts paid to Preferred Providers for emergency services; (2) the amount paid to non-Preferred Providers; or (3) the amount paid by Medicare.

ANCILLARY PROVIDERS

Preferred Ancillary Providers

Preferred Ancillary Providers include members of the PPO Network that have a contractual relationship with Independence Administrators for the provision of services or supplies to Covered Persons. Benefits will be provided as specified in the ***Schedule of Benefits*** for the provision of services or supplies provided to Covered Persons by Preferred Ancillary Providers. Independence Administrators will compensate Preferred Ancillary Providers in the PPO Network in accordance with the contracts entered into between such Providers and Independence Administrators.

Non-Preferred Ancillary Providers

Non-Preferred Ancillary Providers are not members of the PPO Network. Benefits will be provided to the Covered Person at the Non-Preferred cost sharing level. The Covered Person will be penalized by the application of higher cost sharing. For payment of Covered Services provided by a Non-Preferred Ancillary Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this Booklet. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Ancillary Provider, the Covered Person will be responsible to reimburse the Non-Preferred Ancillary Provider for the difference between Independence Administrators payment and the Non-Preferred Ancillary Provider's charge.

ASSIGNMENT OF BENEFITS TO PROVIDERS

The right of a Covered Person to receive benefit payments under this coverage is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this coverage be transferred, either before or after Covered Services are rendered. However, a Covered Person can assign benefit payments to the custodial parent of a Dependent covered under the coverage, as required by law.

RIGHT TO RECOVER EXCESS PAYMENTS

Independence Administrators reserves the right to recover claim payments made in excess of the benefits payable for Covered Services under the Plan. Independence Administrators may request that the payee, either a Covered Person or Provider, return the excess payment to Independence Administrators.

TRANSFER OF COVERAGE

An Employee may enroll in the Plan's coverage during the annual Open Enrollment Period established by the Company.

If written application is made during the annual Open Enrollment Period, coverage under the Plan will be effective on the first of the month following the month of the established Open Enrollment Period.

Notwithstanding anything in this provision to the contrary, the Employee and/or Dependent must satisfy all other eligibility requirements under the Plan prior to or simultaneously with the date that such Employee's coverage under the Plan is effective.

WHEN YOU HAVE A CLAIM

FROM A DOCTOR OR FACILITY

If you are treated for a covered Accidental Injury or Illness at a Facility or a participating doctor's office, present your Independence Administrators identification card. Independence Administrators will pay the provider directly for covered expenses.

If you are required to pay the Facility or the Doctor, be sure to get a receipted, itemized bill. Besides the itemized charges it should show:

- your name and address
- patient's name and age
- doctor's or hospital's name and address
- Provider or Facility identification number
- date of admission or treatment

ADVERSE DETERMINATIONS

An adverse determination is a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part*) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on: a determination that a benefit is not a covered benefit; the source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or a determination that a benefit is experimental, investigational, or not medically necessary or appropriate. This can include both pre-service claims as well as post-service claims. The scope of adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

*Including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding copayments, deductibles, or other cost-sharing requirements.

COMPLAINT PROCESS

Independence Administrators has a process for a Covered Person to express complaints. To register a complaint, the Covered Person should call the Customer Service Department at the telephone number on their identification card or write to Independence Administrators at the address listed below.

Independence Administrators
c/o Processing Center
P.O. Box 21974
Eagan, MN 55121

Most Covered Persons' concerns are resolved informally at this level. However, if Independence Administrators is unable to immediately resolve the complaint, it will be investigated, and the Covered Person will receive a response within thirty (30) days.

APPEAL PROCESS

Filing an Appeal

Independence Administrators maintains procedures for the resolution of appeals. Appeals may be filed within 180 days of the receipt of a decision from Independence Administrators stating an adverse benefit determination. An appeal occurs when the Covered Person or another authorized representative requests a change of a previous decision made by Independence Administrators by following the procedures described here. In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form.

Contact Independence Administrators at the address listed above or access your online services at the address on your identification card to obtain a form to authorize an appeal by a provider or other representative or for questions regarding the requirements for an authorized representative.

The Covered Person or other authorized person on behalf of the Covered Person, may request an appeal by calling or writing to Independence Administrators, as stated in the letter notifying the Covered Person of the decision.

Types of Appeals

The following are the two types of appeals and the issues they address.

- **Medical Necessity Appeal** — An appeal by or on behalf of a Covered Person that focuses on issues of Medical Appropriateness/Medical Necessity and requests Independence Administrators to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on failure to meet established medical guidelines and peer review of medical appropriateness. It may also include the exclusions for Experimental/Investigational services or cosmetic services. Internal and External Appeals apply.*
- **Administrative Appeal** — An appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding Independence Administrators' decision that concerns coverage terms such as exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Appropriateness/Medical Necessity, these are not the primary issues that affect the outcome of the appeal. Internal Appeals apply.*

* **First Step — Internal Appeal** — An appeal filed with your health plan/plan administrator for evaluation and determination.

* **Second Step — External Appeal** — An appeal filed with your health plan/plan administrator for evaluation and determination by an independent review organization (IRO).

Timeframe Classifications

The timeframes described below for completing a review of each appeal depend on whether the appeal is classified as standard appeal or an expedited appeal for urgent care.

- Standard appeal timeframes apply to both pre-service appeals and post-service appeals that concern claims for non-urgent care.

  Standard pre-service appeal — An appeal for benefits that, under the terms of the Plan, must be pre-certified or pre-approved (either in whole or in part) *before* medical care is obtained in order for coverage to be available.

  Standard post-service appeal — An appeal for benefits that is not a pre-service appeal. (Post-service appeals concerning claims for services that the Covered Person has already obtained do not qualify for review as expedited/urgent appeals.)

  Urgent-care/Expedited appeal timeframes may apply to pre-service or on-going requests for urgent care.

- **Expedited appeal for urgent care** — An appeal that provides faster review, according to the procedures described below, on a pre-service issue. Independence Administrators will conduct an urgent-care/expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Covered Person's life, health or ability to regain maximum function or would subject the Covered Person to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

Information for the Appeal Review including Matched Specialist's Report

The Covered Person or other authorized person on behalf of the Covered Person, may submit to Independence Administrators additional information pertaining to your case. You may specify the remedy or action being sought. Upon request at any time during the appeal process, Independence Administrators will provide you or your authorized representative, free of charge, access to, and copies of, all relevant documents and records, including any additional information received and reviewed by the decision maker(s) on the appeal.

Input from a matched specialist is obtained for certain Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the initial adverse benefit determination nor can they be a subordinate of the person who made that determination.

Appeal Decision makers

Independence Administrators has representatives that have been designated to act as decision maker(s) on the appeal. The decision maker(s) did not make the initial adverse benefit determination at issue in the appeal. Each decision maker will review all relevant information for the appeal, whether from the Covered Person or his authorized representative, or obtained from other sources during the investigation of the appeal issues. If the additional information meets plan guidelines the appeal may be overturned by the decision maker(s). To avoid conflict of interest and for compliance with regulatory and accreditation requirements, Independence Administrators also utilizes peer medical reviewers including contracted external review organizations for matched-specialty (peer) reviews, and for review of administrative and medical necessity external appeal review requests. Matched specialty /peer reviewers were not involved in the initial review process and are not subordinates of the person who made the initial determination.

Full and Fair Review

If the reviewer upholds the original decision, Independence Administrator's will provide the Covered Person with the rational and new or additional evidence considered or relied upon in connection with the appeal. This is to give the Covered Person a reasonable opportunity to respond prior to the final determination.

Right to Pursue Civil Action

If you are enrolled in a group health plan that is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you have the right to bring a civil action under Section 502(a) of the Act after completing the appeal processes described here.

Changes in Appeal Processes

Please note that the Appeal processes described here may change due to changes that Independence Administrators makes to comply with applicable state and federal laws and regulations and/or accreditation standards or to improve the appeal processes.

External Review of Adverse Determination/Appeals

You are entitled to the external review process described below for all appeals of adverse determination (denials) concerning:

- Rescission of coverage;
- Medical judgment (including, based on the plans requirements, medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer.

Standard External Review Procedures

External appeals may be filed up to four (4) months after receipt of the notice from Independence Administrators of an adverse determination (denial) or final adverse determination (denial) for appeals involving the above stated issues.

You or your authorized representative can file an external appeal by calling the number listed on your ID card.

The Covered Person may be responsible for a nominal fee for the administrative duties performed in order to process the appeal for the external review.

Preliminary Review

Within five (5) business days following the date of receipt of the external review request, we will complete a preliminary review of the request to determine eligibility for the external review. Within one (1) business day after completion of this preliminary review, we will issue a written notification informing you if it is eligible for external review and if not, the reason why not and additional contact information. If your request is incomplete, we will inform you of the additional information needed to make the request for external review complete. If your request is eligible for external review you may submit, within ten (10) business days following the date of receipt of the notice, additional information that the Independent Review Organization (IRO) will consider when conducting the external review.

Referral to Independent Review Organization (IRO)

Eligible external review requests will be referred to a contracted, accredited independent review organization.

Final external review decisions are made by the external review organization within 45 days and will be forwarded in writing to the claimant and the Plan (Plan Administrator). The external decision is binding on Independence Administrators.

If you have any questions or concerns during the external review process or if you want to initiate an urgent care claim review, you (or your authorized representative) can call the toll-free number on your identification (ID) card.

Expedited External Review Process

If you (the claimant) have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your (claimant's) life or health or

would jeopardize the ability to regain maximum function or if the matter concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility then you or your authorized representative (including your healthcare provider with knowledge of your condition) may request an expedited external review.

You may make a written or oral request for the expedited (urgent) external review.

- Urgent care reviews may be initiated by calling the toll-free number on your identification (ID) card.

Preliminary Review

Immediately upon receipt, we (or the Plan) will determine whether the request meets the eligible review requirements for an expedited (urgent) external review and will notify you of the eligibility for expedited (urgent) review or standard external review.

Referral to Independent Review Organization (IRO)

Upon the determination that a request is eligible for expedited (urgent) external review following the preliminary review we (or the Plan) will assign an independent review organization and provide them all necessary documents and information considered in making the adverse determination or final adverse benefit determination.

If during the external review process, we (or the Plan) reconsiders and decides to provide coverage, we (or the Plan) will provide oral notice followed by written notice within 48 hours.

Notice of the Final External Review Decision

- The IRO/external examiner provides notice of the final external review decision.
- The decision is completed as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external review.
- If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to you (the claimant) and the Plan. within 48 hours after the date of providing that notice,

The external decision is binding on Independence Administrators.

If the Adverse Determination (denial) is Reversed

Upon our receipt of the notice of the external review decision, we immediately will authorize to provide the coverage or payment for the claim as required by federal rule set under the Patient Protection and Affordable Care Act.

NOTICE: Please see the subsection entitled "NOTICE OF CLAIMS" found under the *General Provisions* section of this booklet.

DEFINITIONS

ACCIDENTAL INJURY — A sudden, unforeseen, and identifiable event causing injury to a Covered Person, which is the direct result of the event and which occurs while coverage under the Plan for the Covered Person is in force.

ADMINISTRATIVE SERVICES AGREEMENT — The agreement between the Plan Sponsor and Independence Administrators, under which Independence Administrators provides administrative services to the Plan Sponsor in connection with the Plan.

AMBULANCE — A specially designed and medically equipped vehicle used solely for the transportation of the sick and/or injured.

AMBULATORY SURGICAL CENTER — A Facility that: (1) has permanent facilities and equipment for the primary purpose of performing Surgery on an Outpatient basis; and (2) provides such treatment by or under the supervision of an organized staff of Doctors; and (3) provides nursing services whenever the patient is in the Facility; and (4) does not provide Inpatient accommodations; and (5) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Medicare, or by Independence Administrators; and (6) is not, other than incidentally, a Facility used as an office or clinic for the private practice of a Professional Provider.

AMENDMENT — A supplement made a part of the Plan, which alters the benefits or terms of the Plan.

ANCILLARY PROVIDER — An individual or entity that provides services, supplies or equipment (such as, but not limited to, home infusion therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under the Plan.

ANESTHESIA — The administration of regional or local anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation, or loss of consciousness.

BIRTHING CENTER — A Facility that: (1) is primarily organized and staffed to provide maternity care by a Nurse Midwife; and (2) is licensed as a Birthing Center under the laws of the state where it is located; or (3) is approved by Independence Administrators.

BLUECARD PPO PROGRAM — A program that allows a Covered Person travelling or living outside of their plan's area to receive coverage for services at an in-network benefit level if the Covered Person receives services from Blue Cross Blue Shield providers that participate in the BlueCard PPO Program.

BLUECARD PPO PROVIDER — A Provider that participates in the BlueCard PPO Program as a Preferred Provider.

CERTIFIED REGISTERED NURSE — A Professional Provider who: (1) is a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist; and (2) is certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing.

CLAIM — A request for payment of benefits for services rendered or Supplies received, which is presented to Independence Administrators for payment. Such request must be submitted to Independence Administrators with all statements, questionnaires, certifications, instruments, documents, and affidavits requested by Independence Administrators that are necessary to properly process the request for benefits. Claim forms will be provided by Independence Administrators.

COINSURANCE — The specified percentage of Covered Expense the Covered Person is required to pay.

COMPANY — Clemens Family Corporation

CONDITIONS FOR DEPARTMENTS (for Qualifying Clinical Trials) — The conditions described in this paragraph, for a study or investigation conducted by the Department of Veteran Affairs, Defense or Energy, are that the study or investigation has been reviewed and approved through a system of peer review that the Government determines:

A. To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and

B. Assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.

COVERED EXPENSE — Refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

A. For Covered Services provided by a Facility Provider, "Covered Expense" means the following:

   i. For Covered Services provided by a Preferred Facility or BlueCard PPO Provider, "Covered Expense" for Outpatient services means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or the BlueCard PPO Provider.

   ii. For Covered Services provided by a Preferred Facility or BlueCard PPO Provider, "Covered Expense" for Inpatient services means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or the BlueCard PPO Provider.

   iii. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Outpatient services means the lesser of 1.5 times the Medicare Allowable Payment for Facilities or the Facility Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare

traditional program, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider's charges for Covered Services.

iv. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Inpatient services means the lesser of 1.5 times the Medicare Allowable Payment for Facilities or the Facility Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider's charges for Covered Services.

B. For Covered Services provided by a Professional Provider, "Covered Expense" means the following:

i. For Covered Services by a Preferred Professional Provider or BlueCard PPO Provider, "Covered Expense" means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with Independence Administrators, or the BlueCard PPO Provider.

ii. For a Non-Preferred Professional Provider, "Covered Expense" means the lesser of the Medicare Professional Allowable Payment or the Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent (50%) of the Professional Provider's charges for Covered Services.

C. For Covered Services provided by an Ancillary Provider, "Covered Expense" means the following:

i. For Covered Services provided by a Preferred Ancillary Provider or BlueCard PPO Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or BlueCard PPO Provider.

ii. For Covered Services provided by a Non-Preferred Ancillary Provider, "Covered Expense" means the lesser of the Medicare Ancillary Allowable Payment or the Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent (50%) of the Non-Preferred Ancillary Provider's charges for Covered Services.

D. Nothing in this section shall be construed to mean that Independence Administrators would provide coverage for services other than Covered Services.

COVERED PERSON — The Employee and/or his Dependent, if any, covered under the Plan.

COVERED SERVICE — A service, Supply, equipment, device, or drug specified in the Plan for which benefits will be provided when billed for by a Professional Provider, Facility, or Supplier.

CUSTODIAL CARE — Care that is provided primarily to assist the patient in meeting his activities of daily living. Such care is not provided primarily for its restorative or therapeutic value in the treatment of an Illness, injury, disease, or condition.

DEPENDENT — The Employee's: (1) spouse under a legally valid existing marriage; or (2) same sex domestic Partner; (3) natural born or legally adopted child (including a child for whom adoption proceedings have been initiated), including a stepchild; or (4) unmarried child age 26 or older who is unable to earn his own living due to a physical or Mental Illness or handicap (subject to Eligibility — Continuation of Eligibility).

Dependent spouses may not be on active military service.

DOCTOR — A practitioner, other than a Covered Person, who is acting within the scope of his license as a Doctor of medicine; osteopathy; podiatry; dentistry; optometry; chiropractic; licensed speech pathologist; licensed audiologist; licensed teacher of the hearing impaired; or any other practitioner that the Plan must by law recognize as a Doctor legally entitled to render treatment.

DOMESTIC PARTNER — A member of a Domestic Partnership consisting of two partners of the same sex, each of whom: (a) is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time; (b) is not related to the other partner by adoption or blood; (c) is the sole Domestic Partner of the other partner, with whom he/she has a close committed and personal relationship, and has been a member of this Domestic Partnership for the last six (6) months; (d) agrees to be jointly responsible for the basic living expenses and welfare of the other partner;(e) meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships; and (f) demonstrates financial interdependence by submission of proof of three (3) or more of the following documents: (i) a domestic partner agreement; (ii) a joint mortgage or lease; (iii) a designation of one of the partners as beneficiary in the other partner's will; (iv) a durable property and health care power of attorney; (v) a joint title to an automobile, or joint bank account or credit account; or (vi) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case. Independence Administrators reserves the right to request documentation of any of the foregoing prior to commencing coverage for the Domestic Partner.

DURABLE MEDICAL EQUIPMENT — Charges for: (1) non-disposable equipment that is primarily medical in nature, such as wheelchairs and hospital beds; and (2) orthotics or medical devices that are applied to or around the body for care or treatment of an injury or Illness; and (3) assorted medical items necessary for the treatment of respiratory diseases, such as oxygen tanks, oxygen contents, and oxygen masks.

EMERGENCY ACCIDENT TREATMENT — Provider expenses charged for the initial treatment of an Accidental Injury. Such treatment must begin within 72 hours of the injury that is being treated and excludes Ambulance services.

EMERGENCY MEDICAL TREATMENT — Provider expenses charged for the initial treatment of a condition with acute symptoms that is life threatening or that could cause serious damage to a bodily function. Such treatment must begin within 72 hours of the onset of the condition that is being treated and excludes Ambulance services.

EMPLOYEE — A person employed by the Company.

EMPLOYMENT WAITING PERIOD — The period, beginning with the date of employment, that an Employee must serve continuously before he is eligible to receive benefits under the Plan.

EXPERIMENTAL/INVESTIGATIVE — A drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

A. Is the subject of ongoing clinical trials;

B. Is the research, experimental, study or investigational arm of an on-going clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

C. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;

D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Covered Person's particular condition; or

E. Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental/Investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market with a specific indication for the particular diagnosis or condition present. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the established referenced Compendia identified in the Company's policies recognize the usage as appropriate medical treatment.

Any biological product, device, medical treatment or procedure is not considered Experimental/Investigative if it meets all of the criteria listed below:

A. Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

B. Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure leads to measurable improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.

C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigatory settings.

E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

FACILITY — An institution or entity licensed, where required, to provide care. Such Facilities include:

- Alcoholism Treatment Facility
- Ambulatory Surgical Center
- Birthing Center
- Freestanding Dialysis Facility
- Freestanding Outpatient Facility
- Home Health Care Agency
- Hospital
- Psychiatric Hospital
- Rehabilitation Facility
- Skilled Nursing Facility
- Substance Abuse Treatment Facility

FAMILY UNIT — An Employee and his covered Dependents.

FULL-TIME EMPLOYEE — An Employee of the Company who works at least 40 hours per week for the Company for compensation in the form of salary, wages, or commission. In the case of a proprietorship or partnership, the individual proprietor or each of the partners whose principal occupation is the conduct of the Company's business, and whose duties for the Company normally require at least 40 hours per week, shall be deemed a Full-time Employee.

No member of the Board of Directors shall be deemed a Full-time Employee unless such person is otherwise eligible as a bona fide Employee of the Company.

HOME HEALTH AGENCY — An agency, association, or part of a Hospital that: (1) provides Skilled Nursing Care in the patient's home for the treatment of a physical Illness or injury that requires medical supervision and treatment; and (2) provides such care by or under the supervision of a Registered Nurse acting under the direction of a Doctor; and (3) is

approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

HOSPICE — A Facility that: (1) is primarily engaged in providing palliative care to terminally ill individuals; and (2) is licensed and operated according to the laws of the state in which it is located and approved by Independence Administrators.

HOSPITAL — A short-term, acute care Facility that: (1) is a duly licensed institution; and (2) is primarily engaged in providing Inpatient diagnostic and medical services for the care or treatment of sick and injured persons; and (3) provides such care by or under the supervision of an organized staff of Doctors; and (4) has organized departments of medicine; and (5) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (6) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Independence Administrators. A Hospital is not, other than incidentally, a:

- Nursing Home
- Place for Rest
- Place for the Aged
- Place for the Provision of Hospice care
- Place for the Provision of Rehabilitation Care
- Place for the Treatment of Alcoholism or other Drug Abuse
- Place for the Treatment of Mental Illness
- Skilled Nursing Facility
- Spa or Sanitarium

HOSPITAL-BASED PROVIDER - A physician who provides Medically Necessary services in a Hospital or Preferred Facility Provider supplemental to the primary care being provided in the Hospital or Preferred Facility Provider, for which the Covered Person has limited or no control of the selection of such physician. Hospital-based providers include physicians in the specialties of radiology, anesthesiology and pathology and/or other specialties as determined by Independence Administrators. When these physicians provide services other than in the Hospital or Preferred Facility, they are not considered Hospital-Based Providers.

ILLNESS — A condition marked by pronounced deviation from the normal, healthy state.

IMMEDIATE FAMILY — The Covered Person's spouse, parent, child, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, or son-in-law.

INCURRED — A charge is deemed Incurred as of the date of the service or purchase giving rise to the charge.

INPATIENT — A person who is treated as a registered overnight bed patient in a Facility.

LICENSED PRACTICAL OR VOCATIONAL NURSE (L.P.N. OR L.V.N.) — A nurse who has graduated from a formal practical or vocational nursing education program and is licensed by the appropriate state authority.

LIFE-THREATENING DISEASE OR CONDITION (for Qualifying Clinical Trials) — Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MAINTENANCE CARE — Care provided to maintain the patient's current level of functioning or to prevent deterioration. Such care is not primarily provided for its therapeutic value in the treatment of an Illness, disease, injury, or condition and does not require participation or administration by professional medical personnel.

MEDICALLY APPROPRIATE/MEDICALLY NECESSARY (or MEDICAL APPROPRIATENESS/MEDICAL NECESSITY) — An intervention will be covered if it is (a) a Covered Service, (b) not specifically excluded, and (c) Medically Appropriate/Medically Necessary. An intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by Independence Administrator's medical director or physician designee, it meets all of the following criteria:

A. It is a "Health Intervention". A Health Intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a "medical condition" or to maintain or restore functional ability. A medical condition is one of the following: disease; Illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

B. It is the most appropriate Supply or level of service, considering the potential benefit and harm to the Subscriber.

C. It is known to be "effective" in improving "health outcomes". Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a "new" or "existing" intervention.

i. New interventions: Effectiveness is determined by Scientific Evidence. An intervention is considered new if it is not yet in widespread use for (a) the medical condition, and (b) the patient indications being considered.

"Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

ii. **Existing interventions**: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion. For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for a determination of Medical Necessity. If no Scientific Evidence is available, professional standards of care should be considered. If professional standards of care do not exist, are outdated, or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence. Existing interventions can meet the contractual definition of Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

D. **It is cost-effective for this condition compared to alternative interventions, including no intervention.** "Cost effective" does not necessarily mean lowest price. An intervention is considered cost effective if the benefit and harm relative to costs represent an economically, efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this Medically Appropriate/Medically Necessary definition.

MEDICARE ALLOWABLE PAYMENT FOR FACILITIES — The payment amount, as determined by the Medicare program, for the Covered Service for a Facility Provider.

MEDICARE ANCILLARY ALLOWABLE PAYMENT — The payment amount, as determined by the Medicare program, for the Covered Service for an Ancillary Provider.

MEDICARE PARTS A AND B — "Hospital Insurance Benefits for the Aged and Disabled" under Title XVIII, Part A and/or Part B respectively, of the Social Security Act, as amended from time to time.

MEDICARE PROFESSIONAL ALLOWABLE PAYMENT — The payment amount, as determined by the Medicare program, for the Covered Service based on the Medicare Par Physician Fee Schedule.

MENTAL ILLNESS — An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances are the dominating feature.

Mental or nervous disorders that have a demonstrable organic origin will not be considered Mental Illness.

NON-PREFERRED ANCILLARY PROVIDER — An Ancillary Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED FACILITY PROVIDER — A Facility Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROFESSIONAL PROVIDER — A Professional Provider who is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROVIDER — A Facility Provider, Professional Provider or Ancillary Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NURSE MIDWIFE — A Professional Provider who: (a) is certified to practice as a Nurse Midwife; and (b) is licensed by the appropriate state authority as a Registered Nurse; and (c) has completed a program for the preparation of Nurse Midwife that is approved by the state in which the person is practicing.

OPEN ENROLLMENT PERIOD — The 3-day period immediately prior to the anniversary date of the Plan.

ORGANIC DISEASE — Includes any health condition in which there is an observable and measurable disease process (biomarker), e.g. inflammation or tissue damage: Non organic diseases or functional disorders, demonstrate no disease process which is visible or which can be established through standard diagnostic testing.

OUTPATIENT — A person who receives services or Supplies while not an Inpatient.

PLAN — Clemens Family Corporation Employee Benefit Plan.

PLAN SPONSOR — Clemens Family Corporation

PLAN YEAR DEDUCTIBLE — The amount of eligible expenses the Covered Person is required to pay each plan year before the Plan begins to pay benefits.

PREFERRED ANCILLARY PROVIDER — An Ancillary Provider that is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services and/or supplies to Covered Persons.

PREFERRED FACILITY PROVIDER — A Facility Provider that is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Covered Persons.

PREFERRED PROFESSIONAL PROVIDER — A Professional Provider who is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for "in-network" Covered Services rendered to a Covered Person.

PREFERRED PROVIDER — A Facility Provider, Professional Provider or Ancillary Provider that is a member of the PPO Network or is a BlueCard PPO Provider, authorized to perform specific "in-network" Covered Services at the Preferred level of benefits.

PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK — The network of Providers with whom Independence Administrators has contractual arrangements and BlueCard PPO Providers.

PRIOR AUTHORIZATION — Written approval by Independence Administrators for medical or surgical treatment given prior to such treatment that outlines the Plan's liability for such treatment. Such approval will be given only after Independence Administrators: (1) reviews the case; and (2) receives the Covered Person's medical history and an explanation of the condition and treatment to be given (including any Surgical Procedures to be performed) written by his Doctor, and any supporting documentation.

PRIVATE ROOM — Accommodations in a room designed as such by the Hospital, Rehabilitation Facility, or Skilled Nursing Facility and containing not more than one bed.

PROFESSIONAL PROVIDER — A licensed person or practitioner performing services within the scope of such licensure. The Professional Providers include:

- Certified Registered Nurse
- Chiropractor
- Dentist
- Doctor
- Independent Clinical Laboratory
- Licensed Practical Nurse (LPN)
- Licensed Vocational Nurse (LVN)
- Nurse Midwife
- Optometrist
- Physical Therapist
- Podiatrist
- Psychologist

PROVIDER — A Facility, Professional or Ancillary Provider, licensed where required.

PSYCHIATRIC HOSPITAL — A Facility that: (1) is primarily engaged in providing Inpatient diagnostic, medical, and psychiatric services for the care or treatment of Mental Illness; and (2) provides such services by or under the supervision of an organized staff of Doctors; and (3) provides continuous 24-hour nursing services by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Independence Administrators.

QUALIFIED INDIVIDUAL (for Clinical Trials) — A Covered Person who meets the following conditions:

A. The Covered Person is eligible to participate in an approved clinical trial

according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition; and

B. Either:

1. The referring health care professional is a health care provider participating in the clinical trial and has concluded that the Covered Person's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or

2. The Covered Person provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Covered Person meeting the conditions described above.

QUALIFYING CLINICAL TRIAL — A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is described in any of the following:

A. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

1. The National Institutes of Health (NIH);

2. The Centers for Disease Control and Prevention (CDC);

3. The Agency for Healthcare Research and Quality (AHRQ);

4. The Centers for Medicare and Medicaid Services (CMS);

5. Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);

6. Any of the following, if the Conditions for Departments are met:

a. The Department of Veterans Affairs (VA);

b. The Department of Defense (DOD); or

c. The Department of Energy (DOE).

B. The study of investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In the absence of meeting the criteria listed above, the clinical trial must be approved by the Plan as a Qualifying Clinical Trial.

REGIONAL NETWORK DISCOUNT — The percentage reduction from Facility charges for Covered Services that Independence Administrators passes on to its customers as a share of the savings Independence Administrators is expected to realize from its negotiated Hospital contracts. The balance of any savings not passed on to its

customers is for the sole benefit of Independence Administrators. The amount of the discount may be changed prospectively from time to time.

REGISTERED NURSE (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree program, or baccalaureate program) and is licensed by the appropriate state authority.

REHABILITATION FACILITY — An institution or part of an institution that: (1) specializes in providing restorative and therapeutic services on an Inpatient and Outpatient basis for the treatment of a physical Illness or injury, Mental Illness, drug addiction and alcoholism; and (2) provides such services by or under the supervision of a staff of Doctors; and (3) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

RELIABLE EVIDENCE — Only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS — Routine patient costs include all items and services consistent with the coverage provided under this Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

Routine patient costs do not include:

A. The investigational item, device, or service itself;

B. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

C. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SCHEDULE OF BENEFITS — The Schedule of Benefits, which describes benefits, maximums, and allowances of the coverage provided under the Plan for each Covered Person.

SECOND SURGICAL OPINION/CONSULTATION — A written evaluation by another surgeon/specialist, who is not associated in practice with the first surgeon, as to the Medical Necessity of the surgery recommended by the first surgeon.

SEMIPRIVATE ROOM — Accommodations in a room designated as such by the Hospital, Rehabilitation Facility, or Skilled Nursing Facility and containing no less than two nor more than four beds.

SKILLED NURSING CARE — All covered medical expenses charged for services that are primarily restorative and therapeutic in treatment of a physical Illness or injury that requires medical supervision of a Registered Nurse acting under the direction of a Doctor.

SKILLED NURSING FACILITY — An institution or part of an institution that: (1) specializes in providing Skilled Nursing Care on an Inpatient basis for the treatment of a physical Illness or injury that requires extended medical supervision and treatment; and (2) provides such care by or under the supervision of a staff of Doctors; and (3) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

SUBSTANCE ABUSE — Any use of alcohol or other drug that produces a pattern of pathological use causing impairment in social or occupational functions or that produces physiological dependency evidenced by physical tolerance or withdrawal.

SUBSTANCE ABUSE TREATMENT FACILITY — A Facility that: (1) is primarily engaged in providing detoxification and/or rehabilitation services for alcoholism and/or other drug abuse and (2) is approved by the Joint Commission on Accreditation of Healthcare Organizations, appropriate government agency, or by Independence Administrators.

SUPPLIES — Charges made by a Hospital or Doctor for nonprescription, nondurable, disposable medical and surgical items that are necessary for the care or treatment of an Illness or Accidental Injury.

SURGERY/SURGICAL PROCEDURE — Treatment of an Illness, injury, or deformity by manual and operative methods.

A. **Cosmetic Surgery** — A Surgical Procedure for the correction of superficial areas of the body to enhance appearance or to change contour. Such surgeries are performed without the expectation of restoring function to the body area.

B. **Elective Surgery** — A Surgical Procedure that is of a non-emergency nature and not required to be immediately carried out.

C. **Reconstructive Surgery** — A Surgical Procedure for the correction, restoration, or improvement of bodily functions, or the relief of pain.

THERAPY SERVICES — The following services and Supplies when prescribed by a Doctor for the treatment of an Illness or injury to promote the recovery of the Covered Person:

A. **Radiation Therapy** — Treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

B. **Chemotherapy** — Treatment of malignant disease by chemical or biological antineoplastic agents.

C. **Dialysis Treatment** — Treatment of acute renal failure or chronic irreversible renal

insufficiency for removal of waste materials from the body. This includes hemodialysis or peritoneal dialysis.

D. **Physical Therapy** — Treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain and restore maximum function following disease, injury, or loss of body part.

E. **Respiratory Therapy** — Introduction of dry or moist gases into the lungs for treatment purposes.

F. **Occupational Therapy** — Treatment of a disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

G. **Speech Therapy** — Treatment to restore speech lost or impaired through Illness or injury, or to correct an impairment due to a congenital defect for which corrective Surgery has been performed.

ADMINISTRATIVE INFORMATION

This booklet has been prepared to meet the Summary Plan Description Requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

PLAN NAME	Clemens Family Corporation Employee Benefit Plan
EMPLOYER AND PLAN SPONSOR	Clemens Family Corporation 2700 Clemens Road P.O. Box 902 Hatfield, PA 19440
EMPLOYER IDENTIFICATION NUMBER	75-2990486
TYPE OF PLAN	Health and Welfare
PLAN YEAR ENDS	4/30
PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS	Clemens Family Corporation 2700 Clemens Road P.O. Box 902 Hatfield, PA 19440
PLAN ADMINISTRATIVE SERVICES PROVIDED BY	Independence Administrators c/o Processing Center P.O. Box 21974 Eagan, MN 55121
PLAN'S INDEPENDENCE ADMINISTRATORS GROUP NUMBER(S)	003070
PLAN COSTS	See ***Eligibility***

Upon request, Covered Persons will be given a copy of this booklet which provides a description of each benefit. If misplaced, an additional copy can be obtained from the Plan Administrator, upon request.

ERISA STATEMENT OF RIGHTS

As a participant in this Plan, a Covered Individual is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan 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 participant 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 summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision

without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

Independence

Independence Administrators

Administered by Independence Administrators

To find a network doctor, get forms, or view your health benefits information, visit the website on your identification card.

c/o Processing Center • P.O. Box 21974 • Eagan, MN 55121

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

The Clemens Family Wellness Center

Introduction

Clemens Family Corporation ("Clemens") maintains the Clemens Family Corporation Health Benefit Plan (the "Plan"). This document provides a summary of the onsite medical center (the "Family Wellness Center") offered under the Plan. It is part of the summary plan description of the Plan. As with the other benefits offered under the Plan, Clemens maintains the Family Wellness Center in its discretion and reserves the right to amend or terminate the Family Wellness Center benefit at any time with or without prior notice.

The terms of the Family Wellness Center cannot be modified by written or oral statements by Clemens personnel (other than by Clemens's board of directors or its designee) or by R-Health.

Frequently Asked Questions

Family Wellness Center

Q: What is the Family Wellness Center?

A: The Family Wellness Center is a state-of-the-art onsite medical clinic. The clinic is designed to provide eligible Clemens team members and their families with access to convenient and high-quality health care.

Q: Where is it located?

A: The Family Wellness Center is located near Human Resources. The address is 2700 Clemens Road, Hatfield PA 19440.

Q: Why did Clemens open the Family Wellness Center?

A: The health and well-being of Clemens team members and their families is a top priority for us. We want our team members and their family members to high quality and convenient care. We are in partnership with our team members to strive for a healthy work environment and to build a sustainable culture of health.

Q: Who works at the Family Wellness Center?

A: Clemens, in partnership with R-Health, has recruited a high-quality team of dedicated health care professionals to staff the Family Wellness Center. To help ensure and maintain a strong level of confidentiality for Clemens team members, we are working with R-Health, who will independently oversee the clinic's operation. The team includes a multidisciplinary team that includes a physician, a physician assistant, nurses, a wellness coach, a condition management coach, and a physical therapist. R-Health employs the physician, nurse practitioner and medical assistants that work at the Family Wellness Center, not Clemens.

Q: Who is R-Health?

A: R-Health is a respected, nationwide leader in providing employer-sponsored health care.

Q: How is the Family Wellness Center different?

A: We designed the Family Wellness Center exclusively for Clemens team members and their families. We carefully selected everything from the layout, staff, services, and vendors to bring you high quality, convenient, and affordable care, focused on primary and preventive care services for all stages of life. Also, the Family Wellness Center offers team members an opportunity to use a personalized, patient-centered medical home model, in which a primary care physician leads a team of health care professionals who help coordinate ongoing care for primary, preventive, and acute care services.

Q: Are there any advantages to using the Family Wellness Center?

A: Yes, the many advantages include the following:

- You choose whenever you want to use the Family Wellness Center. It offers convenient hours and appointments to meet your primary and preventive health care needs. It also offers same-day and next-day appointments for patients with urgent medical needs.
- You have access to a team of health care providers conveniently located at the Family Wellness Center to offer coordinated care.
- R-Health keeps your medical records online in a single system, accessible only by the Family Wellness Center care team. This means that your visit history is easily accessible for clinic staff, so you don't have to keep repeating your medical history to different team members.

Q: Do I have to use the Family Wellness Center?

A: No. Use of the Family Wellness Center is voluntary.

Q: Who can use the Family Wellness Center?

A: You may use the Family Wellness Center if you are enrolled in the medical insurance benefit offered under the Plan. Your immediate family members may also use the Family Wellness Center if he or she is enrolled in the medical insurance benefit.

Q: Who is considered an immediate family member?

A: Your immediate family members are your legal spouse and your children under the age of 26. If your family member is eligible and enrolled in the medical benefit offered under the Plan, they are eligible to use the Family Wellness Center.

Q: What are the operation days/time for the Family Wellness Center?

A: The Family Wellness Center is open Monday and Tuesday 7:00 am to 7:00 pm; Wednesday 7:00 am to 8:00 pm; Thursday 7:00 am to 3:00 pm; Friday 9:00 am- 3:00pm; and two Saturdays per month. The Family Wellness Center phone number is 215-368-2500 ext. 6216. From a Clemens phone, dial x6216.

Q. Will the clinic have weekend hours?

A. Yes. The Family Wellness Center is open two Saturdays per month.

Q: How can I make an appointment?

A: You are required to make an appointment to receive services at the Family Wellness Center. You may receive a same- or next-day appointment for urgent care services. You may make an appointment by calling 215-368-2500 ext. 6216 (x6216 within Clemens) or in person at the Family Wellness Center.

Q: If I use the Family Wellness Center, does that mean I should stop seeing my current physician?

A: The physician you visit is completely your choice. You have two options:

- You can make the Family Wellness Center your “medical home” and use the Family Wellness Center as your primary physician; or
- You can continue to see your current physician and consult the Family Wellness Center physician and team whenever it is convenient for you.

Q: Will my physician outside of the Family Wellness Center have access to my medical records?

A: In general, only the staff at the Family Wellness Center will have access to your medical records. (See “Confidentiality,” below.) You can, however, request that the Family Wellness Center share your medical records with outside providers by completing a form that is available at the Family Wellness Center and the staff will help you coordinate the transfer of your records.

Q: What does “patient-centered medical home model” mean?

A: Unlike the more traditional approach, where physicians may treat you without consulting with each other, the medical home model involves the Family Wellness Center’s primary care physician leading a team of health care providers who help coordinate your ongoing care.

- Various types of medical care practitioners and liaisons will be on staff to help you.
- Your medical team will work with you to learn your medical history and lifestyle so they can provide care and treatment options that make sense for you—making you a partner in your own care. This includes assistance with locating the right specialist(s), in your area, based on your needs/diagnosis. The care team will work with you and any specialists to manage your care.

Services

Q: What types of services are offered at the Family Wellness Center?

A: The Family Wellness Center generally offers the same types of services that are offered at a typical primary care physician’s office, including:

- Coordinated and customized primary and preventive care services, including immunizations and allergy shots
- Acute and urgent care, symptom treatment, and management
- Chronic care management
- Clinical laboratory services
- Coordination of care
- Physician and hospital referrals
- Population health management and patient education
- Physical therapy

- Patient-centered medical home
- Wellness services (coaching and referral programs)

Not all services will be available at all times.

Q: Does the Family Wellness Center offer urgent care services?

A: Yes, the Family Wellness Center offers same day acute and urgent care services during operating hours.

Q: Are there any services that the Family Wellness Center does not provide?

A: The Family Wellness Center generally provides the same services that a typical primary care physician provides. The Family Wellness Center does not provide services other than those listed above. The Family Wellness Center also does not offer diagnostic tests such as x-rays, MRIs, or CT scans.

Q: Will there be a pharmacy?

A: There will not be a pharmacy at the Family Wellness Center. Family Wellness Center staff will prescribe most medically necessary medications. You can fill a prescription that you obtain at the Family Wellness Center through any pharmacy you choose.

Q: Are there pediatric services for my eligible children?

A: Yes, you can bring your child age seven years and older in for primary care visits including physicals, immunizations, and illnesses and minor injuries.

Cost of Services

Q: What is the cost for using the Family Wellness Center?

A: There is no copayment for preventive care services. For any other service, you will be responsible for a $10 per visit fee at the time of your visit.

Q: Will I be able to use my health savings account (HSA), a health flexible spending account (FSA) or health reimbursement account (HRA) to reimburse me for expenses I incur at the Family Wellness Center?

A: Yes, qualified medical expenses incurred at the Family Wellness Center are generally reimbursable from an HSA, FSA, or HRA.

Claims and Appeals

Q: How do I appeal a denial of a claim for benefits from the Family Wellness Center?

A: Clemens Human Resources Department will adjudicate all claims and appeals in accordance with the process set forth in the Plan document and summary plan description.

Confidentiality

Q. Will my information and consultation be kept confidential and private?

A. Confidentiality is critical in a health care setting and health care providers are held to strict patient confidentiality rules. As a reminder, your health information is also protected by a federal law called HIPAA (the Health Insurance Portability and Accountability Act of 1996).

Q: Who has access to my medical records?

A: Your medical records are securely managed through the R-Health electronic health record system. Your physician and the Family Wellness Center care team have access to ensure you receive an integrated program of care that is tailored to your individual needs, lifestyle, and health goals. Your visit history is easily accessible for Family Wellness Center staff, as well, so you will not have to repeat your medical history to different providers on the health care team.

Q: Will the Family Wellness Center share my medical records with Clemens or another employer?

A: Except as may be required by law or the operation of the plan, the Family Wellness Center will not share your medical records with another party unless you authorize it to do so in writing.

If you need to have Clemens adjudicate your claim, you will need to provide a written authorization.

CLEMENS FAMILY CORPORATION HEALTH BENEFITS PLAN

98point6 Benefit Program

Introduction

The 98point6 Benefit Program ("**98point6**" or the "**Program**") benefits are provided under the Clemens Family Corporation Health Benefits Plan (the "**Plan**") that Clemens Family Corporation (the "**Employer**") has established and maintains for its eligible employees and their eligible dependents. The effective date of the Program is January 1, 2019.

This document provides an overview of how 98point6 works, as well as your rights and obligations with respect to the Program. This document, together with the Plan Document and Summary Plan Description for the Plan, which is incorporated herein by reference, constitutes the summary plan description for the 98point6 benefits as required by the Employee Retirement Income Security Act of 1974, as amended.

The 98point6 services provided under the Program are paid by the Employer out of its general assets. Program costs may also be paid in part by Eligible Participant contributions, as determined by the Employer in its sole discretion and subject to the terms of the Plan. The Employer will determine and periodically communicate the Eligible Participant's share of the cost to participate in 98point6, if any, and it may change that determination at any time. Participants may also be subject to a per session fee as described in more detail below.

Eligibility and Participation

- *Employees*. An employee is eligible to participate in 98point6 if he or she is (i) an employee of the Employer working other than and (ii) eligible for and enrolls in the medical insurance benefit (the "Medical Insurance Program") that the Employer offers to eligible employees under the Plan.
- *Dependents*. An employee's spouse or dependent is eligible to participate in 98point6 if he or she is an eligible dependent under the terms of the health and welfare benefits sponsored by the Employer under the Plan and is at least one year old.

Eligible employees and their eligible dependents who participate in 98point6 are referred to as "**Eligible Participants**."

Enrollment

Participation in the Program begins on the later of (i) the Program's effective date, or (ii) the date on which an individual becomes an Eligible Participant. An Eligible Participant is automatically enrolled in the Program effective at the same time as such Eligible Participant commences participation in the Medical Insurance Program.

For More Information

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If you have questions about your eligibility or enrollment in the Program, contact the Employer. For questions about Program services, contact 98point6 through the Contact Us form on the 98point6 website or by phone at 1-866-657-7991.

Summary of 98point6 Benefits

98point6 provides the following benefits to Eligible Participants:

- 98point6 provides primary care medicine, including acute care visits and chronic disease management through secure in-app messaging and provides prescriptions, orders for lab services, referrals, follow up, and consultations on medical questions.
- Services are limited to issues, conditions and illnesses that can be identified, treated, and managed virtually.
- An Eligible Participant has access to an online interactive platform (including related iOS and Android applications) for continuity of care, including access to his or her diagnoses and treatment plans.
- An Eligible Participant may also use the platform to access non-urgent primary care via the 98point6 website or mobile application. The provider network is available at www.98point6.com.
    - Primary care services available through 98point6 include evaluation, diagnosis, and development of a treatment plan with respect to non-urgent primary care issues, including (as appropriate) referrals or orders for prescriptions or lab services.
    - Sessions with 98point6 providers can be done online or via two-way video or telephonic. Sessions are not time-limited and there is no limit to the number of visits that an Eligible Participant may have.
    - Sessions are available 24 hours per day, seven days a week.

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Delta Dental of Pennsylvania

THE CLEMENS FAMILY CORPORATION
HEALTH BENEFIT PLAN

Combined Evidence of Coverage and Disclosure Form

deltadentalins.com

Group No. 04476

Effective Date: 04/01/2020

Delta Dental
Administrative Offices
One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 Toll free: (800) 932-0783
TTY/TDD: (888) 373-3582
www.deltadentalins.com

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INTRODUCTION

Delta Dental is pleased to welcome you to the group dental plan for The Clemens Family Corporation Health Benefit Plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

Using This Evidence of Coverage

This Evidence of Coverage discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that YOU and YOUR mean the individuals who are covered. WE, US and OUR always refer to Delta Dental. In addition, please read the **Definition of Terms** section, which will explain any words that have special or technical meanings under the plan.

The benefit explanations contained in this booklet are subject to all provisions of the Group Dental Service Contract on file with your employer, trust fund, or other entity ("Plan Administrator") and do not modify the terms and conditions of that contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Contact Us

If you have any questions about your coverage that are not answered here, please visit our web site at www.deltadentalins.com or call our Customer Service Center. A Customer Service Center representative can answer questions you may have about obtaining dental care, help you locate a Participating Dentist, explain benefits, check the status of a claim, and assist you in filing a claim.

Representatives are available by telephone Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern Time at (717) 766-8500 or toll-free at (800) 932-0783. If you are hearing impaired, you may call our toll-free TTY/TDD number at (888) 373-3582. You can also access Delta Dental's automated information line at (800) 932-0783 to obtain information about enrollee eligibility and benefits, group benefits, or claim status.

If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055

SELECTING YOUR DENTIST

Free Choice of Dentist

Delta Dental recognizes that many factors affect the choice of dentist and therefore supports your right to freedom of choice regarding your dentist. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any licensed dentist for your covered treatment:

- Delta Dental PPO Participating Dentist ("PPO")
- Delta Dental Premier Participating Dentist ("Premier")
- Non-Participating Dentist

In addition, you may choose your own specialist, and you and your family members can see different dentists.

Remember, you enjoy the greatest savings when you choose a PPO Dentist. To take full advantage of your benefits, we highly recommend you verify a dentist's participation status within a Delta Dental network with your dental office before each appointment. Review the section titled "How Claims Are Paid" for an explanation of Delta Dental payment procedures to understand the method of payments applicable to your dentist selection and how that may impact your out-of-pocket costs.

Referrals to Specialists

Your dentist may refer you to another dentist for a consultation or specialized treatment or you may elect to see a specialist on your own. If this is done, be sure that the dentist you are referred to is a Participating Dentist. You can do this by simply asking the specialist when you make your appointment. Visiting a dentist who has agreed to participate in the Delta Dental network can save you money, time, and the hassle of paperwork. Remember, if the dentist is not a Participating Dentist, you may be required to pay all of the treatment cost at the time of service and submit a claim to Delta Dental for reimbursement.

Locating a Delta Dental Participating Dentist

There are several ways in which you can locate a Participating Dentist near you:

- You may contact your personnel office, which has copies of the Delta Dental PPO and Premier Dentist directories.
- You may access information about the plan through our web site at www.deltadentalins.com. This web site includes a dentist search function allowing you to locate Delta Dental Participating Dentists by location, specialty and network type; or
- You may also call Delta Dental and one of our representatives will assist you. He/she can provide you with information regarding a dentist's membership status, specialty and office location.

PLAN INFORMATION

Benefit Summary Charts

The services provided through the plan include all the benefits described in the Benefit Summary Charts on the following pages, depending on the participation status of the dentist providing the services, with the exception of those items presented in the **Limitations and Exclusions** section. The plan covers several categories of benefits when a licensed dentist provides the services and when they are within the standards of generally accepted dental practice. To help you understand the types of procedures that are included in each of the categories of services, examples and descriptions are provided in the charts. The enrollee's share may be higher than the percentages listed in the charts, depending on the applicability of maximums, the difference between the Non-Participating Dentist's fee and the PPO Maximum Plan Allowance or charges for non-covered services.

The information in the following chart applies to services provided by Delta Dental PPO Dentists only.

Benefit Summary Chart

Category of Service	Paid by Delta Dental	Paid By Enrollee
Diagnostic (maximum waived) Periodic exams (twice per contract year) Bitewing x-rays (twice per contract year) Full-mouth x-ray (once per 3-year period) See note on additional benefits during pregnancy.	100%*	0%
Preventive (maximum waived) Prophylaxis (cleaning) (twice per contract year) Fluoride treatments (twice per contract year to age 19) Sealants (to age 19) Space maintainers (to age 14) See note on additional benefits during pregnancy.	100%*	0%
Basic Restorative Fillings (amalgam "silver" and composite "white")	80%*	20%
Major Restorative Single crowns, inlays, onlays (excludes resin onlays)	50%*	50%
Oral Surgery Extraction and other oral surgery procedures, incl. pre- and post-operative care	80%*	20%
Endodontics Root canal, pulpal therapy	80%*	20%
Surgical Periodontics Surgical treatment of the gums and supporting structures of the teeth	80%*	20%
Non-Surgical Periodontics Non-surgical treatment of the gums and supporting structures of the teeth See note on additional benefits during pregnancy.	80%*	20%
Prosthodontics Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures, implant surgical placement & removal, implant supported prosthetics, including repair & recementation.	50%*	50%
Orthodontics For eligible dependents to age 19	50%*	50%
General Anesthesia & IV Sedation Covered when used in conjunction with covered oral surgical procedures and other selected endodontic and periodontic procedures	80%*	20%
Denture Repair & Relining	80%*	20%

	Maximums
Individual (Contract year)	$1,500.00
Family (Contract year)	$ n/a
Orthodontics (Lifetime)	$1,000.00

*** For Delta Dental PPO Dentists, percentages are based on the PPO Allowed Amount, which is the lesser of the dentist's submitted fee or the PPO Maximum Plan Allowance.**

The information in the following chart applies to services provided by Delta Dental Premier Dentists and Non-Participating Dentists only.

Benefit Summary Chart

Category of Service	Paid by Delta Dental	Paid By Enrollee
Diagnostic (maximum waived) Periodic exams (twice per contract year) Bitewing x-rays (twice per contract year) Full-mouth x-ray (once per 3-year period) See note on additional benefits during pregnancy.	100%*	0%
Preventive (maximum waived) Prophylaxis (cleaning) (twice per contract year) Fluoride treatments (twice per contract year to age 19) Sealants (to age 19) Space maintainers (to age 14) See note on additional benefits during pregnancy.	100%*	0%
Basic Restorative Fillings (amalgam "silver" and composite "white")	80%*	20%
Major Restorative Single crowns, inlays, onlays (excludes resin onlays)	50%*	50%
Oral Surgery Extraction and other oral surgery procedures, incl. pre- and post-operative care	80%*	20%
Endodontics Root canal, pulpal therapy	80%*	20%
Surgical Periodontics Surgical treatment of the gums and supporting structures of the teeth	80%*	20%
Non-Surgical Periodontics Non-surgical treatment of the gums and supporting structures of the teeth See note on additional benefits during pregnancy.	80%*	20%
Prosthodontics Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures, implant surgical placement & removal, implant supported prosthetics, including repair & recementation.	50%*	50%
Orthodontics For eligible dependents to age 19	50%*	50%
General Anesthesia & IV Sedation Covered when used in conjunction with covered oral surgical procedures and other selected endodontic and periodontic procedures	80%*	20%
Denture Repair & Relining	80%*	20%

	Maximums
Individual (Contract year)	$1,500.00
Family (Contract year)	$ n/a
Orthodontics (Lifetime)	$1,000.00

*** For Delta Dental Premier Dentists and Non-Participating Dentists, percentages are based on the Premier Allowed Amount, which is the lesser of the dentist's submitted fee or the Premier Maximum Plan Allowance.**

Copayments

The plan will pay a percentage of the applicable allowed amount (PPO Allowed Amount for PPO Dentists and Premier Allowed Amount for Premier Dentists and Non-Participating Dentists) for each covered service, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the copayment and is part of your out-of-pocket cost.

The amount of your copayment will depend on the type of service provided and the dentist providing the service (see section titled "Selecting Your Dentist"). Dentists are required to collect your copayment for covered services.

It is to your advantage to select PPO Dentists because they have agreed to accept the PPO Allowed Amount as payment, which typically results in lower copayments charged to you. Please read the sections titled "Selecting Your Dentist" and "How Claims Are Paid" for more information.

Maximum Benefit

Most dental programs have a maximum benefit. This is the maximum dollar amount a dental plan will pay toward the cost of dental care. The enrollee is personally responsible for paying costs above the maximum benefit. The Benefit Summary Charts show the maximum benefit amount that applies, depending on the participation status of the dentist providing the services. This is the maximum benefit amount that Delta Dental will pay for covered services per enrollee in a contract year.

Note on Additional Benefits During Pregnancy

When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services while the Enrollee is covered under the Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

Limitations and Exclusions

Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical program includes limitations and exclusions, meaning the program does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. These limitations and exclusions are carefully detailed in this booklet and you should make yourself familiar with them. Please read the **Limitations and Exclusions** section to help you understand the limitations and exclusions of this dental plan.

HOW CLAIMS ARE PAID

Payment by Delta Dental for any single procedure that is a covered service will be made upon completion of the procedure. Payment for care is applied to the contract year maximum benefit based on the date of service. Delta Dental will provide payment for covered services at the percentage indicated in the Benefit Summary Chart, up to a maximum for each enrollee in a contract year.

Payment for Services — Delta Dental PPO Dentist

Payment for covered services performed for you by a PPO Dentist is calculated based on the PPO Allowed Amount. PPO Dentists have agreed to accept a PPO Allowed Amount as the full charge for covered services.

Delta Dental calculates its share of the PPO Allowed Amount ("Delta Dental Payment") using the applicable percentage from the Benefit Summary Chart and sends it directly to the PPO Dentist who has submitted the claim. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Enrollee Payment"). These charges are generally your share of the allowed amount ("Co-payment"), charges where the maximum benefit has been exceeded, and/or charges for non-covered services.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded):

Submitted Amount (Dentist Fee)	= $100
PPO Maximum Plan Allowance	= $70
PPO Allowed Amount	= $70
Co-payment (50% of PPO Allowed Amount)	= $35
Delta Dental Payment	= $35
Enrollee Payment	= $35

Payment for Services — Delta Dental Premier Dentist

A Delta Dental Premier Dentist is a Participating Dentist, but is not a Delta Dental PPO Dentist. Premier Dentists have not agreed to accept a PPO Allowed Amount as full payment for services, but instead have agreed to accept a Premier Allowed Amount. Payment for covered services performed for you by a Premier Dentist is calculated based on the Premier Allowed Amount, which is the lesser of the dentist's submitted fee or the Premier Maximum Plan Allowance.

The portion of the Premier Allowed Amount payable by Delta Dental ("Delta Dental Payment") is limited to the applicable percentage shown in the Benefit Summary Chart. Delta Dental's Payment is sent directly to the Premier Dentist who submitted the claim. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Enrollee Payment"). These charges are generally your share of the Premier Allowed Amount, charges where the maximum benefit has been exceeded, and/or charges for non-covered services.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded):

Submitted Amount (Dentist Fee)	= $100
Premier Maximum Plan Allowance	= $80
Premier Allowed Amount	= $80
Co-payment (50% of Premier Allowed Amount)	= $40
Delta Dental Payment	= $40
Enrollee Payment	= $40

Payment for Services — Non-Participating Dentist

Non-Participating Dentists have not agreed to accept the PPO Allowed Amount as full payment for services. Payment for services performed for you by a Non-Participating Dentist is also calculated by Delta Dental based on the Premier Allowed Amount, which is the lesser of the dentist's submitted fee or the Premier Maximum Plan Allowance. The portion of the Premier Allowed Amount payable by Delta Dental ("Delta Dental Payment") is limited to the applicable percentage shown in the Benefit Summary Chart.

However, when dental services are received from a Non-Participating Dentist, Delta Dental's payment is sent directly to the primary enrollee. You are responsible for payment of the Non-Participating Dentist's total fee. Non-Participating Dentists will bill you for their normal charges, which may be higher than the Premier Allowed Amount for the service. You may be required to pay the dentist yourself and then submit a claim to Delta Dental for reimbursement. Since the Delta Dental payment for services you receive may be less than the Non-Participating Dentist's actual charges, your out-of-pocket cost may be significantly higher.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded):

Submitted Amount (Dentist Fee)	= $100
Premier Maximum Plan Allowance	= $80
Premier Allowed Amount	= $80
Co-payment (50% of Premier Allowed Amount)	= $40
Enrollee Payment	= $100
Delta Dental Payment to Enrollee	= $40
Enrollee Out-of-Pocket Payment	= $60

Orthodontic Payments

Unless otherwise specified in the contract, Delta Dental will pay half of its orthodontic payment up front, at the time of banding. (Delta Dental's orthodontic payment is calculated in the same manner as the "Delta Dental Payment" in the above examples.) The remaining half will be paid one year later. If the treatment time is 12 months or less, Delta Dental's orthodontic payment will be paid as a lump sum at the beginning of the orthodontic treatment. If treatment began prior to the enrollee becoming eligible with Delta Dental, any payments made by a previous dental carrier will be applied to the enrollee's lifetime orthodontic maximum.

How to Submit a Claim

Delta Dental does not require any special claim forms. Most dental offices have standard claim forms available. Participating Dentists will fill out and submit your claims paperwork for you. Some Non-Participating Dentists may also provide this service upon your request. If you receive services from a Non-Participating Dentist who does not provide this service, you can submit your own claim directly to Delta Dental. For your convenience, you can print a claim form from our web site: www.deltadentalins.com.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and mail it to:

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055-6999

Payment Guidelines

Delta Dental does not pay Participating Dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your dentist files a claim for services more than twelve (12) months after the date you received the services, payment may be denied. If the services were received from a Non-Participating Dentist, you are still responsible for the full cost. If the payment is denied because your Participating Dentist failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your Participating Dentist that you were an enrollee of the plan at the time you received the service, you may be responsible for the cost of that service.

We explain to all Participating Dentists how we determine or deny payment for services. We describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided and the program's limitations and exclusions. If any claims are not covered, or if limitations or exclusions apply to services you have received, you may be responsible for the full payment.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, contact Delta Dental.

Optional Treatment and Non-Covered Services

You must pay for any non-covered or optional dental benefits that you choose to have done. Refer to the **Limitations and Exclusions** section for information about excluded services and limitations.

Often there are several approaches or different methods that a dentist may use to treat dental needs. This program is designed to cover dental treatment using standards of care consistent with the delivery of quality, affordable dental treatment to the enrollee. If you request a treatment that is more costly than standard practice, you must pay for the charges in excess of the covered dental benefit.

Example: If a metal filling would fix the tooth and you choose to have the tooth crowned, you are responsible for paying the difference between the cost of the crown and the cost of the filling. You must pay this money directly to your dentist.

Pre-Treatment Estimates

If you and your dentist are unsure of your benefits for a specific course of treatment, or if treatment costs are expected to exceed $300, Delta Dental recommends that you ask for a pre-treatment estimate. You should ask your dentist to submit the claim form in advance of performing the proposed services. Pre-treatment estimate requests are not required but may be submitted for more complicated and expensive procedures such as crowns, wisdom tooth extractions, bridges, dentures, or periodontal surgery. You'll receive an estimate of your share of the cost and how much Delta Dental will pay before treatment begins. Delta Dental will act promptly in returning a pre-treatment estimate to you and the attending dentist with non-binding verification of your current availability of benefits and applicable maximums. The pre-treatment estimate is non-binding as the availability of benefits may change subsequent to the date of the estimate due to a change in eligibility status, exhaustion of applicable maximum benefit or application of frequency of procedure limitations.

Other Health Insurance

Be sure to advise your dentist of all programs under which you have dental coverage and have him or her complete the dual coverage portion of the claim form, so that you will receive all benefits to which you are entitled. When you have coverage under more than one benefit program, the primary and secondary carriers coordinate the two programs, so that the primary carrier pays its portion first and then the secondary carrier pays its portion, not to exceed the dentist's fees for the covered services.

The following rules will be followed to establish the order of determining the liability of this or any other programs:

1. The program covering the enrollee as an employee will determine its benefits before the program covering the enrollee as a dependent.

2. The program covering the enrollee as a dependent of an employee whose birthday falls earlier in the calendar year will determine it benefits before the program covering the enrollee as a dependent of an employee whose birthday falls later in the calendar year. If both employees have the same birthday, the program covering the employee for the longest period will be primary over the program covering the employee for the shorter period.

3. The program covering the enrollee having custody of the dependent will determine its benefits first; then the program of the spouse of the parent with custody of the dependent; and finally, the program of the parent not having custody of the dependent. However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the dependent, the benefits of that program are considered first. The prior sentence will not apply with respect to any period during which any benefits are actually paid or provided before a program has actual knowledge of the court order.

4. The program covering the enrollee as an employee or as a dependent of an employee will determine its benefits before one that covers the enrollee as a laid-off or retired employee or as the dependent of such person. If the other plan does not have a rule concerning laid-off or retired employees, and as a result each plan determines its benefits after the other, then this paragraph will not apply.

5. If the other program does not have a rule establishing the same order of determining liability for benefits or is one which is "excess" or always "secondary," Delta Dental will determine its benefits first. If such determination indicates that Delta Dental should not have been the first program to determine its benefits, Delta Dental will be considered as not the first to determine its benefits.

6. In situations not described in items 1 through 5, the program under which the enrollee has been enrolled for the longest period of time will determine its benefits first.

When Delta Dental is the first to determine its benefits, benefits will be paid without regard to coverage under any other program. When Delta Dental is not the first to determine its benefits, and there are remaining expenses of the type allowable under this program, Delta Dental will pay only the amount by which its benefits under this plan exceed the amount of benefits payable under the other program or the amount of such remaining expenses, whichever is less.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirement

You will become eligible to receive benefits on the date stated in the contract after completing any eligibility periods required by the group. Under this dental plan, the eligibility requirement for new hires is the 1st of the month following 60 days of employment. You may enroll for individual and family coverage.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents are your:

- Spouse.

- Married or unmarried children and/or dependent grandchildren until the end of the month of their 26th birthday. Such children include: (a) your biological child, (b) your legally adopted child (including a child living with the adopting parents and/or grandparents during the period of probation), (c) a child for whom you have legal guardianship or temporary guardianship of more than 12 months duration and for a shorter period if the guardianship is of a dependent minor and granted by testamentary, (d) a stepchild, or child or grandchild who is the subject of a Court Order of support directed to you, without regard to the amount of support contributed by you, the amount of time the child spends in your home, or the custodial arrangement for the child. Documentation of the above must be furnished upon request by Delta Dental.

- Married or unmarried children and/or dependent grandchildren of any age who are incapable of self-support by reason of mental or physical incapacity that occurred before the age of 26 (end of the month) and were covered prior to age 26 (end of the month). The dependent child must also be chiefly dependent on you for support and maintenance, but is not required to reside with a parent or legal guardian who is a primary enrollee. Eligibility of these dependent children and/or grandchildren will not be terminated while the contract remains in force and the dependent child and/or grandchild remains in such condition. Proof of physical or mental disability must be furnished as required by Delta Dental.

- Newborn children and/or dependent grandchildren of any enrollee for 31 days from: (a) the moment of birth, (b) the date of placement for adoption or upon placement in the foster home, or (c) the date of appointment for a minor for whom guardianship has been granted by court or testamentary appointment. Proof of birth or adoption or foster home placement must be furnished upon request by Delta Dental. In order for the coverage to continue beyond the 31-day period, you must notify the Plan Administrator of the birth, adoption, placement in the foster home, or appointment of guardianship.

Changes in Eligibility Status

Changes in eligibility status (i.e. marriage, divorce, birth, etc.) must be reported to the Plan Administrator within 31 days following the event causing the change. If you do not change coverage when first eligible, you may change later during a subsequent open enrollment period. Changes become effective on the exact day of notification of the change.

Loss of Eligibility

Your coverage ends on the exact day on which termination of employment occurs or immediately when this program ends. Coverage for all dependents also ceases at that time, or when dependent status is lost. Your dependent children and/or grandchildren will be disqualified for benefits when they reach the disqualifying age.

COMPLAINTS, GRIEVANCES AND APPEALS

Our commitment to you is to ensure quality throughout the entire treatment process: from the courtesy extended to you by our customer service representatives to the dental services provided by our Participating Dentists. If you have questions about any services received, we recommend that you first discuss the matter with your dentist. However, if you continue to have concerns, please call Delta Dental's Customer Service Center.

Delta Dental attempts to process all claims within 30 days. If a claim will be delayed more than 30 days, Delta Dental will notify the enrollee in writing within 30 days stating the reason for delay.

Questions or complaints regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Delta Dental, or the quality of dental services performed by the dentist may be directed in writing to Delta Dental or by calling Delta Dental at (717) 766-8500 or toll-free at (800) 932-0783. You can also e-mail questions by accessing the "Contact Us" section of Delta Dental's web site at www.deltadentalins.com.

A grievance is a written expression of dissatisfaction with the provision of services or claims practices of Delta Dental. When you write, please include the name of the enrollee, the primary enrollee's name and enrollee ID, and your telephone number on all correspondence. You should also include a copy of the claim form, Benefits Statement, Invoice or other relevant information.

Appeals

Any dissatisfaction with adjustments made or denials of payment should be brought to Delta Dental's attention, and if unresolved to your satisfaction, to the Plan Administrator. The Plan Administrator will advise you of your rights of appeal or other recourse.

Appeals on claims denied must be submitted in writing. The following section explains the claim review and appeal process and time limits applicable to such process. This information can also be found in your Benefits Statement.

If a post-service claim is denied in whole or in part, Delta Dental will notify you and your attending dentist of the denial in writing within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 14 days, for processing. If there is an extension, you and your attending dentist will be notified of the extension and the reason for the extension within the original 30-day period. If an extension is necessary because either you or your attending dentist did not submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You or your attending dentist will be afforded at least 45 days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent contract provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary. The notice of denial shall also contain an explanation of Delta Dental's claim review and appeal process and the time limits applicable to such process, including a statement of the enrollee's right to bring a civil action under ERISA upon completion of Delta Dental's second level of review. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, an explanation is available free of charge upon request by you or your attending dentist.

If you or your attending dentist wants the denial of benefits reviewed, you or your attending dentist must write to Delta Dental within 180 days of the date on the denial letter. In the letter, you or your attending dentist should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice should accompany the request for review. You or your attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

The review shall be conducted on behalf of Delta Dental by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available to you or your attending dentist on request. In making the review, Delta Dental will not afford deference to the initial adverse benefit determination.

If after review, Delta Dental continues to deny the claim, Delta Dental will notify you and your attending dentist in writing of the decision on the request for review within 30 days of the date the request is received. Delta Dental will send to you or your attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific contract provisions on which the benefit determination is based. The notice shall state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, an explanation is available free of charge upon request by either you or your attending dentist. The notice shall also state that you have a right to bring an action under ERISA upon completion of Delta Dental's second level of review, and shall state: "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."

If in the opinion of you or your attending dentist, the matter warrants further consideration, you or your attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if requested by you or your attending dentist. The Dental Affairs Committee will render a decision within 30 days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with an ERISA or other civil action.

Send your grievance, appeal, or claims review request to Delta Dental at the address shown below:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055

GENERAL PROGRAM INFORMATION

Proof of Claim

Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an enrollee as may be required to administer the claim, or that an enrollee be examined by a dental consultant retained by Delta Dental, in or near the community or residence. Delta Dental will in every case hold such information and records confidential.

Physical Access

Delta Dental has made efforts to ensure that our offices and the offices and facilities of Participating Dentists are accessible to the disabled. If you are not able to locate an accessible dentist, please call our Customer Service Center and a representative will help you find an alternate dentist.

Access for the Hearing Impaired

The hearing impaired may contact the Customer Service Center through our toll-free TTY-TDD number at (888) 373-3582.

Privacy

Delta Dental values its relationship with you. Protecting your personal information is of great importance to us. Delta Dental will obtain from the enrollee only nonpublic information that relates to Delta Dental's administration of the dental benefits we provide. Information may include, but not be limited to name, address, social security number, enrollee ID, and date of birth. We do not disclose any nonpublic personal information about you to any affiliated or nonaffiliated third parties except as is necessary in order to provide our service to you or as we are required or permitted by law. Delta Dental maintains physical, electronic, and procedural security measures to safeguard your nonpublic personal information in our possession.

Web Site Security

Delta Dental employs security measures to control access to the eligibility and dental benefit information under our control. Delta Dental uses industry standards, such as firewalls and Secure Socket Layers, to safeguard the confidentiality of personal enrollee information.

There are areas of our web site that require a specific user ID and password for web site access. In order to receive a user ID and password, Delta Dental requires enrollees to contractually agree to not provide information they may access to other individuals. The user identification and password required for site access is internally validated to ensure this information cannot be viewed without proper authority and security authentication.

Reduction for Automobile Insurance Benefits *(For Pennsylvania Enrollees Only)*

Fees for services or supplies for injuries or conditions payable under this plan will be reduced by the amount of any first party benefits under automobile insurance and by any catastrophic loss benefits paid by the Catastrophic Loss Trust Fund. Fees not paid as first party benefits will be payable proportionately as the obligation of Delta Dental and enrollee in the percentages shown in the Benefit Summary Chart.

ENROLLEE RIGHTS AND RESPONSIBILITIES

We believe that you, as a Delta Dental enrollee, have the right to expect quality, affordable care that protects not only your dental health, but also your privacy and ability to make informed choices. We also believe that you have certain responsibilities to help protect these rights.

The Right to Choose

The Delta Dental system maintains some of the largest dentist networks in the industry — each with a full range of specialists — to give you the widest possible choice of dentists. Dentists are never penalized for referring you to a specialist. You can visit any dentist at any time, without prior notification or authorization from Delta Dental.

The Right to Quality Assurance

While we support the right of enrollees to choose their dentist, we recognize our responsibility to provide some assurances of quality care.

Therefore, each dentist who has contracted with Delta Dental agrees to provide care that meets the standards of the dental profession. Dentist contracts allow Delta Dental to audit dental offices in person — at random and for cause — to help ensure that these standards are met. If you should ever receive substandard care from a Delta Dental dentist, Delta Dental will fully investigate the matter and can arrange for you to be reimbursed and/or retreated as needed.

The Right to Affordability

Delta Dental contracts with dentists to provide fair and reasonable compensation. Those contracts also prohibit dentists from billing you for excess charges, "add-on" procedures that should already be included, or for any amount that is Delta Dental's responsibility.

Delta Dental benefit plans are designed to promote preventive care, avoiding dental disease before more costly treatment becomes necessary.

The Right to Full Disclosure

You have the right to clear and complete information about your dental benefits, including treatment that is subject to limitations or not covered. You are entitled to know what your share of costs will be before you receive treatment ("pre-treatment estimate"), and how your dentist is compensated by Delta Dental. Delta Dental provides materials to explain these features to you.

Delta Dental dentists are not subject to policies sometimes called "gag clauses." You are entitled to hear about all treatment options your dentist may recommend, whether covered or not, and to obtain a second opinion if you choose.

The Right to Fair Review and Appeal

Delta Dental supports your right, as well as your dentist's, to a fair and prompt review of any of Delta Dental's coverage decisions. We maintain effective complaint resolution systems in the event of disagreement over coverage or concern about the quality of care.

The Responsibility to Protect These Rights

Protection of the rights described above is possible only with your cooperation. In order to ensure the continued enjoyment of these rights, you share:

- The responsibility to participate in your own dental health — practicing personal dental hygiene and receiving regular professional care. You should avoid substances and behaviors that could jeopardize your oral health, and should cooperate with your dentist on his or her recommended treatment plans.

- The responsibility to become familiar with your coverage. This includes meeting any financial obligation incurred as a result of treatment (including the appropriate copayments required by the program). It means cooperation with Delta Dental policies designed to protect against health care fraud schemes by fellow enrollees or dentists. It also means taking advantage of the information available on dental health and your dental program so that you can become a more informed consumer.

LIMITATIONS AND EXCLUSIONS

Excluded Benefits

The plan covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your dentist.

The plan does not provide benefits for:

1. Treatment or materials that are benefits to an enrollee under Medicare or Medicaid unless this exclusion is prohibited by law.

2. Treatment or materials to correct congenital or developmental malformations (including treatment of enamel hypoplasia) except for newborn children eligible at birth, so long as such eligible children continue to be enrolled. When services are not excluded under this provision congenital defects or anomalies specifically includes individuals born with cleft lip or cleft palate, and other limitations and exclusions of this section shall specifically apply.

3. Treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury.

4. Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected teeth are excluded.

5. Treatment or materials for which the enrollee would have no legal obligation to pay.

6. Services provided or materials furnished prior to the effective eligibility date of an enrollee under this plan, unless the treatment was a year in duration and completed after the enrollee became eligible if no other limitations shall apply.

7. Periodontal splinting, equilibration, gnathological recordings and associated treatment and extra-oral grafts.

8. Preventive plaque control programs, including oral hygiene instruction programs.

9. Myofunctional therapy, unless covered by the exception in Item 2, above.

10. Temporomandibular joint dysfunction, unless covered by the exception in Item 2, above.

11. Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.

12. Experimental procedures that have not been accepted by the American Dental Association.

13. Services provided or material furnished after the termination date of coverage for which premium has been paid, as applicable to individual enrollees, except this shall not apply to services commenced while the plan was in effect or the enrollee was eligible.

14. Charges for hospitalization or any other surgical treatment facility, including hospital visits.

15. Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.

16. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.

17. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered benefit.

Limitations

Benefits to enrollees are limited as follows:

Limitation on Optional Treatment Plan. In all cases in which there are optional plans of treatment carrying different treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment, so long as such treatment will restore the oral condition in a professionally accepted manner, with the balance of the treatment cost remaining the responsibility of the enrollee. Such optional treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.

Limitation on Major Restorative Benefits. If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the enrollee and the dentist select another type of restoration, the obligation of Delta Dental shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental treatment excluded from coverage under this plan.

- Replacement of crowns, jackets, inlays and onlays (excluding resin onlays) shall be provided no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied, whether paid for under the provisions of this plan, under any prior dental care contract, or by the enrollee.

Limitation on Prosthodontic Benefits. Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services, including denture repair and relining, which are necessary to make such appliances fit will be provided as outlined in the section "Covered Benefits." Prosthodontic appliances and abutment crowns will be replaced only after five years has elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.

Implants provided under any Delta Dental plan will replaced only after five years have passed. Replacement of an implant supported prosthesis not provided under a Delta Dental program will be covered if it is unsatisfactory and cannot be made satisfactory. Implant removal is limited to once for each tooth during the Enrollee's lifetime.

Limitation on Orthodontic Benefits. Orthodontic benefits are limited to devices and procedures for the correction of malposed teeth of dependents up to age 19, through the completion of the procedures; or to the date coverage terminates, which ever occurs first. The obligation of Delta Dental to make monthly or other periodic payments for orthodontic treatment will cease upon termination of treatment for any reason, prior to completion of the procedure. Delta Dental will not make any payment for repair or replacement of orthodontic appliances.

Limitation on Oral Surgery Benefits. Benefits for specific oral surgery procedures, including but not limited to reduction of fractures, removal of tumors, and removal of impacted teeth payable under a medical insurance contract or a medical or hospital service contract by which the enrollee is covered shall be determined first under this plan. Delta Dental's obligation for these oral surgery services shall be limited to the difference between benefits paid under such other contracts up to the applicable allowed amount for the procedure less the enrollee copayment. When there is no medical or hospital coverage, Delta Dental's obligation for oral surgery services shall be limited to the applicable allowed amount for those services provided under the contract less the enrollee copayment.

Limitation on Periodontal Surgery. Benefits for periodontal surgery in the same quadrant are limited to once in any five-year period. The five-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this plan, under any prior dental contract, or by the enrollee.

Limitation on Sealants. Treatment with sealants as a covered Service is limited to applications to eight posterior teeth. Applications to deciduous teeth or teeth with caries are not covered Services. Sealants will be replaced only after three (3) years have elapsed following any prior provision of such materials.

Limitation on Occlusal Restorations. Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve months, and two or three surface restorations within six months, which include occlusal surfaces on which sealants have been placed are not covered Services. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six months after a sealant has been applied to that tooth, the obligation of Delta Dental shall be only to pay the fee appropriate to the restoration in excess of the fee paid for the application of the sealant.

DEFINITION OF TERMS

The following are definitions of words that have special or technical meanings under the plan.

Attending Dentist Statement: The written report of a series of procedures recommended for the treatment of a specific dental disease, defect or injury, prepared for an enrollee by a dentist as a result of an examination made by such dentist.

Benefits Statement: The statement you receive after a claim is processed, detailing how your claim payment was calculated including the procedures and fees submitted and the amount for which you are responsible.

Calendar Year: The time period beginning on January 1st and ending on December 31st.

Claim Form: A written or electronically submitted document to request payment for completed dental treatment or to request a pre-treatment estimate for proposed dental treatment. The claim form is also sometimes called an Attending Dentist's Statement.

Company: The employer, union or other organization or group contracting to obtain benefits.

Contract: The written agreement between Delta Dental and The Clemens Family Corporation Health Benefit Plan to provide dental benefits. The contract, together with this Evidence of Coverage, forms the terms and conditions of benefits available to you under the dental plan.

Contract Year: The 12-month period beginning on the effective date and each yearly period thereafter.

Copayment: Your share of the cost of a covered service, usually expressed as a percentage of the applicable allowed amount.

Delta Dental Payment: The portion of the PPO Allowed Amount or the Premier Allowed Amount payable by Delta Dental.

Delta Dental PPO ("PPO") Dentist: A Participating Dentist who is a member of the Delta Dental PPO Dentist network.

Delta Dental Premier ("Premier") Dentist: A Participating Dentist who is a member of the Delta Dental Premier Dentist network.

Delta Dental PPO ("PPO") Maximum Plan Allowance: The maximum amount, determined by Delta Dental, usually less than its Maximum Plan Allowance for Delta Dental Premier programs, from claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area blended by Delta Dental with dentist fee information from a number of other sources, including dentist fee filings, using various factors, subject to regulatory limitations and adjustment for extreme difficulty or unusual circumstances.

Delta Dental Premier ("Premier") Maximum Plan Allowance: The maximum amount payable for services of Participating and Non-Participating Dentists, calculated by Delta Dental, for use in payment by it and by its enrollees from claim charges submitted, on a regional basis, for a given service by dentists of similar training within the same geographical area blended by Delta Dental with dentist fee information from a number of other sources, including dentist fee filings, using various factors, subject to regulatory limitations and adjustment for extreme difficulty or unusual circumstances.

Dependent: Eligible family members as defined in the **Eligibility and Enrollment** section of this Evidence of Coverage.

Effective Date: The date the dental program begins. This date is given on the front cover of this Evidence of Coverage.

Employee: An employee of the company who meets the eligibility requirements, accepted by Delta Dental, for enrollment under the contract, and who is so specified for enrollment.

Enrollee: Collectively, the primary enrollee and all enrolled dependents.

Enrollee Payment: The amount the enrollee pays after calculation of the Delta Dental payment.

Exclusions: Services that are not covered under this dental plan.

Family: The primary enrollee and all enrolled dependents of the primary enrollee.

Limitations: The number of services allowed, frequency of services allowed, and the most affordable dentally appropriate service.

Maximum Benefit: The total maximum dollar amount Delta Dental will pay toward the cost of covered dental care incurred by an individual enrollee in a given period.

Network: A collective expression for all Participating Dentists who have contracted with Delta Dental to offer services to enrollees and who have agreed to abide by certain administrative guidelines.

Non-Participating Dentist: A dentist who has not contracted with Delta Dental and who is not contractually bound to abide by Delta Dental's administrative guidelines.

Out-of-Pocket Costs: The portion of dental fees that you pay. Out-of-pocket costs include your copayment, any amount exceeding the maximum benefit amount, and services not covered by the dental plan.

Participating Dentist: A dentist who contracts with Delta Dental and agrees to abide by certain administrative guidelines.

PPO Allowed Amount: For covered services, the PPO Allowed Amount is either the Delta Dental PPO Maximum Plan Allowance or the equivalent amount set for PPO Participating Dentists of other state Delta Dental Plans or the charged fee, whichever is less. For non-covered services, the PPO Allowed Amount is zero.

Premier Allowed Amount: For covered services, the Premier Allowed Amount is either the Delta Dental Premier Maximum Plan Allowance or the charged fee, whichever is less. For non-covered services, the Premier Allowed Amount is zero.

Pre-Treatment Estimate: A pre-treatment estimate gives a non-binding estimate of how much of a proposed treatment plan will be covered under an enrollee's dental program and what the enrollee's out-of-pocket cost will be.

Primary Enrollee: An employee who is enrolled in this dental plan.

Services: Treatment performed by a dentist or under his/her supervision and direction and when necessary, customary and reasonable, as determined by Delta Dental, using standards of generally accepted dental practice.

Single Procedure: A dental procedure to which a separate procedure number is assigned by Delta Dental.

Submitted Amount: The amount the dental office actually submits on the claim form. This is the fee normally charged by the dentist for services provided to all enrollees, regardless of insurance coverage.

Treatment: A caring for or dealing with an oral condition.

SCHEDULE II

DELTA DENTAL PPO[SM] DENTAL SERVICE CONTRACT
FOR EXPERIENCE RATED GROUPS

Group No.	Group Name	Effective Date
04476	THE CLEMENS FAMILY CORPORATION HEALTH BENEFIT PLAN	May 1, 2019

In order to obtain the maximum benefit under this Contract, Enrollees must have Services performed by a PPO Dentist. Higher patient co-payment, or higher deductibles or lower maximums, or any combination of these will be applied to Services performed by Participating Dentists who are not PPO Dentists and Non-Participating Dentists. Differences in co-payment, deductibles and maximums for Services provided by PPO Dentists versus Services provided by Participating Dentists who are not PPO Dentists and Non-Participating Dentists are set forth in Section 2, Subsection C of this Schedule II. There will be no limit to the amount of balance billing to Enrollees for Services performed by a Non-Participating Dentists.

SECTION 1. SERVICES

Subject to the exclusions, conditions and limitations hereinafter set forth, each Enrollee hereunder shall be entitled to the following benefits **as indicated by a check in the box preceding the applicable benefit**:

A. Basic Benefits consisting of:

☒ 1. Diagnostic. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, procedures to assist Dentists in evaluating the existing conditions to determine the required dental Treatment.

☒ 2. Preventive. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, procedures to prevent the occurrence of all disease. These services include:

a. Prophylaxis
b. Topical application of fluoride solutions
c. Space maintainers when used to maintain existing space to age 14
d. Sealants to age 14

☒ 3. Basic Restorative. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, amalgam, synthetic porcelain and plastic restorations for Treatment of carious lesions.

☒ 4. Major Restorative. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, single crowns, inlays and onlays, gold or cast restorations when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.

☒ 5. Oral Surgery. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for extraction and other oral surgery including pre- and post-operative care.

☒ 6. Endodontics. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for pulpal therapy and root canal filling.

☒ 7. Non-Surgical Periodontics. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for non-surgical Treatment of disease of the gums and supporting structures of the teeth.

☒ 8. Prosthodontics. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, materials and procedures for constructions of bridges, partial and complete dentures, implant surgical placement and removal; and for implant support prosthetics, including implant repair and recementation.

☒ 9. Orthodontics. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, materials, devices and procedures for the correction of malposed teeth.

☒ 10. Surgical Periodontics. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for surgical Treatment of disease of the gums and supporting structures of the teeth.

☒ 11. General Anesthesia. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for general anesthesia and IV sedation when administered by a Dentist for a covered oral surgery procedure or for select endodontic and periodontic surgeries.

SECTION 2. GENERAL EXCLUSIONS AND LIMITATIONS

A. Excluded Benefits:

1. Treatment or materials which are benefits to an Enrollee under Medicare or Medicaid unless this exclusion is prohibited by law.

2. Treatment or materials with respect to congenital skeletal malformation or Treatment of enamel hypoplasia (lack of development), except that this exclusion shall not affect eligible newborn children as described in the definition of Dependent in Article I of the Contract so long as such dependent children continue to be eligible. When Services are not excluded under this provision as to Dependent children who continue to be eligible, other limitations and exclusions of this Schedule shall specifically apply.

3. Treatment that increases the vertical dimension of an occlusion, replace tooth structure lost by attrition or erosion, or otherwise unless it is part of a Treatment dentally necessary due to accident or injury and directly attributable thereto or a covered procedure in a Rider to this Schedule.

4. Treatment or materials primarily for cosmetic purposes including but not limited to Treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a Treatment dentally necessary due to accident or injury and directly attributable thereto. If Services are not excluded as to particular teeth under this provision, cosmetic Treatment of teeth adjacent or near the affected ones is excluded.

5. Treatment or materials for which the Enrollee would have no legal obligation to pay.

6. Services provided or materials furnished prior to the effective eligibility date of an Enrollee under this Contract unless the Treatment was a year in duration and was completed after the Enrollee became eligible except insofar as the limitations in Section 2, Subsection B, Paragraphs 2 and 5 of the Schedule do not apply.

7. Periodontal splinting, equilibration, gnathological recordings and associated Treatment and extra-oral grafts.

8. Preventive plaque control programs, including oral hygiene instruction programs.

9. Myofunctional therapy, unless covered by the exception in Section 2, Subsection A, Paragraph 2 of this Schedule or a covered procedure in a Rider to this Schedule.

10. Temporomandibular joint dysfunction, unless covered by the exception in Section 2, Subsection A, Paragraph 2 of this Schedule or under a Rider to this Schedule.

11. Prescription drugs including topically applied medication for Treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in Section 1, Subsection A, Paragraph 11 of this Schedule or in a Rider to this Schedule.

12. Experimental procedures which have not been accepted by the American Dental Association.

13. Services provided or materials furnished after the termination date of coverage for which Premium has been paid, as applicable to individual Enrollees or Company, except this shall not apply to Services commenced while the Contract was in effect or the Enrollee was eligible.

14. Treatment or materials provided in a hospital or any other surgical Treatment facility except as a covered benefit in Section 1, Subsection A of this schedule.

15. Dental practice administrative services including but not limited to, preparation of claims, any non-Treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing Treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.

16. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.

17. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered benefit.

B. Benefits to Enrollees shall be limited as follows unless otherwise limited under separate Rider(s) to this Schedule:

1. Limitation on Optional Treatment Plan. In all cases in which there are optional plans of Treatment carrying different Treatment costs, payment will be made only for the applicable percentage of the least costly course of Treatment, so long as such Treatment will restore the oral condition in a professionally accepted manner, with the balance of the Treatment cost remaining the responsibility of the Enrollee. Such optional Treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.

2. Limitation on Major Restorative Benefits. If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the Enrollee and the Dentist select another type of restoration, the obligation of Delta Dental shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the Treatment shall be considered a dental Treatment excluded from coverage under this Contract. Replacement of crowns, jackets, inlays and onlays shall be provided no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied, whether paid for under the provisions of this Contract, under any prior dental care contract, or by the Enrollee.

3. Limitation on Diagnostic Aids. Full mouth x-rays and panorex x-rays accompanied by bitewing x-rays are limited to once in any three-year period. Bitewing x-rays are limited to twice in any Contract-Year period. Periodic examinations of the full mouth are limited to twice in any Contract-Year period. When an eligible Enrollee is pregnant one additional oral examination shall be benefited during the Contract-Year period.*

4. Limitation on Prophylaxes and Fluoride. Prophylaxes and fluoride application may be performed either together or separately. Prophylaxes are limited to twice in any Contract-Year period. When an eligible Enrollee is pregnant, the Enrollee shall receive an additional pregnancy benefit which includes either one (1) additional routine prophylaxis during the Contract-Year period or one (1) additional periodontal scaling and root planing per quadrant in any Contract-Year period, subject to the normal periodontal reporting guidelines.* Fluoride applications as a benefit are limited to twice in any Contract-Year period up to age 19.

5. Limitation on Prosthodontic Benefits. Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances fit will be provided in accordance with the Contract. Prosthodontic appliances and abutment crowns will be replaced only after five (5) years have elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.

*Written confirmation of the pregnancy must be provided by the Enrollee or her Dentist when the claim is submitted.

Implants provided under any Delta Dental plan will be replaced only after five (5) years have passed. Replacement of an implant supported prosthesis not provided under a Delta Dental program will be covered if it is unsatisfactory and cannot be made satisfactory. Implant removal is limited to once for each tooth during the Enrollee's lifetime.

6. Limitation on Orthodontic Benefits. Orthodontic benefits are limited to devices and procedures for the correction of malposed teeth of Dependents up to age 19, through the completion of the procedures; or to the date eligibility terminates or the Contract terminates, which ever occurs first. Delta Dental shall pay half of the orthodontic payment at the time of banding and the remaining half shall be paid one year later. If the Treatment is 12 months or less, Delta Dental's orthodontic payment will be paid as a lump sum at the beginning of the orthodontic Treatment. The obligation of Delta Dental to make payments for orthodontic Treatment will cease upon termination of Treatment for any reason, prior to completion of the procedure. Delta Dental will not make any payment for repair or replacement of orthodontic appliances furnished pursuant to the Contract.

7. Limitation on Oral Surgery Benefits. Benefits for specific oral surgery procedures, including but not limited to reduction of fractures, removal of tumors, and removal of impacted teeth payable under a medical insurance contract or a medical or hospital service contract by which the Enrollee is covered shall be determined first under this contract. Delta Dental's obligation for these oral surgery Services shall be limited to the difference between benefits paid under such other contracts up to the Allowed Amount for the procedure less the applicable deductible and patient co-payment. When there is no medical or hospital coverage, Delta Dental's obligation for oral surgery Services shall be limited to the Allowed Amount for those Services provided under the Contract less the applicable deductible and patient co-payment.

8. Limitation on Periodontal Surgery. Benefits for periodontal surgery in the same quadrant are limited to once in any five-year period. The five-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this Contract, under any prior dental contract, or by the Enrollee.

9. Limitation on Sealants. Treatment with sealants as a covered Service is limited to applications to eight posterior teeth. Applications to deciduous teeth or teeth with caries are not covered Services. Sealants will be replaced only after three (3) years have elapsed following any prior provision of such materials.

10. Limitation on Occlusal Restorations. Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve months, and two or three surface restorations within six months, which include occlusal surfaces on which sealants have been placed are not covered Services under Section 1, Subsection A, Paragraph 3 of Schedule II. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six months after a sealant has been applied to that tooth, the obligation of Delta Dental shall be only to pay the fee appropriate to the restoration in excess of the fee paid for the application of the sealant.

C. Payments for Services to Enrollees shall be limited as follows:

1. Offset for Workers' Compensation. Services or supplies for injuries or conditions which are compensable under Workers' Compensation or Employers' Liability laws shall be an offset against amounts payable under this Contract. The offset shall be credited against the obligation of Delta Dental and Enrollee in the percentages set forth in Section 2, Subsection C, Paragraph 3 of this Schedule.

2. Deductible:

a. If Services are provided by a PPO Dentist, Delta Dental shall not be obligated to pay for or otherwise discharge, in whole or in part, a deductible consisting of the first $n/a of fees for Services, calculated in accordance with Article VI, which are covered benefits received by an Enrollee under the Contract. Such deductible amount shall not exceed $n/a for all Enrollees in a single Family.

b. If Services are provided by a Participating Dentist who is not a PPO Dentist or a Non-Participating Dentist, Delta Dental shall not be obligated to pay for or otherwise discharge, in whole or in part, a deductible consisting of the first $n/a of fees for Services, calculated in accordance with Article VI, which are covered benefits received by an Enrollee during the Contract Term. Such deductible amount shall not exceed $n/a for all Enrollees in a single Family.

c. Such deductible amount shall apply:

n/a Once each Calendar Year or portion thereof during which the Enrollee is continuously eligible under this Contract.
n/a Once each Contract Year or portion thereof during which the Enrollee is continuously eligible under this Contract.
n/a Once in the lifetime of the Enrollee.

d. Payments by Enrollees for Services which are not Contract benefits, co-payment made by Enrollees pursuant to Schedule II, Section 2, Subsection C, Paragraph 3, and payments made to Non-Participating Dentists in excess of fees for Services calculated in accordance with Article VI shall not be counted in determining whether the deductible amount has been satisfied.

3. Co-Payment:

a. If Services are provided by a PPO Dentist, Enrollee shall pay a proportionate share of the fee as calculated in accordance with Article VI, after application of the deductible set forth in Schedule II, Section 2, Subsection C, Paragraph 2a, as follows:

SERVICES PERFORMED		PAID BY DELTA DENTAL	PAID BY PATIENT AS CO-INSURER
I.	Diagnostic	100%	0%
II.	Preventive	100%	0%
III.	Basic Restorative	80%	20%
IV.	Major Restorative	50%	50%
V.	Oral Surgery	80%	20%
VI.	Endodontics	80%	20%
VII.	Non-Surgical Periodontics	80%	20%
VIII.	Prosthodontics	50%	50%
IX.	Orthodontics	50%	50%
X.	Surgical Periodontics	80%	20%
XI.	General Anesthesia	80%	20%

b. If Services are provided by a Participating Dentist who is not a PPO Dentist or a Non-Participating Dentist, Enrollee shall pay a proportionate share of the fee as calculated in accordance with Article VI, after application of the deductible set forth in Schedule II, Section 2, Subsection C, Paragraph 2b, as follows: Delta Dental does not limit charges of Non-Participating Dentists, so they may charge amounts in excess of Delta Dental benefits and patient co-payment to the Enrollee.

SERVICES PERFORMED		PAID BY DELTA DENTAL	PAID BY PATIENT AS CO-INSURER
I.	Diagnostic	100%	0%
II.	Preventive	100%	0%
III.	Basic Restorative	80%	20%
IV.	Major Restorative	50%	50%
V.	Oral Surgery	80%	20%
VI.	Endodontics	80%	20%
VII.	Non-Surgical Periodontics	80%	20%
VIII.	Prosthodontics	50%	50%
IX.	Orthodontics	50%	50%
X.	Surgical Periodontics	80%	20%
XI.	General Anesthesia	80%	20%

4. Maximum:

a. If Services are provided by a PPO Dentist, the maximum amount payable provided to any Enrollee for benefits as defined in Schedule II, Section 1 and limited by any deductibles and the co-payment set forth in Schedule II, Section 2, Subsection C, Paragraphs 2a and 3a respectively is $1,500.00.

b. If Services are provided by a Participating Dentist who is not a PPO Dentist or a Non-Participating Dentist, the maximum amount payable provided to any Enrollee for benefits as defined in Schedule II, Section 1 and limited by any deductibles and the co-payment set forth in Schedule II, Section 2, Subsection C, Paragraphs 2b and 3b respectively is $1,500.00.

c. Such maximum amount shall apply:

n/a For each Calendar Year or portion thereof during which the Enrollee is continuously eligible under this Contract.

x For each Contract Year or portion thereof during which the Enrollee is continuously eligible under this Contract.

n/a To all benefits except the following:

Diagnostic and Preventive.

d. If Services are provided by a PPO Dentist, the maximum amount payable for orthodontics for the lifetime of the Enrollee, whether paid for under the provisions of this Contract or under any prior dental care contract for benefits as defined in Schedule II, Section 1 and limited by any deductibles and the co-payment set forth in Schedule II, Section 2, Subsection C, Paragraphs 2a and 3a respectively shall be $1,000.00.

e. If Services are provided by a Participating Dentist who is not a PPO Dentist or a Non-Participating Dentist, the maximum amount payable for orthodontics for the lifetime of the Enrollee, whether paid for under the provisions of this Contract or under any prior dental care contract for benefits as defined in Schedule II, Section 1 and limited by any deductibles and the co-payment set forth in Schedule II, Section 2, Subsection C, Paragraphs 2b and 3b respectively shall be $1,000.00.

5. Emergency Services. When emergency Treatment is necessary and the Enrollee cannot attend a PPO Dentist, payment for such emergency Services shall be limited to any applicable deductibles, co-payment and maximums set forth in Schedule II, Section 2, Subsection C, Paragraphs 2a, 3a, and 4a, as if the emergency Services were provided by a PPO Dentist. Emergency Services include emergency examinations and emergency palliative Treatment to relieve acute pain. Documentation of the emergency nature of such Services including radiographs and/or a narrative from the treating Dentist may be required by Delta Dental. Should the patient receive further Services from the same treating Dentist, payment will be calculated in accordance with Article VI, Paragraph B.

6. Reduction for Automobile Insurance Benefits. Fees for Services or supplies for injuries or conditions payable under this Contract shall be reduced by the amount of any first party benefits under automobile insurance and by any catastrophic loss benefits paid by the Catastrophic Loss Trust Fund. Fees not paid as first party benefits shall be payable proportionately as the obligation of Delta Dental and Enrollee in the percentages set forth in Section 2, Subsection C, Paragraph 3 of this Schedule.

   Any deductible under Section 2, Subsection C, of this Schedule shall be considered satisfied to the extent of first party benefits under automobile insurance and by any catastrophic loss benefits paid by the Catastrophic Loss Fund.

D. Notification for Enrollees:

When a claim for Services is approved for payment, Delta Dental shall notify the Enrollee of the Dentist's charge, Delta Dental's calculation of the PPO Allowed Amount, or Delta Dental's calculation of the Allowed Amount as defined in Article I, and amounts for which the Enrollee is obligated to pay under this Contract.

If the Services are provided by a PPO Dentist, the Enrollee's obligation to pay the PPO Dentist is limited to any applicable deductible and co-payment, and any portion of the PPO Allowed Amount which exceeds applicable program maximums.

If the Services are provided by a Participating Dentist who is not a PPO Dentist, the Enrollee's obligation to pay that Participating Dentist is limited to any applicable deductible, co-payment, and any portion of the Allowed Amount, as defined in Article I, which exceeds applicable program maximums.

If the Services are provided by a Non-Participating Dentist, the Enrollee's payment obligation to the Non-Participating Dentist is not limited by this Contract.

IN WITNESS WHEREOF, the parties hereto have caused this Schedule II to be substituted for the Schedule II attached to the original contract; in all other respects the original contract shall remain in full force and effect.

THE CLEMENS FAMILY CORPORATION HEALTH BENEFIT PLAN

By: _____

Title: _____

DELTA DENTAL OF PENNSYLVANIA

By: _____

Title: EVP, Chief Legal Officer

RIDER

To

SCHEDULE II

DENTAL SERVICE CONTRACT

Group No.	Group Name	Effective Date
04476	THE CLEMENS FAMILY CORPORATION HEALTH BENEFIT PLAN	May 1, 2019

SECTION 1. SERVICES

Subject to the exclusions, conditions and limitations in Schedule II and as modified herein, each Enrollee shall be entitled to the following benefit **as indicated by a check in the box preceding the applicable benefit**:

A. Basic Benefits Consisting of:

☒ Denture Repair. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for repair of broken, complete or partial dentures, repair or replacement of broken teeth on dentures, reattachment, replacement or repair of broken clasps on dentures.

SECTION 2. GENERAL EXCLUSIONS AND LIMITATIONS

A. Excluded Benefits:

Materials and procedures for construction of bridges, partial and complete dentures, except as a covered benefit in Section 1, Subsection A of this Rider, or except where prosthodontics are a covered benefit in Section 1, Subsection A of Schedule II.

B. Benefits to Enrollees shall be limited as follows:

Limitation on Prosthodontic Benefits. If prosthodontics are a benefit under Section 1, Subsection A of Schedule II, the Limitation on Prosthodontics, found in Section 2, Subsection B of Schedule II shall be modified to the extent that the Services described therein are a covered benefit in Section 1, Subsection A of this Rider.

C. Payments for Services to Enrollees shall be limited as follows:

Co-Payment:

Enrollee shall pay a proportionate share of the fee as calculated in accordance with Article VI, after application of the deductible, as follows:

SERVICE PERFORMED	PAID BY DELTA DENTAL	PAID BY PATIENT AS CO-INSURER
Denture Repair	80%	20%

In all other respects the above referenced Contract shall be in full force and effect.

THE CLEMENS FAMILY CORPORATION HEALTH BENEFIT PLAN

By: _____

Title: _____

DELTA DENTAL OF PENNSYLVANIA

By: _____

Title: EVP, Chief Legal Officer

RIDER

To

SCHEDULE II

DENTAL SERVICE CONTRACT

Group No.	Group Name	Effective Date
04476	THE CLEMENS FAMILY CORPORATION HEALTH BENEFIT PLAN	May 1, 2019

SECTION 1. SERVICES

Subject to the exclusions, conditions and limitations in Schedule II and as modified herein, each Enrollee shall be entitled to the following benefit **as indicated by a check in the box preceding the applicable benefit**:

A. Basic Benefits consisting of:

☒ Denture Relining. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for relining of complete or partial dentures performed at a Dentist's office or by a laboratory.

SECTION 2. GENERAL EXCLUSIONS AND LIMITATIONS

A. Excluded Benefits:

Materials and procedures for construction of bridges, partial and complete dentures, except as covered benefit in Section 1, Subsection A of this Rider, or except where Prosthodontics are a covered benefit in Section 1, Subsection A of Schedule II.

B. Benefits to Enrollees shall be limited as follows:

Limitation on Prosthodontic Benefits. If Prosthodontics are a benefit under Section 1, Subsection A of Schedule II, the Limitation on Prosthodontics, found in Section 2, Subsection B of the Schedule II shall be modified to the extent that the Services described therein are a covered benefit in Section 1, Subsection A of this Rider.

C. Payments for Services to Enrollees shall be limited as follows:

Co-Payment:

Enrollees shall pay a proportionate share of the fee as calculated in accordance with Article VI, after application of the deductible, as follows:

SERVICES PERFORMED	PAID BY DELTA DENTAL	PAID BY PATIENT AS CO-INSURER
Denture Relining	80%	20%

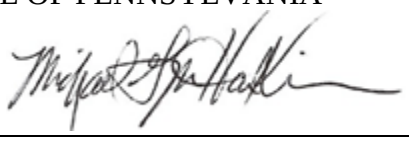
In all other respects the above referenced Contract shall be in full force and effect.

THE CLEMENS FAMILY CORPORATION HEALTH BENEFIT PLAN

By: _____

Title: _____

DELTA DENTAL OF PENNSYLVANIA

By: 

Title: EVP, Chief Legal Officer

Employee Group Benefits

UNDERWRITTEN BY

SUN LIFE ASSURANCE COMPANY OF CANADA

HOME OFFICE: TORONTO, CANADA

Clemens Family Corporation

YOUR GROUP LIFE INSURANCE CONTAINS AN ACCELERATED BENEFITS OPTION. DEATH BENEFITS WILL BE REDUCED IF AN ACCELERATED BENEFIT IS PAID. RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE. ASSISTANCE SHOULD BE SOUGHT FROM YOUR TAX ADVISOR.

GROUP POLICY NUMBER - 230523-001
BOOKLET EFFECTIVE DATE - May 1, 2013
BOOKLET AMENDMENT DATE - April 1, 2020

Welcome to Sun Life Assurance Company of Canada ("Sun Life"). Sun Life is pleased to be your Employer's insurance carrier for the benefits provided in the Group Policy. The description of Eligible Classes in the Benefit Highlights will help you determine what benefits apply to you.

The booklet is intended to provide a summarized explanation of the current Group Policy Benefits. However, the Group Policy is the document which forms Sun Life's contract to provide benefits. If the terms of the booklet and the Group Policy differ, the Group Policy will govern. A complete copy of the Group Policy is in the possession of your Employer and is available for your review. In the event of any changes in benefits or Group Policy provisions, you will be provided with a new booklet or a supplement which describes any changes.

Possession of this booklet does not necessarily mean you are insured under the Group Policy. The requirements for becoming eligible for insurance and the dates your insurance begins or ceases are explained within this booklet.

This booklet uses insurance terms and phrases that are listed in the Definitions Section.

For information, call the Sun Life Group Customer Service Center toll free at (800) 247-6875.

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EMPLOYEE LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

ELIGIBLE CLASSES

All Full-Time United States Benefit Level 05, 25, 35, 45, 50, 55, 60, 65, 70 and 75 Employees working in the United States scheduled to work at least 30 hours per week.

CLASSIFICATION

1 All Eligible Hourly Employees Benefit Level 05 and 25
2 All Eligible Salaried Employees Benefit Level 05 and 25
3 All Eligible Employees Benefit Level 35
4 All Eligible Employees Benefit Level 45
5 All Eligible Employees Benefit Level 50
6 All Eligible Employees Benefit Level 55
7 All Eligible Employees Benefit Level 60 and 65
8 All Eligible Employees Benefit Level 70
9 All Eligible Employees Benefit Level 75

CLASS	LIFE	AD&D
1 and 2	$15,000	$15,000
3, 4 and 5	$75,000	$75,000
6	$150,000	$150,000
7	$400,000	$400,000
8 and 9	$500,000	$500,000

Your amount of Life and Accidental Death and Dismemberment Insurance reduces to 50% when you reach age 70.

Your Life and Accidental Death and Dismemberment Insurance cancels at your retirement.

BENEFIT HIGHLIGHTS

WAITING PERIOD

(The period of time you must be employed in an Eligible Class before you can apply for benefits)

All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina hired prior to December 9, 2019
None

All Other Eligible Employees
Until the first of the month coincident with or next following 60 days of employment

CONTRIBUTIONS

The cost of your Employee Life and Employee Accidental Death and Dismemberment Insurance is paid for entirely by your Employer. This is your non-contributory insurance.

The following Questions and Answers will help you to better understand your benefits.

Please read them carefully and refer any questions to your Employer or call the Sun Life Group Customer Service Center toll free at 1-800-247-6875.

ELIGIBILITY AND EFFECTIVE DATE OF EMPLOYEE INSURANCE

When am I eligible for insurance?

If you are in an Eligible Class shown in the Benefit Highlights, you are eligible on the later of:
- May 1, 2013; or
- December 9, 2019 for All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina; or
- the first day of the month coincident with or next following the date you complete your Waiting Period.

When does my insurance start?

Your insurance starts on the date you are eligible, if you are Actively at Work on that date.

What if I am not Actively at Work on that date?

If you are not Actively at Work on the date your insurance would normally start, your insurance will not start until you are Actively at Work.

When do changes in my amount of insurance occur?

If your amount of insurance increases, your increase will take effect immediately upon the date of change, as long as you are Actively at Work on that date.

If your amount of insurance decreases, your decrease will take effect immediately upon the date of change.

If you are not Actively at Work on the date an increase in your insurance would normally start, the increase in your insurance will not start until you are Actively at Work.

TERMINATION OF EMPLOYEE INSURANCE

When does my insurance cease?

Your insurance ceases on the earliest of:
- the date the Group Policy terminates.
- the date you are no longer in an Eligible Class.
- the date your class is no longer included for insurance.
- the last day for which any required premium has been paid for your insurance.
- the date you retire.
- the date you request in writing to terminate your insurance.
- the date you enter active duty in any armed service during a time of war (declared or undeclared).
- the date your employment terminates.
- the date you cease to be Actively at Work.

Are there any conditions under which my insurance can continue?

Yes.

Your insurance will continue during any period the premium for your insurance is waived under the Group Policy.

If you are on temporary layoff, leave of absence or vacation, your Employer may continue your insurance by paying the required premium for the length of time specified below.

Layoff - up to 1 month.
Leave of Absence – up to 1 month
Vacation – up to 3 months

If you are absent from work due to an injury or sickness, your Employer may continue your Life and Accidental Death and Dismemberment insurance, by paying the required premium, for up to 12 months.

If you are "Totally Disabled" you may be eligible for a longer continuation of Life Insurance. Refer to "What is the Waiver of Premium Provision" in the Life Benefit Section. Please note you need to apply for continued benefits under the Waiver of Premium Provision within 12 months after you cease to be Actively at Work.

If your coverage terminates and you are not eligible for any of the described continuations, you may be eligible for a Conversion Privilege. Refer to the "Conversion Privilege" in the Life Benefit section. Please note that you need to apply for the conversion and pay the required premium within 31 days following your termination of insurance.

You may be eligible to continue your insurance coverage pursuant to the Family and Medical Leave Act of 1993, as amended or continue coverage pursuant to a state required continuation period (if any). You should contact your Employer for more details.

You may be eligible to continue your insurance coverage pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA). You should contact your Employer for more details.

BENEFIT PROVISIONS

EMPLOYEE LIFE INSURANCE

What is the Life Insurance Benefit?

If you die while insured, your Beneficiary will receive the amount of your Life Insurance in force when Sun Life receives written Notice and Proof of Claim.

What is the amount of my Life Insurance?

The amount of your Life Insurance as determined in the Benefit Highlights.

Your amount of Life Insurance is subject to any age reductions or terminations shown in the Benefit Highlights.

What is the Waiver of Premium Provision?

If you become Totally Disabled while insured, the Waiver of Premium Provision may continue your Life Insurance without any further payment of premiums by you or your Employer.

When am I eligible for the Waiver of Premium Provision?

You are eligible if Sun Life receives Notice and Proof of Claim that you became Totally Disabled:
- while insured; and
- before your 70th birthday; and
- before you retire.

What is the amount of Life Insurance that is continued under the Waiver of Premium Provision?

For Total Disabilities that begin before age 65, Sun Life will continue the amount of your Life Insurance in force on the last day you were Actively at Work. This amount is subject to the same reductions or terminations that would have been applicable had you not become Totally Disabled.

For Total Disabilities that begin on or after age 65 but before 70, Sun Life will continue the amount of your Life Insurance in force on the last day you were Actively at Work for a period of up to 1 year. This amount is subject to the same reductions or terminations that would have been applicable had you not become Totally Disabled.

If you have converted your Life Insurance to an individual policy, the continued insurance will be reduced by that converted amount unless you exchange that individual policy for a full refund of premiums paid.

When does my Waiver of Premium cease?

Your Waiver of Premium ceases on the earliest of:
- the date you are no longer Totally Disabled.
- the date you do not provide Proof that you continue to be Totally Disabled.
- the date you do not submit to an examination by a Physician of Sun Life's choice.
- the date you are no longer under the regular and continuing care of a Physician providing appropriate treatment by means of examination and testing in accordance with your disabling condition.
- the date you reach age 65 or for 12 months, whichever is later, if your Total Disability began before you reached age 65.
- the first anniversary after your Total Disability began for Total Disabilities that begin on or after you reach age 65.
- the date you retire.

For the purposes of this Waiver of Premium Provision, you are considered retired when you receive any compensation from a Retirement Plan of your Employer, or when you reach age 70, whichever is earlier.

If your Waiver of Premium ceases and you do not return to work with your Employer, your Life Insurance will terminate. You may be eligible to convert your Life Insurance under the Conversion Privilege.

BENEFIT PROVISIONS

EMPLOYEE LIFE INSURANCE

Applicable to All Employees Excluding All Employees Benefit Level 05 and 25

Receipt of Accelerated Benefits may be taxable. Assistance should be sought from your personal tax advisor.

Note: Death Benefits will be reduced if an Accelerated Benefit is paid.

What is the Accelerated Benefit Terminal Condition Coverage?

If Sun Life receives satisfactory proof that you have a Terminal Condition, part of your Life Insurance may be payable to you while you are still living.

When am I eligible for an Accelerated Benefit?

You are eligible if:

(Applicable if you were hired on or before May 1, 2013)

- you were Actively at Work on May 1, 2013; and

(Applicable to All Employees)

- you are certified by a Physician as having a Terminal Condition; and
- you are insured for at least $20,000 of Life Insurance.

How do I receive an Accelerated Benefit?

You need to submit a written request to Sun Life.

If you have assigned your Life Insurance or named an irrevocable Beneficiary, you must have a signed agreement from those parties.

What is the amount of Accelerated Benefit?

You can request up to 75% of the amount of your Life Insurance currently in effect. The maximum amount you can request is $500,000. The minimum amount that you may request is the greater of 25% of the amount of your Life Insurance in force or $10,000.

How is the Accelerated Benefit paid?

The Accelerated Benefit is paid in one lump sum amount.

Can I receive more than one Accelerated Benefit?

You may request the Accelerated Benefit only once under Sun Life's Group Policy.

Are there any charges if I request an Accelerated Benefit?

No.

What happens to my Life Insurance if I receive an Accelerated Benefit?

If you have received an Accelerated Benefit, your Life Insurance will be reduced by an amount equal to the Accelerated Benefit paid by Sun Life.

If you request an Accelerated Benefit, you will receive a Benefit Payment Notice which outlines the Accelerated Benefit payment made, the remaining amount of your Life Insurance in force and the required premium, if any, on the remaining amount of your Life Insurance.

Some Important Notes about your Accelerated Benefit

Your Accelerated Benefit is not a long term care policy. The amount your Accelerated Benefit would pay may not be enough to cover nursing home expenses or other bills. You may use the money received from the Accelerated Benefit for any purpose.

Receipt of your Accelerated Benefit may affect your Medicaid eligibility

No Accelerated Benefit payment will be processed if you are required to request it by a third party, including any creditor, governmental agency, trustee in bankruptcy or any other person, or as the result of a court order.

Benefits payable under this provision MAY be taxable. You should consult your tax advisor. Sun Life does not give tax or legal advice.

Applicable to All Employees

What is the Conversion Privilege?

If your Life Insurance ceases, you may be able to convert your Life Insurance to an individual policy. You need to apply for the Conversion Privilege within 31 days. See question "How do I convert my Life Insurance?".

When can I convert my Life Insurance?

1. You can convert if all or part of your Life Insurance ceases or reduces due to:
   - termination of your employment;
   - termination of your membership in an Eligible Class;
   - your retirement;
   - your reaching a specified age; or
   - your changing to a different Eligible Class; or
   - termination of your Waiver of Premium continuation; or
   - your continuation period ending during your layoff or leave of absence.

2. You can convert if you have been continuously insured for 5 or more years under Sun Life's Group Life Policy and all or part of your Life Insurance ceases or reduces due to:
   - termination of the Life Insurance Benefit Provision;
   - termination of the Group Policy;
   - an amendment to the Group Policy to reduce the amount of Life Insurance in your Eligible Class; or
   - an amendment to the Group Policy to terminate your Eligible Class.

What amount of Life Insurance can I convert?

The amount of Life Insurance you can convert depends on the reason your Life Insurance ceases.

EMPLOYEE LIFE INSURANCE

If your amount of Life Insurance ceased or reduced for the reasons stated in #1 "When can I convert my Life Insurance?", you can convert up to the amount that ceased or reduced. If your amount of Life Insurance that ceased is $10,000 or more, the minimum amount of your individual policy must be $10,000.

If your amount of Life Insurance ceased or reduced for the reasons stated in #2 "When can I convert my Life Insurance?", you can convert up to the lesser of:

- $2,000; or
- the amount that ceased or reduced less any amount of group life insurance you may become eligible for within 31 days after your Life Insurance ceased or reduced.

How do I convert my Life Insurance?

You convert by applying to Sun Life for an individual policy along with sending payment of the first premium within 31 days after any part of your Life Insurance ceases or reduces. This is your 31 day conversion period. However, if you are not notified by your Employer of this conversion privilege, you will have an additional 15 days to exercise this conversion privilege. In no event will this conversion privilege be extended beyond 60 days following your 31 day conversion period.

What type of individual policy is available?

You can convert to any plan of permanent life insurance available by Sun Life for conversion. The individual policy will not include any additional benefits such as disability benefits or accidental death and dismemberment benefits.

You do not have to submit Evidence of Insurability to convert to an individual policy.

When does my individual policy start?

If your application for the individual policy is received and the first premium is paid when due, your individual policy starts on the day after the 31 day conversion period.

What happens if I die during the 31 day conversion period?

If Sun Life receives Notice and Proof of Claim, a death benefit is payable to your Beneficiary, whether or not you had applied for an individual policy or had paid the first premium.

The death benefit is the amount of Life Insurance you would have been eligible to convert.

BENEFIT PROVISIONS

EMPLOYEE LIFE INSURANCE

What happens when my Employer transfers Insurance Carriers to Sun Life?

In order to prevent losing your insurance, Sun Life will provide the following coverage.

If you are not Actively at Work on May 1, 2013*, you will be insured if:

1. you were insured under the prior insurer's group Life policy at the time of the transfer; and
2. you are a member of an Eligible Class; and
3. premiums for you are paid up to date; and
4. you are not receiving or eligible to receive benefits under the prior insurer's group Life policy.

Any Life benefit payable will be the lesser of:
- the Life benefit payable under the Group Policy; or
- the Life benefit payable under the prior insurer's group Life policy had it remained in force.

All other provisions of Sun Life's Group Policy will apply.

* December 9, 2019 for All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

What is the Accidental Death and Dismemberment Benefit?

If Sun Life receives written Notice and Proof of Claim that you:
- died from an accidental drowning while insured; or
- sustained an Accidental Bodily Injury while insured, which results in loss of life, sight or limb; or
- sustained a loss of life, sight or limb due to an accidental exposure to the elements while insured;

an Accidental Death and Dismemberment benefit may be payable to you or to your Beneficiary.

The benefit is a percentage of the amount of Accidental Death and Dismemberment Insurance in force for your class shown in the Benefit Highlights on the date of the Accidental Bodily Injury. The following is a list of percentages payable for the applicable loss.

Life	100%
Sight of one eye	50%
One limb	50%
Speech and hearing	100%
Speech or hearing	50%
Thumb and index finger of the same hand	25%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%

The maximum amount of Accidental Death and Dismemberment Benefit payable for losses resulting from any one accident is 100%.

Loss of limb means severance of the hand or foot at or above the wrist or ankle joint. Loss of sight, speech or hearing must be total and irrecoverable. Loss of thumb and index finger means severance through or above the metacarpophalangeal joints.

Quadriplegia means the total and permanent paralysis of both upper and lower limbs. Paraplegia means the total and permanent paralysis of both lower limbs. Hemiplegia means the total and permanent paralysis of the upper and lower limbs on one side of the body.

What is the Business Travel Benefit?

If your loss of life occurs while traveling on business for your Employer an additional Business Travel Benefit will be payable.

The Business Travel Benefit is the lesser of:
- $25,000; or
- 25% of the amount of Accidental Death Benefit payable.

Business Travel means traveling to another location to conduct the Employer's business other than your normal workplace. Business Travel starts from the time you leave your place of residence to commence your Employer's business until you return to your place of residence. Business Travel does not include personal deviations; nor your vacation.

Personal Deviation means an activity that is not reasonably related to your Employer's business and not incidental to the business trip.

Your place of residence will change to the location of the Business Travel if your stay at that location exceeds 60 days.

What is the Seat Belt Benefit?

If your loss of life occurs as a result of an automobile accident and you were wearing a seat belt at the time of the accident, an additional Seat Belt Benefit is payable.

The Seat Belt Benefit is 25% of the amount of Accidental Death Benefit payable or $25,000, whichever is less.

Sun Life must receive satisfactory written proof that your death resulted from an automobile accident and that you were wearing a seat belt at the time of the accident. A copy of the police report is required.

What is the Air Bag Benefit?

If your loss of life occurs as a result of an automobile accident, you were wearing a seat belt and positioned in a seat protected by a Supplemental Restraint System which inflated on impact, an additional Air Bag Benefit is payable.

The Air Bag Benefit is 10% of the amount of Accidental Death Benefit payable or $5,000, whichever is less.

Sun Life must receive satisfactory written proof that your death resulted from an automobile accident and that the Supplemental Restraint System properly inflated. A copy of the police report is required.

Seat Belt means a properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

Supplemental Restraint System means a factory installed air bag which inflates for added protection to the head and chest areas.

Automobile means a motor vehicle licensed for use on public highways.

What is the Helmet Benefit?

If your loss of life occurs as a result of a Motorcycle accident, you were wearing a helmet, and the driver of the Motorcycle held a valid driver's license with a Motorcycle endorsement, an additional Helmet Benefit is payable.

The Helmet Benefit is 50% of the amount of Accidental Death Benefit payable or $25,000, whichever is less.

Sun Life must receive satisfactory written proof that your death resulted from a Motorcycle accident and that you were wearing a Helmet at the time of the accident. A copy of the police report is required.

Helmet means a protective head covering made of a hard material to resist impact and which is approved by the American National Safety Institute (ANSI) and/or Snell.

Motorcycle means a motor vehicle licensed for use on public highways which requires a Motorcycle endorsement on a driver's license to operate the vehicle.

What happens if I Disappear?

Sun Life will presume, subject to no objective evidence to the contrary, that you are dead and your death is a result of an Accidental Bodily Injury if:
- you disappear as a result of an accidental wrecking, sinking or disappearance of a conveyance in which you were known to be a passenger; and
- your body is not found within 365 days after the date of the conveyance's disappearance.

What is the Bereavement Counseling Benefit?

A Bereavement Counseling Benefit is payable for up to 12 months of an Immediate Family Member's period of bereavement if you die and an Accidental Death Benefit is payable under the Group Policy.

Immediate Family Member means you, your spouse or your child under age 19 or age 23 if a full-time student

What expenses are reimbursed under the Bereavement Counseling Benefit?

The Bereavement Counseling Benefit equals the Immediate Family Member's incurred expenses for counseling reduced by any reimbursement the Immediate Family Member receives for counseling from other sources.

The Maximum Bereavement Counseling Benefit payable is $250 per Immediate Family Member, to a maximum of $1,000 per insured's death.

Written Proof of the actual out of pocket counseling expenses incurred must be submitted to Sun Life prior to payment.

What is the Dependent Education Benefit?

If you die and an Accidental Death Benefit is payable under the Group Policy, your Dependent may be eligible for a Dependent Education Benefit.

What is the Education Benefit for my Dependent Child?

A Dependent Child is eligible for an Education Benefit if the Dependent Child enrolls as a full-time student at a post-secondary school before reaching age 23 and within 1 year after your date of death.

The annual Dependent Child's Education Benefit is the lesser of:
- Incurred Expenses; or
- $2,500; or
- 5% of your amount of Accidental Death Benefit payable.

The Dependent Child Education Benefit is payable at the end of each semester per dependent child, for a maximum of four consecutive years per child. Proof of the child's enrollment and Incurred Expenses are required each semester prior to payment of the benefit.

Incurred Expenses include tuition, fees, cost of books, room and board, transportation and any other costs paid directly to the school.

What is the Education Benefit for my Dependent Spouse?

A Dependent Spouse is eligible for an Education Benefit if the Dependent Spouse enrolls in any school for the purpose of retraining or developing skills needed for employment within 1 year after your date of death.

The Dependent Spouse's Education Benefit is equal to the expenses paid directly to such school or $3,000, whichever is less. Proof of enrollment and expenses are required prior to payment of the benefit.

What are the Exclusions?

No AD&D benefit will be payable for your loss that is due to or results from:

- suicide while sane or insane.
- intentionally self-inflicted injuries**.**
- bodily or mental infirmity or disease of any kind, or an infection unless due to an Accidental cut or wound.
- your committing or attempting to commit a felony or other criminal act.
- active participation in a war (declared or undeclared) or active duty in any armed service during a time of war.
- your active participation in a riot, rebellion, or insurrection.
- injury sustained from any aviation activities, other than your riding as a fare-paying passenger.
- your voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless administered on the advice of a Physician.
- your operation of any motorized vehicle while intoxicated. Intoxicated means the minimum blood alcohol level required to be considered operating an automobile under the influence of alcohol in the jurisdiction where the accident occurred. For the purposes of this Exclusion, "Motorized Vehicle" includes, but is not limited to, automobiles, motorcycles, boats and snowmobiles.

BENEFIT PROVISIONS

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

What happens when my Employer transfers Insurance Carriers to Sun Life?

In order to prevent losing your insurance, Sun Life will provide the following coverage.

If you are not Actively at Work on May 1, 2013* you will be insured if:

1. you were insured under the prior insurer's group AD&D policy at the time of transfer; and
2. you are a member of an Eligible Class; and
3. premiums for you are paid up to date; and
4. you are not receiving or eligible to receive benefits under the prior insurer's group AD&D policy.

Any AD&D benefit payable will be the lesser of:
- the AD&D benefit payable under the Group Policy; or
- the AD&D benefit payable under the prior insurer's group AD&D policy had it remained in force.

All other provisions of Sun Life's Group Policy will apply.

* December 9, 2019 for All Eligible Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina

CLAIM PROVISIONS

How is a claim submitted?

To submit a claim, you or someone on your behalf must send Sun Life written Notice and Proof of Claim within the time limits specified. Your Employer has the Sun Life Notice and Proof of Claim forms.

When does written Notice of Claim have to be submitted?

for a Death Claim - written notice of claim must be given to Sun Life no later than 30 days after the date of death.

for Life Waiver of Premium - written notice of claim must be given to Sun Life no later than 12 months after you cease to be Actively at Work.

for Accidental Dismemberment - written notice of claim must be given to Sun Life no later than 12 months after the date of your loss.

for all other claims - written notice of claim must be given to Sun Life no later than 12 months after the date of loss or within 12 months after the date the expense was incurred.

If notice cannot be given within the applicable time period, Sun Life must be notified as soon as it is reasonably possible.

When Sun Life has received written notice of claim, Sun Life will send the forms for proof of claim. If the forms are not received within 15 days after written notice of claim is sent, proof of claim may be sent to Sun Life without waiting to receive the proof of claim forms.

When does written Proof of Claim have to be submitted?

for a Death Claim - proof of claim needs to be given to Sun Life prior to any payment of a death claim.

for Life Waiver of Premium - proof of claim must be given to Sun Life no later than 15 months after you cease to be Actively at Work.

for Accidental Dismemberment - proof of claim must be given to Sun Life no later than 15 months after the date of your loss.

for all other claims - proof of claim must be given to Sun Life no later than 15 months after the date of loss or within 15 months after the date the expense was incurred.

If proof cannot be given within these time limits, proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time proof is otherwise required unless the individual is legally incompetent.

CLAIM PROVISIONS

What is considered Proof of Claim?

Proof of Claim must consist of at least the following information:
- a description of the loss or disability;
- the date the loss, disability or expense occurred; and
- the cause of the loss, disability or expense.

(For example: a Death Claim would include at least the Death Certificate for Proof of Claim)

Proof of Claim may include, but is not limited to, police accident reports, autopsy reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials as required.

Proof of Claim for disability must include evidence demonstrating the disability including, but not limited to, hospital records, Physician records, Psychiatric records, x-rays, narrative reports, or other diagnostic testing materials as appropriate for the disabling condition.

Proof must be satisfactory to Sun Life.

Sun Life may require as part of the Proof, authorizations to obtain medical and non-medical information.

Proof of your continued disability and regular and continuous care by a Physician must be given to Sun Life within 30 days of the request for proof.

When are benefits payable?

Benefits are payable immediately when Sun Life receives satisfactory Proof of Claim.

When will a decision on my claim be made?

Sun Life will send you a written notice of decision on your claim within a reasonable time after Sun Life receives the claim but not later than 45 days after receipt of the claim. If Sun Life cannot make a decision within 45 days after receiving your claim, Sun Life will request a 30 day extension as permitted by U.S. Department of Labor regulations. If Sun Life cannot render a decision within the extension period, Sun Life will request an additional 30 day extension. Any request for extension will specifically explain:
1. the standards on which entitlement to benefits is based;
2. the unresolved issues that prevent a decision on the claim; and
3. the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date Sun Life sends notice of the extension to you until the date on which you respond to the request for additional information. You will have at least 45 days to provide the specified information.

What if my claim is denied?

If Sun Life denies all or any part of your claim, you will receive a written notice of denial setting forth:
1. the specific reason or reasons for the denial;
2. the specific Group Policy provisions on which the denial is based;
3. your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
4. a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
5. a description of the appeal procedures and time limits;
6. your right to bring a civil action under ERISA, §502(a) following an adverse determination on review;

7. the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request; and
8. the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

Can I request a review of a claim denial?

If all or part of your claim is denied, you may request in writing a review of the denial within 180 days after receiving notice of denial.

You may submit written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

Sun Life will review the claim on receipt of the written request for review, and will notify you of Sun Life's decision within a reasonable time but not later than 45 days after the request has been received. If an extension of time is required to process the claim, Sun Life will notify you in writing of the special circumstances requiring the extension and the date by which Sun Life expects to make a determination on review. The extension cannot exceed a period of 45 days from the end of the initial review period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date Sun Life sends notice of the extension to you until the date on which you respond to the request for additional information. You will have at least 45 days to provide the specified information.

What if my claim is denied on review?

If Sun Life denies all or any part of your claim on review, you will receive a written notice of denial setting forth:
1. the specific reason or reasons for the denial;
2. the specific Group Policy provisions on which the denial is based;
3. your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
4. your right to bring a civil action under ERISA, §502(a);
5. the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request;
6. 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."; and
7. the identity of any medical or vocational experts whose advice was obtained in connection with the appeal, regardless of whether the advice was relied upon to deny the appeal.

Who are benefits payable to?

Benefits payable upon your death are payable to your Beneficiary living at the time (other than your Employer). You must name your Beneficiary on a form acceptable to Sun Life. Unless you otherwise specify, if more than one Beneficiary survives you, all surviving Beneficiaries will share equally. If no Beneficiary is alive on the date of your death, payment will be made to your estate.

If you named Beneficiaries under your Employer's Plan prior to the effective date of the Group Policy, that beneficiary designation will remain in effect unless you elect to change Beneficiaries.

Accidental Death and Dismemberment benefits are payable as shown above unless otherwise specified in the Accidental Death and Dismemberment Benefit Section.

All other benefits payable during your lifetime are payable to you.

If a benefit is payable to your estate, if you are a minor, or you are not competent, Sun Life has the right to pay an amount of the benefit up to $5,000 to any of your relatives that Sun Life considers entitled. If Sun Life pays benefits in good faith to a relative, Sun Life will not have to pay those benefits again.

If your Beneficiary is a minor or is not competent, Sun Life has the right to pay up to $1,000 to the person or institution that appears to have assumed custody and main support for the minor, until the appointed legal representative makes a formal claim. If Sun Life pays benefits in good faith to a person or institution, Sun Life will not have to pay those benefits again.

Can I change my Beneficiary?

You can change your Beneficiary at any time, unless you have stated your choice of Beneficiary is irrevocable or you have assigned your interest in your Life Insurance to another person. Any request for change of Beneficiary must be in a written form and will take effect on the date you sign and file the change with your Employer. If Sun Life has taken any action or made payment before receiving notice of that change, your change of Beneficiary will not affect any action or payment made by Sun Life. The consent of your Beneficiary is not required to change any Beneficiary unless the Beneficiary designation was irrevocable.

Can I assign my Life Insurance?

You can transfer ownership of your Life Insurance under the Group Policy by means of an absolute assignment. You cannot make an absolute assignment to your Employer. All your rights and duties as owner are transferred to the new owner. The new owner can make any change the Group Policy allows, such as a change of Beneficiary.

If you made an assignment under your Employer's plan prior to the effective date of the Group Policy, that assignment remains in force with respect to the Group Policy.

Any assignment must be in a written form and will take effect on the date you sign and file the assignment with your Employer. If Sun Life has taken any action or made payment before receiving notice of that change, the assignment will not affect any action or payment made by Sun Life. Sun Life will not be responsible for the legal, tax or other effects of any assignment.

GENERAL PROVISIONS

How can statements made in any application for insurance be used?

All statements made in any application are considered representations and not warranties. No representation by you in applying for insurance under the Group Policy will be used to reduce or deny a claim unless a copy of your written application for insurance is or has been given to you or to your Beneficiary, if any.

No statement made by you relating to Evidence of Insurability for an initial, increased or additional amount of insurance, will be used in contesting the validity of that insurance, after such initial, increased or additional amount of insurance has been in force for a period of two years during that individual's lifetime. This statement must be contained in a form signed by that individual.

What happens if an age is misstated?

If your age is not accurate:
- an equitable adjustment of premium will be made; and
- the true age will be used to determine if and in what amount insurance is valid under the Group Policy.

If the amount of benefit depends on your age, the benefit will be the amount you would have been entitled to if your correct age were known.

What are Sun Life's examination and autopsy rights?

Sun Life at its own expense, has the right to have any person, whose Injury or Sickness is the basis of a claim:
- examined by a Physician, other health professional or vocational expert of its choice; and/or
- interviewed by an authorized Sun Life representative.

This right may be used as often as reasonably required.

Sun Life has the right, in the case of death, to request an autopsy.

What are the time limits for legal proceedings?

No legal action may start:
- until 60 days after Proof of Claim has been given; nor
- more than 3 years after the time Proof of Claim is required.

Do these group benefits affect Workers' Compensation?

The Group Policy is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance.

Can the Policyholder act as a Sun Life agent?

For all purposes of the Group Policy, the Policyholder or third party administrator acts on its own behalf or as your agent. Under no circumstances will the Policyholder or third party administrator be deemed a Sun Life agent.

DEFINITIONS

These are some of the general terms you need to know.

Actively at Work means that you perform all the regular duties of your job for a full work day scheduled by your Employer at your Employer's normal place of business or a site where your Employer's business requires you to travel.

You are considered Actively at Work on any day that is not your regular scheduled work day (e.g., you are on vacation or holiday) as long as you were Actively at Work on your immediately preceding scheduled work day, and you:
- are not hospital confined; or
- are not disabled due to an injury or sickness.

You are considered Actively at Work if you usually perform the regular duties of your job at your home as long as you can perform all the regular duties of your job for a full work day and could do so at your Employer's normal place of business, if required, and you:
- are not hospital confined; or
- are not disabled due to an injury or sickness.

Eligibility Date means the date or dates you become eligible for insurance under the Group Policy. Classes eligible for insurance are shown in the Benefit Highlights.

Employee (You) means a person who is employed by the Employer within the United States, scheduled to work at least the number of hours shown in the Benefit Highlights, and paid regular earnings. If you are working on a temporary assignment outside of the United States for a period of 12 months or less, you will be deemed to be working within the United States. If you are working outside of the United States for more than 12 months or other than on a temporary assignment, you will not be considered an Employee under the Group Policy unless Sun Life approves your eligibility in writing.

Employer means Clemens Family Corporation and includes any Subsidiary or Affiliated company insured under the Group Policy.

Evidence of Insurability means a statement or records of your medical history upon which acceptance for insurance will be determined by Sun Life. In some cases, Sun Life may require that you submit to a paramedical examination, at Sun Life's expense, as part of the Evidence of Insurability.

Injury means bodily harm resulting directly from an accident and independently of all other causes.

Physician means an individual who is operating within the scope of his license and is either:
- licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- legally qualified as a medical practitioner and required to be recognized, under the Group Policy for insurance purposes, according to the insurance regulations of the governing jurisdiction.

The Physician cannot be you, your spouse or the parents, brothers, sisters or children of you or your spouse.

Pregnancy means childbirth, miscarriage, abortion or any disease resulting from or aggravated by the pregnancy.

Retirement Plan means a program which provides retirement benefits to you and is not funded entirely by your contributions. The term does not include a 401(k) plan, a 403(b) plan, a profit sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan, or a nonqualified plan of deferred compensation.

Your Employer's Retirement Plan will include any Retirement Plan:
- which is part of any federal, state, county, municipal or association retirement system; and
- you are eligible for as a result of your employment with your Employer.

Sickness means illness, disease or pregnancy.

Waiting Period means the length of time immediately before your Eligibility Date during which you must be employed in an Eligible Class. Any period of time before the Group Policy Effective Date that you were Actively at Work for your Employer as a full-time Employee will count towards completion of your Waiting Period. The Waiting Period is shown in the Benefit Highlights.

DEFINITIONS

These are Life Insurance terms you need to know.

Beneficiary means the person (it cannot be your Employer) who is entitled to receive death benefit proceeds as they become due under the Group Policy. A Beneficiary must be named by you on a form acceptable to Sun Life and executed by you.

Retirement for the purposes of your being considered retired means the first of the following dates to occur:

1. the effective date of your retirement benefits under:
   a. any plan of a federal, state, county, municipal or an association retirement system for which you are eligible as a result of your employment with your Employer;
   b. any Retirement Plan your Employer sponsors; or
   c. any Retirement Plan your Employer makes or has made contributions to.

2. the effective date of your retirement benefits under the Social Security Act or any similar plan or act. However, if you meet the definition of an Employee Actively at Work and you are receiving retirement benefits under the Social Security Act or similar plan or act, you will not be considered retired.

Terminal Condition means your Sickness or Injury from which there is no reasonable prospect of recovery and which is expected to result in your death within twelve months or less.

Total Disability or Totally Disabled for purposes of determining eligibility for Waiver of Premium, means because of your Injury or Sickness, you are unable to perform the material and substantial duties of any occupation for which you are or become reasonably qualified for by education, training or experience.

DEFINITIONS

These are Accidental Death and Dismemberment Insurance terms you need to know.

Accidental Bodily Injury means bodily harm caused by an accident which is sustained directly and independently of all other causes.

SUN LIFE ASSURANCE COMPANY OF CANADA

PORTABILITY RIDER

Effective May 1, 2013, the following provision is added to Group Certificate No. 230523-001 Life Insurance Benefit Provision

What is the Portability Privilege?

If, prior to age 70, your Life Insurance ceases because you terminate employment, you may apply for portable coverage, during the 31 day conversion period, instead of converting to an individual policy.

How does this differ from the Conversion Privilege?

Portable coverage is group term life insurance. This benefit may be continued only to age 70. At the end of that time, you may convert the coverage then in force to an individual permanent life policy under a Conversion Privilege.

Are there reasons I would not be able to port my Life coverage?

Yes. You may not port your coverage if:
- you are age 70 or older; or
- you retire; or
- you have an injury or sickness that would have a material effect on your life expectancy or would prevent you from performing your own occupation on a full-time basis; or
- your employment hours with the Employer have been reduced; or
- you remain in employment with the Employer, other than a full-time basis; or
- your insurance is being continued under the Waiver of Premium provision.

What amounts of insurance are portable?

You may apply for portable coverage up to the amount of Life Insurance that ceased, to a maximum of $500,000. If you port your Life Insurance, you may also port any AD&D Insurance that ceased due to your termination of employment.

When does my portable coverage start?

If your application is approved and the first premium is paid when due, your coverage will start on the day after the 31 day conversion period. If your application is declined, you will be given a 31 day period to apply for an individual permanent life policy under the conversion privilege.

How do I apply for portable coverage?

You must complete an application for portable coverage, and send it, with payment of the first premium, to Sun Life within 31 days of the date your Life Insurance ceases.

The application contains a table to calculate the applicable premium, based on your age and the amount of coverage elected.

The application is available from your Employer.

When does my portable coverage cease?

Your portable coverage ceases on the earliest of:
- the date you reach age 70; or
- the date you do not submit premium to Sun Life for your portability coverage; or
- the date the portable group insurance policy ceases.

SUN LIFE ASSURANCE COMPANY OF CANADA

Dean A. Connor
President and Chief Executive Officer

Clemens Family Corporation Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its employees.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Administrator provide you with a Summary Plan Description which discloses required information about the employee benefit plan. The following section entitled "Summary Plan Description" is not part of the Group Insurance Policy. The information in the Summary Plan Description is provided by the Policyholder and is included in this Booklet/Certificate for your convenience. Sun Life Assurance Company of Canada assumes no responsibility for the accuracy or sufficiency of the information in the Summary Plan Description.

SUMMARY PLAN DESCRIPTION

Plan Sponsor: Clemens Family Corporation
2700 Clemens Rd
Hatfield, PA 19440

Plan Administrator: Clemens Family Corporation
2700 Clemens Rd
Hatfield, PA 19440

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

Subsidiaries/Affiliates: Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina

Agent for Service of Legal Process:

Clemens Family Corporation
2700 Clemens Rd
Hatfield, PA 19440

Employer Identification Number (EIN): 75-2990438

Plan Number: 501

End of Plan Year: June 30th

Type of Administration: The Plan is administered by the Plan Administrator. The benefits provided by the Group Insurance Policy issued by Sun Life Assurance Company of Canada are included in the Plan.

Participants: The insured employees described in the Sun Life Assurance Company of Canada Booklet/Certificate.

Plan Changes and Termination: The Plan Administrator may amend, modify or terminate the Plan.

Contributions: The cost of your benefits under the Plan is paid for by your employer and (if applicable) includes the cost of any insurance premiums contributed by you.

Funding: Sun Life provides the Plan Administrator with certain insurance benefits in connection with the Plan. Those insurance benefits are described in your Booklet/Certificate.

Claims Procedure: When you or your beneficiary wish to file a claim under the Plan, you should contact your personnel office for claim forms and instructions for filing. Your Booklet/Certificate explains the procedure for filing a claim under the Group Insurance Policy.

If your claim for benefits is denied in whole or in part, you will receive a written notice within the time required by ERISA from the date you filed your claim, stating the reasons why your claim was denied. You will then have the right, upon written notice from you or your authorized representative, to review that claim denial. The claim denial notice will include the name and address of the person you may ask for such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

Your Rights under ERISA:

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a 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. 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 of the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 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.

Sun
Life Financial®

SUN LIFE ASSURANCE COMPANY OF CANADA

Home Office: Toronto, Canada

Policyholder:	Clemens Family Corporation
Policy Number:	230523-001
Policy Effective Date:	May 1, 2013
Policy Anniversary:	May 1, 2014
Policy Amendment Effective Date:	April 1, 2020

This Policy is delivered in Pennsylvania and is subject to the laws of that jurisdiction. Premiums are due and payable monthly on the first day of each month. Policy anniversaries will be annual beginning on May 1, 2014.

Sun Life Assurance Company of Canada (Sun Life) agrees to pay the benefits in accordance with all provisions provided by this Policy for Employee Life and Employee Accidental Death and Dismemberment Insurance. This Policy is issued in consideration of the Application of the Policyholder, a copy of which is attached, and continued payment of premiums by the Policyholder. The following pages including any Riders, Endorsements or Amendments are a part of this Policy.

For the purpose of effective dates and termination dates under this Policy, all days begin at 12:00 midnight and end at 11:59:59pm.

Signed at Sun Life's U.S. Headquarters, One Sun Life Executive Park, Wellesley Hills, MA 02481.

Dean A. Connor
President and Chief Executive Officer

READ YOUR POLICY CAREFULLY

Group Term Insurance Policy

Non-Participating

Sun Life Financial®

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ELIGIBLE CLASSES

All Full-Time United States Benefit Level 05, 25, 35, 45, 50, 55, 60, 65, 70 and 75 Employees working in the United States scheduled to work at least 30 hours per week.

WAITING PERIOD

All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina hired prior to December 9, 2019
None

All Other Eligible Employees
Until the first of the month coincident with or next following 60 days of employment

Section I
Schedule of Benefits

EMPLOYEE LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

CLASSIFICATION

1 All Eligible Hourly Employees Benefit Level 05 and 25
2 All Eligible Salaried Employees Benefit Level 05 and 25
3 All Eligible Employees Benefit Level 35
4 All Eligible Employees Benefit Level 45
5 All Eligible Employees Benefit Level 50
6 All Eligible Employees Benefit Level 55
7 All Eligible Employees Benefit Level 60 and 65
8 All Eligible Employees Benefit Level 70
9 All Eligible Employees Benefit Level 75

CLASS	LIFE	AD&D
1 and 2	$15,000	$15,000
3, 4 and 5	$75,000	$75,000
6	$150,000	$150,000
7	$400,000	$400,000
8 and 9	$500,000	$500,000

An Employee's amount of Life and Accidental Death and Dismemberment Insurance shown in the Schedule will reduce to 50% when he attains age 70.

An Employee's Life and Accidental Death and Dismemberment Insurance terminates at the Employee's retirement.

CONTRIBUTIONS

Employees will not contribute to the cost of their Employee Life and Employee Accidental Death and Dismemberment Insurance.

INITIAL MONTHLY PREMIUM RATES

Employee Life Insurance	Refer to Attachment A
Employee Accidental Death and Dismemberment Insurance	Refer to Attachment A

The initial monthly premium rates are guaranteed until April 30, 2015 unless otherwise specified in Section VIII, Premiums. See Section VIII, Premiums for more information.

Section II
Definitions

In this section Sun Life defines some basic terms needed to understand this Policy. All male terms include the female term, unless stated otherwise.

For purposes of this Policy:

Actively at Work means that an Employee performs all the regular duties of his job for a full work day scheduled by the Employer at the Employer's normal place of business or a site where the Employer's business requires the Employee to travel.

An Employee is considered Actively at Work on any day that is not his regular scheduled work day (e.g. vacation or holiday), provided the Employee was Actively at Work on his immediately preceding scheduled work day and the Employee:

- is not hospital confined; or
- is not disabled due to an injury or sickness.

An Employee is considered Actively at Work if he usually performs the regular duties of his job at his home, provided the Employee can perform all the regular duties of his job for a full work day and could do so at the Employer's normal place of business if required to do so, and the Employee:

- is not hospital confined; or
- is not disabled due to an injury or sickness.

Application means the document pertaining to the plan of insurance applied for by the Policyholder. This document is attached to this Policy.

Certificate means a written booklet prepared by Sun Life which includes any Riders, Endorsements or Amendments, containing a summary of:

1. the insurance benefits an Employee is entitled to;
2. to whom the benefits are payable; and
3. any limitations, exclusions or requirements that may apply.

Eligibility Date means the date or dates an Employee in an Eligible Class becomes eligible for insurance under this Policy. Classes eligible for insurance are shown in Section I, Schedule of Benefits.

Employee means a person who is employed by the Employer within the United States, scheduled to work at least the number of hours shown in Section I, Schedule of Benefits, and paid regular earnings. If the Employee is working on a temporary assignment outside of the United States for a period of 12 months or less, the Employee will be deemed to be working within the United States. If the Employee is working outside of the United States for more than 12 months or other than on a temporary assignment, the Employee will not be considered an Employee under this Policy unless Sun Life approves the Employee in writing.

Employer means Clemens Family Corporation and includes any Subsidiary or Affiliated company named in the Application.

Evidence of Insurability means a statement of an Employee's medical history upon which acceptance for insurance will be determined by Sun Life. The Employee must agree to submit to a paramedical examination and/or provide copies of medical records, if requested by Sun Life. Sun Life will pay the cost of any paramedical examination ordered by Sun Life for the purpose of providing Evidence of Insurability.

Grace Period means the 60 days following a premium due date.

Hospital or Institution means a legally operated facility providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians.

Injury means bodily harm resulting directly from an accident and independently of all other causes.

Non-Contributory Insurance means insurance for which the premium is paid entirely by the Employer.

Physician means an individual who is operating within the scope of his license and is either:

1. licensed to practice medicine and prescribe and administer drugs or to perform surgery; or

2. legally qualified as a medical practitioner and required to be recognized, under this Policy for insurance purposes, according to the insurance regulations of the governing jurisdiction.

The Physician cannot be the Employee, his spouse or the parents, brothers, sisters or children of the Employee or his spouse.

Policyholder means the entity to whom the Policy is issued.

Pregnancy means childbirth, miscarriage, abortion or any disease resulting from or aggravated by the pregnancy.

Retirement Plan means a program which provides retirement benefits to Employees and is not funded wholly by Employee contributions. The term will not include a 401(k) plan, a 403(b) plan, a profit sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan, or a nonqualified plan of deferred compensation.

Employer's Retirement Plan will include any Retirement Plan:

1. which is part of any federal, state, county, municipal or association retirement system; and
2. the Employee is eligible for as a result of employment with the Employer.

Sickness means illness, disease or pregnancy.

U.S. Headquarters means Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481.

Waiting Period means the length of time immediately before an Employee's Eligibility Date during which he must be employed in an Eligible Class. Any period of time prior to the Policy Effective Date the Employee was Actively at Work for the Employer as a full-time Employee will count towards completion of the Waiting Period. The Waiting Period is shown in Section I, Schedule of Benefits.

Section II
Definitions

The following Definitions are applicable to Life Insurance

Beneficiary means the person (other than the Employer) who is entitled to receive death benefit proceeds as they become due under this Policy. A Beneficiary must be named by the Employee on a form acceptable to Sun Life and executed by the Employee.

Retirement means the first of the following to occur:

1. the effective date of the Employee's retirement benefits under:
   a. any plan of a federal, state, county, municipal or an association retirement system which the Employee is eligible as a result of his employment with the Employer;
   b. any Retirement Plan the Employer sponsors; or
   c. any Retirement Plan to which the Employer:
      i. makes contributions to; or
      ii. has made contributions.

2. the effective date of the Employee's retirement benefits under the Social Security Act or any similar plan or act. However, if the Employee meets the definition of Employee and is receiving retirement benefits under the Social Security Act or similar plan or act, the Employee will not be considered retired.

Terminal Condition means an Employee's Sickness or Injury from which there is no reasonable prospect of recovery and which is expected to result in death within twelve months or less.

Total Disability or Totally Disabled for purposes of determining eligibility for Waiver of Premium means an Employee, because of Injury or Sickness, is unable to perform the material and substantial duties of any occupation for which he is or becomes reasonably qualified for by education, training or experience.

Section II
Definitions

The following Definitions are applicable to Accidental Death and Dismemberment Insurance

Accidental Bodily Injury means bodily harm caused by an accident which is sustained directly and independently of all other causes.

AD&D means Accidental Death and Dismemberment.

Section III
Eligibility and Effective Dates

A. Eligible Classes

The class(es) eligible for insurance are shown in Section I, Schedule of Benefits.

B. Eligibility Date

An Employee in an Eligible Class will be eligible for insurance on the latest of the following dates:

1. May 1, 2013; or
2. December 9, 2019 for All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North America; or
3. the first day of the month coincident with or next following the date the Employee completes the Waiting Period.

If a former Employee is rehired by the Employer within 1 week of his termination date, all past periods of employment during which the Employee was Actively at Work with the Employer will count towards completion of the Waiting Period. The Employee's Eligibility Date will be the later of the date he is rehired or the day after completion of the Waiting Period.

If a former Employee is rehired by the Employer 1 week or later after his termination date, the Employee's Eligibility Date will be the day after he completes a new Waiting Period.

C. Effective Date of Insurance

An Employee will be insured, subject to the Delayed Effective Date of Insurance, on his Eligibility Date.

Delayed Effective Date of Insurance

The Effective Date of any initial, increased or additional insurance will be delayed for an Employee if he is not Actively at Work. The initial, increased or additional insurance will become effective on the date the Employee returns to an Actively at Work status.

Refusal of Coverage

If an eligible Employee declines his insurance, or terminates his insurance in writing while continuing to be eligible, the Employee will become insured after he applies for insurance and Evidence of Insurability is approved by Sun Life.

Changes in Insurance

Changes in an Employee's amount of insurance will take effect immediately upon the date of change.

However, any increase in insurance will be subject to the Delayed Effective Date of Insurance provision.

Section IV
Benefit Provisions

Employee Life Insurance

Death Benefit

If Sun Life receives Notice and Proof of Claim that an Employee dies while insured, then Sun Life will pay the amount of Life Insurance in force on the Employee's date of death.

The amount of Life Insurance is the Employee's amount of insurance as determined in Section I, Schedule of Benefits.

The amount of Life Insurance is subject to any age reductions or terminations shown in Section I, Schedule of Benefits.

If a former Employee had converted his Life Insurance under the Conversion Privilege of this Policy, his amount of Life Insurance will be reduced by the amount of any insurance remaining in force under that individual policy.

Waiver of Premium Provision

Total Disabilities that begin before age 70

If Sun Life receives Notice and Proof of Claim that an Employee becomes Totally Disabled:
- while insured; and
- before his 70th birthday; and
- before his retirement;

the amount of Life Insurance will continue for that Employee:
- from the date of Total Disability without further payment of premiums for Total Disabilities that begin before age 65;
- from the date of Total Disability without further payment of premiums for a period of one year for Total Disabilities that begin on or after age 65.

The Employee must apply for Waiver of Premium no later than 12 months after the Employee ceases to be Actively at Work. Proof of Claim is required no later than 15 months after the Employee ceases to be Actively at Work. Sun Life may require periodic proof of the continuance of Total Disability.

All amounts of life insurance under this Waiver of Premium Provision are subject to the same Policy terms and conditions including subsequent reductions and terminations at specified ages and/or at retirement as would have been applicable had the Employee not been Totally Disabled. This amount will be further reduced by the amount of any individual policy issued to the Employee pursuant to the Conversion Privilege of this Policy unless that individual policy is exchanged for a full refund of premiums paid.

Sun Life has the right to designate a Physician to examine the Employee when and as often as may be reasonably required.

The Waiver of Premium for an Employee ceases on the earliest of:
- the date he ceases to be Totally Disabled.
- the date he fails to furnish any required Proof that he continues to be Totally Disabled.
- the date he fails to submit to any required Examinations.
- any period the Employee is not under the regular and continuing care of a Physician providing appropriate treatment by means of examination and testing in accordance with the disabling condition.
- the date he retires.
- the date he attains age 65 or 12 months, whichever is later, for Total Disabilities beginning before age 65.
- the first anniversary of the beginning of Total Disability for Total Disabilities beginning on or after age 65.

Employee Life Insurance

An Employee is deemed to be retired when he receives any compensation from a Retirement Plan of the Employer or when the Employee attains age 70, whichever occurs first.

An Employee's rights to continued benefits pursuant to this Waiver of Premium Provision are determined on the date Total Disability begins. These rights are subject to the terms of this Policy and will not be affected by subsequent amendment or termination of this Waiver of Premium Provision.

Applicable to All Employees Excluding All Employees Benefit Level 05 and 25

Accelerated Benefit Terminal Condition Coverage

Sun Life will pay an Accelerated Benefit to the Employee at the Employee's request, if Sun Life receives satisfactory proof of the Employee's Terminal Condition.

To be eligible for the Accelerated Benefit an Employee must:

(Applicable to Employees employed on or before May 1, 2013)

- have been Actively at Work on May 1, 2013;

(Applicable to All Employees)

- be certified by a Physician as having a Terminal Condition;
- submit a written request for the Accelerated Benefit to Sun Life while the Employee's Life Insurance is in force;
- be insured for at least $20,000 of Life Insurance;
- have a signed acknowledgment and agreement to pay the Accelerated Benefit from any applicable absolute assignee or irrevocable beneficiary.

Sun Life may, at its own expense, confirm the diagnosis of a Terminal Condition with a medical examination performed by a Physician of Sun Life's choice.

An Employee may elect an Accelerated Benefit of up to 75% of his applicable amount of Life Insurance as of the date Sun Life receives a written request to provide an Accelerated Benefit.

The Accelerated Benefit will be paid in one lump sum. The maximum amount of the Accelerated Benefit is $500,000. The minimum amount of the Accelerated Benefit that can be requested is the greater of 25% of the amount of his Life Insurance in force or $10,000. The Accelerated Benefit may be elected only once during the lifetime of the Employee.

If an Employee receives an Accelerated Benefit payment, the amount of Life Insurance remaining in force will be reduced by an amount equal to the Accelerated Benefit paid. The remaining amount of life insurance is subject to the same Policy terms and conditions including subsequent reductions and terminations at specified ages and/or at retirement as would have been applicable had the Employee not received an Accelerated Benefit.

If an Employee requests an Accelerated Benefit, an Employee will receive a Benefit Payment Notice which outlines the Accelerated Benefit payment made, the remaining amount of Life Insurance in force and the required premium, if any, on the remaining amount of Life Insurance.

If the Employee is eligible for Waiver of Premium, the amount of life insurance remaining in force on which premiums are waived will be based on the reduced amount of life insurance.

If the Employee subsequently converts his amount of life insurance, the amount eligible for conversion will be based on the reduced amount of life insurance.

Applicable to All Employees

Conversion Privilege

Benefit

1. If all or part of an Employee's Life Insurance ceases or reduces due to:
   - termination of his employment; or
   - termination of his membership in an Eligible Class; or
   - the Employee's retirement; or
   - the Employee reaching a specified age; or
   - the Employee changing to a different Eligible Class; or
   - termination of the Employee's Waiver of Premium continuation; or
   - the Employee's continuation period ending during layoff or an approved leave of absence;

   then the Employee may apply for an individual policy on his own life up to the amount that ceased. If the amount of Life Insurance that ceased is $10,000 or more, the minimum amount of the individual policy must be $10,000.

2. If the Employee has been continuously insured for five or more years under this Policy's Life Benefit Provision and all or part of the Employee's Life Insurance ceases or reduces due to:
   - reduction of the amount of Life Insurance in an Eligible Class by an amendment to the Life Insurance Benefit Provision; or
   - termination of the Life Insurance Benefit Provision; or
   - termination of this Policy; or
   - termination of an Eligible Class by an amendment to the Life Insurance Benefit Provision;

   then the Employee may apply for an individual policy on his own life. The maximum amount of the policy will be the lesser of:
   - $2,000; or
   - the amount that ceased, reduced by the amount of any life insurance the Employee is eligible for under any group policy within 31 days after his Life Insurance ceased.

The Employee will be issued an individual policy without Evidence of Insurability.

Application for the Individual Policy

1. written application must be made to Sun Life along with payment of the first premium, within the 31 day period (the 31 day conversion period) following the date the insurance ceases or reduces. If the Employee is not given notice of this conversion privilege within 15 days following the date his insurance ceases or reduces, the Employee shall have an additional 15 days to exercise this conversion privilege. In no event will this conversion privilege be extended beyond 60 days following the 31 day conversion period.

2. the individual policy may be any plan of permanent life insurance available for conversion by Sun Life at the attained age and amount requested, but without disability or other supplemental benefits.

3. the premium will be the rate Sun Life charges for the standard class of risk and age to which the Employee belongs on the effective date of the individual policy.

4. the effective date of the individual policy will be the day after the 31 day conversion period.

Employee Life Insurance

Death Within 31 Days

If the Employee dies during the 31 day conversion period, a benefit will be paid upon receipt of Notice and Proof of Claim, whether or not application for the individual policy or payment of the first premium has been made. The benefit is the amount of Life Insurance the Employee would have been eligible to convert.

Section IV
Benefit Provisions

Employee Life Insurance

Continuity of Coverage

In order to prevent loss of coverage for an Employee when this Policy replaces a group Life policy the Employer had in force with another insurer immediately prior to May 1, 2013*, Sun Life will provide the following coverage.

Employees not Actively at Work on May 1, 2013*

An Employee may become insured under this Policy on May 1, 2013*, subject to all of the following conditions:

1. he was insured under the prior insurer's group Life policy immediately prior to May 1, 2013*; and
2. he is not Actively at Work on May 1, 2013*; and
3. he is a member of an Eligible Class under this Policy; and
4. premiums for the Employee are paid up to date; and
5. he is not receiving or eligible to receive benefits under the prior insurer's group Life policy.

Any Life benefit payable will be the lesser of:
- the Life benefit payable under this Policy; or
- the Life benefit payable under the prior insurer's group Life policy had it remained in force.

All other provisions of Sun Life's Policy will apply.

* December 9, 2019 for All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina

Section IV
Benefit Provisions

Employee Accidental Death and Dismemberment Insurance

If Sun Life receives Notice and Proof of Claim that an Employee:
- dies from accidental drowning while insured; or
- sustains an Accidental Bodily Injury while insured, which results in loss of life, sight or limb; or
- sustains a loss of life, sight or limb due to an accidental exposure to the elements while insured;

Sun Life will pay, subject to the Exclusions, the following percentage of Accidental Death and Dismemberment Insurance shown in Section I, Schedule of Benefits that was in force on the date of the Accidental Bodily Injury for the following losses:

Life	100%
Sight of one eye	50%
One limb	50%
Speech and hearing	100%
Speech or hearing	50%
Thumb and index finger of the same hand	25%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%

The maximum amount of Accidental Death and Dismemberment Benefit payable for losses resulting from any one accident is 100%.

Loss of limb means severance of hand or foot at or above the wrist or ankle joint. Loss of sight, speech or hearing must be total and irrecoverable. Loss of thumb and index finger means severance through or above the metacarpophalangeal joints.

Quadriplegia means the total and permanent paralysis of both upper and lower limbs. Paraplegia means the total and permanent paralysis of both lower limbs. Hemiplegia means the total and permanent paralysis of the upper and lower limbs on one side of the body.

Business Travel Benefit

Sun Life will pay an additional Business Travel Benefit if an Employee's loss of life occurs while traveling on business for the Employer.

The Business Travel Benefit is the lesser of:
- $25,000; or
- 25% of the amount of Accidental Death Benefit payable.

Business Travel means traveling to another location to conduct the Employer's business other than the Employee's normal workplace. Business Travel starts from the time the Employee leaves his place of residence to commence the Employer's business until the Employee returns to his place of residence. Business Travel does not include personal deviations; nor Employee vacations.

Personal Deviation means an activity that is not reasonably related to the Employer's business and not incidental to the business trip.

An Employee's place of residence will change to the location of the Business Travel if an Employee's stay at that location exceeds 60 days.

Seat Belt/Air Bag Benefit

Sun Life will pay an additional Seat Belt/Air Bag Benefit if an Employee dies as a result of an automobile accident and an Accidental Death Benefit is payable under this Policy.

Seat Belt Benefit

The Seat Belt Benefit is payable if the Employee was wearing a seat belt at the time of the accident.

The Seat Belt Benefit is 25% of the amount of Accidental Death Benefit payable or $25,000, whichever is less.

Sun Life must receive satisfactory written proof that the Employee's death resulted from an automobile accident and that the Employee was wearing a seat belt at the time of the accident. A copy of the police report is required.

Air Bag Benefit

The Air Bag Benefit is payable if a Seat Belt Benefit is payable and the Employee was positioned in a seat protected by a Supplemental Restraint System which inflated on impact.

The Air Bag Benefit is 10% of the amount of Accidental Death Benefit payable or $5,000, whichever is less.

Sun Life must receive satisfactory written proof that the Employee's death resulted from an automobile accident and that the Supplemental Restraint System properly inflated. A copy of the police report is required.

Seat Belt means a properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

Supplemental Restraint System means a factory installed air bag which inflates for added protection to the head and chest areas.

Automobile means a motor vehicle licensed for use on public highways.

Helmet Benefit

Sun Life will pay an additional Helmet Benefit if an Employee dies as a result of a Motorcycle accident and an Accidental Death Benefit is payable under this Policy.

The Helmet Benefit is payable if the Employee was wearing a Helmet at the time of the accident and the driver of the Motorcycle held a valid drivers license with a Motorcycle endorsement.

The Helmet Benefit is 50% of the amount of Accidental Death Benefit payable or $25,000, whichever is less.

Sun Life must receive satisfactory written proof that the Employee's death resulted from a Motorcycle accident and that the Employee was wearing a Helmet at the time of the accident. A copy of the police report is required.

Helmet means a protective head covering made of a hard material to resist impact and which is approved by the American National Safety Institute (ANSI) and/or Snell.

Motorcycle means a motor vehicle licensed for use on public highways which requires a Motorcycle endorsement on a drivers license to operate the vehicle.

Disappearance

Sun Life will presume, subject to no objective evidence to the contrary, that an Employee is dead and has died as a result of an Accidental Bodily Injury if:

1. an Employee disappears as a result of an accidental wrecking, sinking or disappearance of a conveyance in which the Employee was known to be a passenger; and
2. the body of the Employee is not found within 365 days after the date of the conveyance's disappearance.

Bereavement Counseling Benefit

If an Accidental Death Benefit is payable, Sun Life will pay a Bereavement Counseling Benefit during an Employee's Immediate Family Member's period of bereavement for up to 12 months after an Employee's death.

The Bereavement Counseling Benefit equals the Immediate Family Member's incurred expenses reduced by any reimbursement the Immediate Family Member receives from other sources.

The Maximum Bereavement Counseling Benefit payable is $250 per Immediate Family Member, to a maximum of $1,000 per Employee's death.

Immediate Family Member means an Employee, an Employee's spouse or an Employee's child under age 19 or age 23 if a full-time student.

Written Proof of the actual out of pocket counseling expenses incurred must be submitted to Sun Life prior to payment.

Dependent Education Benefit

If an Employee Accidental Death Benefit is payable under this Policy, an Employee's Dependent may be eligible for a Dependent Education Benefit.

A Dependent Child is eligible for an Education Benefit if the Dependent Child enrolls as a full-time student at a post-secondary school before reaching age 23 and within 1 year after the Employee's date of death.

The annual Dependent Child's Education Benefit is the lesser of:
- Incurred Expenses; or
- $2,500; or
- 5% of the Employee's amount of Accidental Death Benefit payable.

The Dependent Child Education Benefit is payable at the end of each semester per dependent child, for a maximum of four consecutive years per child. Proof of the child's enrollment and Incurred Expenses are required each semester prior to payment of the benefit.

Incurred Expenses include tuition, fees, cost of books, room and board, transportation and any other costs paid directly to the school.

Employee Accidental Death and Dismemberment Insurance

A Dependent Spouse is eligible for an Education Benefit if the Dependent Spouse enrolls in any school for the purpose of retraining or developing skills needed for employment within 1 year after the Employee's date of death.

The Dependent Spouse's Education Benefit is equal to the expenses paid directly to such school or $3,000 whichever is less. Proof of enrollment and expenses are required prior to payment of the benefit.

Exclusions

No Accidental Death or Accidental Dismemberment payment will be made for a loss which is due to or results from:

- suicide while sane or insane.
- intentionally self-inflicted injuries.
- bodily or mental infirmity or disease of any kind, or infection unless due to an accidental cut or wound.
- committing or attempting to commit a felony or other criminal act.
- active participation in a war (declared or undeclared) or active duty in any armed service during a time of war.
- active participation in a riot, rebellion, or insurrection.
- injury sustained from any aviation activities, other than riding as a fare-paying passenger.
- the Employee's voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless administered on the advice of a Physician.
- the Employee's operation of any motorized vehicle while intoxicated. Intoxicated means the minimum blood alcohol level required to be considered operating an automobile under the influence of alcohol in the jurisdiction where the accident occurred. For the purposes of this Exclusion, "Motorized Vehicle" includes, but is not limited to, automobiles, motorcycles, boats and snowmobiles.

Employee Accidental Death and Dismemberment Insurance

Continuity of Coverage

In order to prevent loss of coverage for an Employee when this Policy replaces a group AD&D policy the Employer had in force with another insurer immediately prior to May 1, 2013*, Sun Life will provide the following coverage.

Employees not Actively at Work on May 1, 2013*

An Employee may become insured under this Policy on May 1, 2013*, subject to all of the following conditions:

1. he was insured under the prior insurer's group AD&D policy immediately prior to May 1, 2013*; and
2. he is not Actively at Work on May 1, 2013*; and
3. he is a member of an Eligible Class under this Policy; and
4. premiums for the Employee are paid up to date; and
5. he is not receiving or eligible to receive benefits under the prior insurer's group AD&D policy.

Any AD&D benefit payable will be the lesser of:
- the AD&D benefit payable under this Policy; or
- the AD&D benefit payable under the prior insurer's group AD&D policy had it remained in force.

All other provisions of Sun Life's Policy will apply.

* December 9, 2019 for All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina

Section V
Termination Provisions

Termination of Employee's Insurance

An Employee will cease to be insured on the earliest of the following dates:

1. the date this Policy terminates.
2. the date the Employee is no longer in an Eligible Class.
3. the date the Employee's Class is no longer included for insurance.
4. the last day for which any required premium has been paid.
5. the date the Employee retires.
6. the date employment terminates. Ceasing to be Actively at Work will be deemed termination of employment, except:
   a. insurance will be continued for an Employee absent due to a disability during any period the premium is being waived under this Policy.
   b. the Policyholder may continue the insurance by paying the required premiums, subject to the following:
      i. insurance may be continued for up to 1 month after the Employee has been temporarily laid off.
      ii. insurance may be continued for up to 1 month after the Employee has been given an approved leave of absence.
      iii. insurance may be continued for up to 3 months of the Employee's paid vacation.
      iv. For Life and Accidental Death and Dismemberment Insurance - insurance may be continued for up to 12 months after an Employee is absent from work due to Injury or Sickness.

   The Policyholder in all of the above situations must act so as not to discriminate unfairly among Employees in similar situations.

7. the date the Employee requests, in writing, to have his insurance terminated.
8. the date the Employee ceases to be Actively at Work due to a labor dispute, including any strike, work slowdown, or lockout.
9. the date the Employee enters active duty in any armed service during a time of war (declared or undeclared).

While this Policy is in force, the Policyholder may continue an Employee's coverage pursuant to the Family and Medical Leave Act of 1993, as amended or continue coverage pursuant to a state required continuation period (if any).

While this Policy is in force, the Policyholder may continue an Employee's coverage pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Section V
Termination Provisions

Termination of Policy

This Policy will terminate for any of the following reasons:

1. If the Policyholder fails to pay any premium within the Grace Period, this Policy will terminate on the last day of the Grace Period.

2. The Policyholder may terminate this Policy by advance written notice delivered to Sun Life at least 31 days prior to the termination date. This Policy will not terminate during any period for which premium has been paid. The Policyholder will be liable to Sun Life for all premiums due and unpaid for the full period this Policy is in force.

3. Sun Life may terminate this Policy on any premium due date by giving written notice to the Policyholder at least 31 days in advance if:

    a. the number of insured Employees is less than 10; or
    b. less than 100% of the Employees eligible are insured; or
    c. the Policyholder fails to:
        i. furnish promptly any information Sun Life may reasonably require; or
        ii. perform any other obligations pertaining to this Policy.

4. After this Policy has been in force for at least 12 months, Sun Life may terminate this Policy on any Policy Anniversary by giving written notice to the Policyholder at least 60 days in advance.

Termination of this Policy may take effect on an earlier date when both the Policyholder and Sun Life agree.

Section V
Termination Provisions

Termination of Benefit Provision

A Benefit Provision will terminate for any of the following reasons:

1. The Policyholder may terminate a Benefit Provision by advance written notice delivered to Sun Life at least 31 days prior to the termination date. The Benefit Provision will not terminate during any period for which premium has been paid. The Policyholder will be liable to Sun Life for all premiums due and unpaid for the full period that Benefit Provision is in force.

2. Sun Life may terminate a Benefit Provision on any premium due date by giving written notice to the Policyholder at least 31 days in advance if:

   a. the number of insured Employees for that Benefit is less than 10; or
   b. less than 100% of the Employees eligible are insured; or
   c. the Policyholder fails to furnish promptly any information which Sun Life may reasonably require.

3. Sun Life may terminate any Benefit Provision on any Policy Anniversary by giving written notice to the Policyholder at least 60 days in advance.

Termination of a Benefit Provision may take effect on an earlier date when both the Policyholder and Sun Life agree.

Section VI
General Policy Provisions

A. Statements

All statements made in any Application are considered representations and not warranties. No representation by:

1. the Policyholder in applying for this Policy will render it void unless the representation is contained in the Application; or

2. any Employee in applying for insurance under this Policy will be used to reduce or deny a claim unless a copy of the Employee's written application for insurance is or has been given to the Employee or the Employee's beneficiary, if any.

B. Entire Contract - Policy Changes

1. This Policy is the entire contract. It consists of:

   a. all of the pages of the Policy;
   b. the attached Application of the Policyholder;
   c. each Employee's written application for insurance (Employee retains his own copy).

2. This Policy may be changed in whole or in part. Only an executive officer of Sun Life may approve a change. The approval must be in writing and endorsed on or attached to this Policy.

3. Any other person, including an agent, may not change this Policy or waive any part of it.

C. Employee's Certificate

Sun Life will provide a Certificate to the Policyholder for delivery to each Employee. The Certificate is intended to provide a brief explanation of the Policy benefits, but it does not form a part of this Policy. If the terms of a Certificate and this Policy differ, this Policy will govern.

D. Furnishing of Information - Access To Records

1. The Employer will furnish at regular intervals to Sun Life:

   a. information relative to individuals:
      i. who qualify to become insured;
      ii. whose amounts of insurance change; and/or
      iii. whose insurance terminates.

   b. any other information about this Policy that may be reasonably required.

The records which, in the opinion of Sun Life, are material to the insurance, will be opened for inspection by Sun Life at any reasonable time.

2. Clerical error or omission will not:
   a. deprive an individual of insurance;
   b. affect an individual's amount of insurance; or
   c. effect or continue an individual's insurance which otherwise would not be in force.

The Policyholder's or Employer's failure to report notice or proof of claim in a timely manner shall not constitute clerical error.

E. Misstatement of Age

If the age of an individual is not accurate:
1. an equitable adjustment of premium will be made; and
2. the true age will be used to determine if and in what amount insurance is valid under this Policy.

If the amount of the benefit is dependent upon an individuals age, (as shown in Section I, Schedule of Benefits), the benefit will be the amount an individual would have been entitled to if his correct age was known.

F. Examination and Autopsy

Sun Life, at its own expense, has the right to have any person, whose Injury or Sickness is the basis of a claim:

1. examined by a Physician, other health professional or vocational expert of its choice; and/or
2. interviewed by an authorized Sun Life representative.

This right may be used as often as reasonably required.

Sun Life has the right, in the case of death, to request an autopsy where not prohibited by law.

G. Legal Proceedings (other than for Life Insurance)

No legal action may start:

1. until 60 days after Proof of Claim has been given; nor
2. more than 3 years after the time Proof of Claim is required.

H. Workers' Compensation

This Policy is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance.

I. Agency

For all purposes of this Policy, the Policyholder or third party administrator acts on its own behalf or as an agent of the Employee. Under no circumstances will the Policyholder or third party administrator be deemed an agent of Sun Life.

J. Incontestability

Policyholder

The validity of this Policy shall not be contested, except for non-payment of premium, after it has been in force for two years from the Policy Effective Date.

Individual

No statement made by an individual, relating to his insurability for an initial, increased or additional amount of insurance, will be used in contesting the validity of that insurance, after such initial, increased or additional amount of insurance has been in force for a period of two years during the individual's lifetime.

This statement must be contained in a form signed by that individual.

Section VII
Claim Provisions

A. Notice and Proof of Claim

Sun Life must receive Notice and Proof of Claim prior to any payment under this Policy.

1. Notice of Claim

for Death Claim - written notice of claim must be given to Sun Life no later than 30 days after date of death.

for Life Waiver of Premium - written notice of claim must be given to Sun Life no later than 12 months after the Employee ceases to be Actively at Work.

for Accidental Dismemberment - written notice of claim must be given to Sun Life no later than 12 months after the Employee's date of loss.

for all other claims - written notice of claim must be given to Sun Life no later than 12 months after the Employee's date of loss or within 12 months after the date the expense is incurred.

If notice cannot be given within the applicable time period, Sun Life must be notified as soon as it is reasonably possible.

When Sun Life has received written notice of claim, Sun Life will send the forms for proof of claim. If the forms are not received within 15 days after written notice of claim is sent, proof of claim may be sent to Sun Life without waiting for the form.

2. Proof of Claim

for Death Claim - proof of claim needs to be given to Sun Life prior to any payment of a death claim.

for Life Waiver of Premium - proof of claim must be given to Sun Life no later than 15 months after the Employee ceases to be Actively at Work.

for Accidental Dismemberment - proof of claim must be given to Sun Life no later than 15 months after the Employee's date of loss.

for all other claims - proof of claim must be given to Sun Life no later than 15 months after the Employee's date of loss or within 15 months from the date the expense is incurred.

If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time proof is otherwise required unless the individual is legally incompetent.

Proof of Claim must consist of:
- a description of the loss or disability;
- the date the loss, disability or expense occurred; and
- the cause of the loss, disability or expense.

Proof of Claim may include, but is not limited to, police accident reports, autopsy reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials as required.

Proof of Claim for disability must include evidence demonstrating the disability including, but not limited to, hospital records, Physician records, Psychiatric records, x-rays, narrative reports, or other diagnostic testing materials as appropriate for the disabling condition.

Proof must be satisfactory to Sun Life.

Sun Life may require as part of the Proof authorizations to obtain medical and non-medical information.

Proof of the Employee's continued disability and regular and continuous care by a Physician must be given to Sun Life within 30 days of the request for proof.

B. Insurer's Authority

The Plan Administrator has delegated to Sun Life its entire discretionary authority to make all final determinations regarding claims for benefits under the benefit plan insured by this Policy. This discretionary authority includes, but is not limited to, the determination of eligibility for benefits, based upon enrollment information provided by the Policyholder, and the amount of any benefits due, and to construe the terms of this Policy.

Any decision made by Sun Life in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing Sun Life's determinations shall uphold such determination unless the claimant proves that Sun Life's determinations are arbitrary and capricious.

C. Notice of Decision on Claim

A written notice of decision on a claim will be sent within a reasonable time after Sun Life receives the claim but not later than 45 days after receipt of the claim. If a decision cannot be made within 45 days after Sun Life receives the claim, Sun Life will request extensions of time as permitted under U.S. Department of Labor regulations. Any request for extension of time will specifically explain:

1. the standards on which entitlement to benefits is based;
2. the unresolved issues that prevent a decision on the claim; and
3. the additional information needed to resolve those issues.

If a period of time is extended because the claimant failed to provide necessary information, the period for making the benefit determination is tolled from the date Sun Life sends notice of the extension to the claimant until the date on which the claimant responds to the request for additional information. The claimant will have at least 45 days to provide the specified information.

D. Review Procedure

If all or any part of a claim is denied, the claimant may request in writing a review of the denial within 180 days after receiving notice of denial.

The claimant may submit written comments, documents, records or other information relating to the claim for benefits, and may request free of charge copies of all documents, records and other information relevant to the claimant's claim for benefits.

Sun Life will review the claim on receipt of the written request for review, and will notify the claimant of Sun Life's decision within a reasonable time but not later than 45 days after the request has been received. If an extension of time is required to process the claim, Sun Life will notify the claimant in writing of the special circumstances requiring the extension and the date by which Sun Life expects to make a determination on review. The extension cannot exceed a period of 45 days from the end of the initial review period.

If a period of time is extended because the claimant failed to provide necessary information, the period for making the decision on review is tolled from the date Sun Life sends notice of the extension to the claimant until the date on which the claimant responds to the request for additional information.

E. Time of Payment of Claims

Benefits are payable immediately when Sun Life receives satisfactory Proof of Claim.

F. Payment of Claims

Benefits payable upon the death of the Employee are payable to the Beneficiary living at the time (other than the Employer). Unless otherwise specified, if more than one Beneficiary survives the Employee, all surviving Beneficiaries will share equally. If no Beneficiary is alive on the date of the Employee's death, payment will be made to the Employee's estate.

Accidental Death and Dismemberment benefits are payable as shown above unless otherwise specified in the Accidental Death and Dismemberment Benefit Section.

All other benefits payable during the lifetime of the Employee are payable to the Employee.

If a benefit is payable to the Employee's estate, an Employee who is a minor, or an Employee who is not competent, Sun Life has the right to pay up to $5,000 to any of the Employee's relatives whom Sun Life considers entitled. If Sun Life pays benefits in good faith to a relative, Sun Life will not have to pay those benefits again.

If a Beneficiary is a minor or is not competent, Sun Life has the right to pay up to $1,000 to the person or institution that appears to have assumed custody and main support, until the appointed legal representative makes a formal claim. If Sun Life pays benefits in good faith to a person or institution, Sun Life will not have to pay those benefits again.

G. Amendment or Termination of Benefit Provision

An Employee's rights to any disability benefits are determined on the date the Employee's disability begins. The right is subject to the terms of this Policy in effect on the date disability begins and will not be affected by subsequent amendment or termination of this Policy.

H. Change of Beneficiary

If this Policy replaces existing coverage under the Employer's group life insurance plan, Employees' nominations of Beneficiaries under the plan will remain in force unless changed by the Employee. All nominations of Beneficiaries are revocable unless otherwise stated by the Employee. Any request for change of Beneficiary must be in a written form and will take effect as of the date the Employee signs and files the change with the Employer. If Sun Life has taken any action or made payment prior to receiving notice of that change, the change of Beneficiary will not affect any action or payment made by Sun Life. The consent of the Beneficiary is not required to change any Beneficiary unless the Beneficiary designation has been irrevocable.

I. Assignments

The Employee is permitted to assign all his rights under this Policy. Any assignment must be in a written form and will take effect as of the date the Employee signs and files the assignment with the Employer. Sun Life will honor an Employee's prior assignment of rights and benefits under the Employer's plan, whether or not this Policy is specified in the Assignment. If Sun Life has taken any action or made payment prior to receiving notice of that change, the assignment will not affect any action or payment made by Sun Life. Sun Life will not be responsible for the legal, tax or other effects of any assignment.

J. Methods of Payment

The Death Benefit may be payable by a method other than a lump sum. The available methods of payment will be based on the benefit options offered by Sun Life at the time of election.

Section VIII
Premiums

A. Premium Rates

Sun Life determines its initial or any subsequent monthly premium rate on the basis of the coverage being provided. After the initial monthly premium rate has been in effect until April 30, 2015, Sun Life has the right to recalculate any premium rate. However, Sun Life has the right to recalculate the initial or any subsequent monthly premium rate when any of the following occurs:

1. the terms of this Policy are changed, including but not limited to the Schedule of Benefits; or
2. a new Division, Subsidiary or Affiliated Company of the Policyholder is added to or deleted from this Policy; or
3. the number of Employees insured changes by 25% or more from the number of Employees insured on the Policy Effective Date or the immediately preceding Policy Anniversary Date; or
4. one or more class(es) are added to or deleted from this Policy.

No premium rate may be increased unless Sun Life notifies the Policyholder at least 31 days in advance of the increase. Premium rate increases may take effect on an earlier date when both Sun Life and the Policyholder agree.

B. Payment of Premiums

1. All premiums due under this Policy, including adjustments, if any, are payable by the Policyholder on or before the respective due dates at Sun Life's U.S. Headquarters or at another location designated by Sun Life. The due dates are specified on the first page of this Policy.
2. The premiums due under this Policy on each premium due date are based upon the premium rates in effect for the benefit provided. The premium due is the sum of the monthly premiums for all insured Employees for all benefits.
3. Premiums payable to Sun Life will be paid in United States dollars on the premium due date.
4. The premium for additional or increased insurance becoming effective during a Policy month will be charged from the next premium due date.
5. The premium for insurance terminated during a Policy month will cease at the end of the Policy month in which such insurance terminates.
6. Except for fraud, premium adjustments, refunds or charges will be made for only:
   a. the current Policy Year; and
   b. the prior Policy Year.

C. Grace Period

The Grace Period is 60 days following a premium due date. During the Grace Period the Policy shall continue in force, unless the Policyholder has given Sun Life written notice to discontinue this Policy. In any event, premiums are payable for any period of time the Policy remains in force.

SUN LIFE ASSURANCE COMPANY OF CANADA

PORTABILITY RIDER

Effective May 1, 2013, the following provision is added to Group Policy No. 230523-001 Life Insurance Benefit Provision

Portability Privilege

Benefit

If, prior to age 70, the Employee's Life Insurance ceases due to termination of his employment, the Employee may apply for portable coverage on his own life up to the amount of Life Insurance that ceased, to a maximum of $500,000. An Employee is not eligible to port if:

- he is age 70 or older; or
- he retires; or
- he has an injury or sickness that would have a material effect on his life expectancy or would prevent the Employee from performing his own occupation on a full-time basis; or
- his employment hours with the Employer have been reduced; or
- he remains in employment with the Employer, other than a full-time basis; or
- his insurance is being continued under the Waiver of Premium provision.

If the Employee elects to port any amount of his Life Insurance, he may also apply to port any AD&D Insurance that ceased due to his termination of employment.

An Employee whose coverage has been continued on Waiver of Premium under this Policy is not eligible to apply for portable coverage.

An Employee who elects to convert his coverage to an individual policy under the Conversion Privilege is not eligible to apply for portable coverage.

Application for Portable Coverage

1. Written application must be made to Sun Life within 31 days following the date the Life Insurance ceases.

2. Portable coverage will be effective on the date that Sun Life approves the Employee's Application for portable coverage.

3. Portable coverage will be provided under a group term life policy providing death and accidental death and dismemberment benefits only, without waiver of premium or Accelerated Death benefits.

4. The premium will be the current rate Sun Life charges for the standard class of risk and age the insured belongs to under the Portable Group Life Policy.

5. If the application for Portable Coverage is declined by Sun Life, the Employee will be given 31 days, commencing on the date the application is declined, to convert to an individual policy under the Conversion Privilege.

Termination of Portable Coverage

Portable coverage will terminate on the occurrence of the earliest of the following:

- the date for which the last premium has been paid by the Employee; or
- the date the Employee attains age 70; or
- the date the portable group insurance policy terminates.

When Portable Coverage terminates, the Employee will have the right to convert the amount of coverage to an individual policy.

SUN LIFE ASSURANCE COMPANY OF CANADA

Dean A. Connor
President and Chief Executive Officer

SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
One Sun Life Executive Park
Wellesley Hills, MA 02481

(800) 247-6875
www.sunlife.com/us

Sun Life Assurance Company of Canada certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

Policy Number:	245546-001
Policy Effective Date:	November 1, 2016
Policyholder:	Clemens Family Corporation
Employer:	Clemens Family Corporation
Issue State:	Pennsylvania
Amendment Effective Date:	December 9, 2019

This Certificate contains the terms of the Group Insurance Policy that affect your insurance. This Certificate is part of the Group Insurance Policy.

This Certificate is governed by the laws of the Issue State shown above unless otherwise preempted by the federal Employee Retirement Income Security Act ("ERISA").

Signed at Wellesley Hills, Massachusetts.

Dean A. Connor
President and Chief Executive Officer

Troy Krushel
Vice-President, Associate General Counsel and Corporate Secretary

Group Basic Long Term Disability Income Insurance Certificate
Non-Participating

Sun Life Financial®

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1. BENEFIT HIGHLIGHTS

Eligible Classes:

All Full-Time United States Management Employees who are at the Benefit Grade of 35 or higher working in the United States scheduled to work at least 30 hours per week.

Eligibility Waiting Period:

All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina hired prior to December 9, 2019
None

All Other Eligible Employees
Until the first of the month coincident with or next following 60 days of employment

1. BENEFIT HIGHLIGHTS

Your disability income insurance will be based on the following:

Benefit:
60% (Benefit Percentage) of your Total Monthly Earnings

Benefits will be paid monthly.

Maximum Benefit:
$10,000

Minimum Benefit:
$100

Elimination Period:
90 days

Maximum Benefit Duration:
Benefit duration to age 65 with graded ADEA

Gainful Occupation Percentage:
60% of your Indexed Total Monthly Earnings.

Total Monthly Earnings:
Your basic monthly earnings as reported by your Employer immediately before the first date your Total Disability begins. Total Monthly Earnings includes deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, health savings account or flexible spending account, but does not include income received due to commissions, bonuses, overtime pay or any other extra compensation.

If you are paid on an hourly basis, Total Monthly Earnings will be based on your hourly rate of pay, but will not exceed 40 hours per week.

Contributions:
The cost of your insurance is paid entirely by you. This is your Contributory Insurance.

The following Additional Benefit(s) are included:
Accidental Dismemberment/Loss of Sight Benefit
COBRA Continuance Premium Benefit
Rehabilitation Services
Survivor Benefit
Waiver of Premium

Maximum Benefit Duration - Definitions

Benefit duration to age 65 with graded ADEA means:

Age at Disability	Maximum Benefit Duration
Less than age 60	To age 65, but not less than 60 Months
60	60 Months
61	48 Months
62	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69 and over	12 Months

2. DEFINITIONS

Accident means an external event that an average person would consider sudden and unforeseeable and is independent of any illness, disease or other bodily malfunction.

A Disability caused by an Accident must:
- occur while covered under the Policy; and
- not otherwise be excluded under the Policy.

Actively at Work means that you perform all the regular duties of your job for a full work day at your Employer's normal place of business, a site approved by your Employer or a site where your Employer's business requires you to travel.

You are considered Actively at Work if you usually perform the regular duties of your job at your home as long as you can perform all the regular duties of your job for a full work day and could do so at your Employer's normal place of business.

You are considered Actively at Work on any day that is not your regular scheduled work day (e.g., you are on vacation or holiday) as long as you were Actively at Work on your immediately preceding scheduled work day, and you are neither Confined nor disabled due to an Accident or Sickness.

Any Occupation means any Gainful Occupation that you are performing or may reasonably become qualified for by education, training or experience.

Chemical and Environmental Illness means an allergy or sensitivity to chemicals or the environment including, but not limited to:
- Environmental allergies;
- Sick Building Syndrome;
- Multiple Chemical Sensitivity Syndrome; or
- Chronic Toxic Encephalopathy.

Chemical and Environmental Illness does not include asthma or allergy-induced reactive lung disease.

Chronic Fatigue Illness means an illness that is characterized by a debilitating fatigue in the absence of known medical or psychological conditions, which includes, but is not limited to:
- Chronic Fatigue Syndrome as supported by Center for Disease Control Guidelines;
- Chronic Fatigue Immunodeficiency Syndrome as supported by Center for Disease Control Guidelines;
- Systemic Exertion Intolerance Disease (SEID);
- Post Viral Syndrome;
- Limbic Encephalopathy;
- Epstein-Barr virus infection;
- Herpes virus type 6 infection; or
- Myalgic Encephalomyelitis.

Chronic Fatigue Illness does not include a disorder identified as a:
- Neoplastic disorder;
- Neurologic disorder;
- Endocrine disorder;
- Hematologic disorder;
- Rheumatologic disorder; or
- Depression.

Confined or Confinement means confined to a Hospital or similar facility.

Contributory Insurance means insurance for which you pay all or part of the premium.

Continuing Care means you visit a Physician whose medical specialty is the most appropriate specialty to evaluate, manage or treat your Accident or Sickness and you receive care and Treatment as frequently as is Medically Necessary according to generally accepted medical standards.

2. DEFINITIONS

Deductible Sources of Income means Other Income that is deducted from your Gross Benefit as described in the "Other Income" provisions. Deductible Sources of Income include:

- benefits under or in lieu of Workers' Compensation Law, Occupational Disease Law, Unemployment Compensation Law, or any other act or law of like intent;
- state mandated disability income plans;
- an automobile insurance policy providing disability wage loss benefits;
- benefits under The Railroad Retirement Act;
- benefits under The Jones Act; Title 46 US Code, section 30104;
- any labor management trustee, union or employee benefit plans that are funded in whole or in part by your Employer;
- any disability income benefits under:
  - any other group plan of your Employer; or
  - any governmental retirement system as a result of your job with your Employer;
- any disability income benefits you receive under your Employer's Retirement Plan;
- the Employer-paid portion of any Retirement Plan. Disability income benefits that reduce your accrued Retirement Plan benefit will be treated as a retirement benefit;
- disability or retirement benefits under the United States Social Security Act, as follows:
  - disability income benefits you are eligible to receive;
  - retirement benefits you receive;

  If your Disability begins after your Social Security Normal Retirement Age, your Social Security retirement benefits will not be offset if, prior to your Disability, you were already receiving Social Security retirement benefits.
- the amount you receive from any salary continuation paid to you by your Employer; Deductible Sources of Income includes only the amount of these benefits which, when combined with your benefit, exceeds 100% of your Total Monthly Earnings. The amount in excess of 100% of Total Monthly Earnings will be used to reduce your benefit.
- the amount you receive from any sick leave paid to you by your Employer;
- any amount you receive by compromise, settlement or other method as a result of or related to any actual or threatened litigation or a claim for lost wages, income replacement, or any Other Income benefit. Such amount includes any amount received as a result of alleged malpractice, tort, other similar litigation, or third party claim; or
- any amount you receive from a separation of employment agreement from your Employer including severance pay or any other income settlement of an employment contract.

Disability and Disabled means that you are Totally Disabled or Partially Disabled. If a particular occupation requires a license, you will not be considered Disabled solely because you are unable to obtain a license or continue to qualify for a license.

Disability Earnings means the income you receive from work performed while Partially Disabled or while participating in a Rehabilitation Program. Disability Earnings does not include income you receive from work performed prior to your Disability, nor income that is not derived from work performed while Disabled.

Drug and Alcohol Illness means:

- alcoholism;
- the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance; or
- the use of prescription medications other than as prescribed by your Physician.

Eligibility Waiting Period means the length of time you must be a member in an Eligible Class before you can apply for insurance. The Eligibility Waiting Period is shown in the Benefit Highlights.

Elimination Period means the number of consecutive days of Total Disability, shown in the Benefit Highlights, which must be completed before we will pay you the benefit. No benefits will be paid to you for any portion of your Total Disability that occurs during your Elimination Period.

2. DEFINITIONS

During your Elimination Period, a Total Disability that is caused by the same or related Accident or Sickness will be considered as continuous even if you cease to be Totally Disabled and return to work for a period not to exceed 30 trial workdays.

We will not count these trial workdays toward satisfaction of your Elimination Period. However, if you become eligible for insurance under another group disability income insurance policy, the terms of this provision will not apply.

Employee means a person who is:

- employed by the Employer within the United States;
- a U.S. citizen or a U.S. resident;
- scheduled to work at least the minimum hours shown in the Benefit Highlights;
- paid regular earnings in accordance with applicable state and federal wage and hour laws; and
- has a legitimate federal tax identification number.

Employee does not include a seasonal or temporary employee whose annual work schedule is less than 12 months during a calendar year.

If you are an Employee and you are working on temporary assignment outside of the United States for 12 months or less, you will be deemed to be working within the United States. If you are an Employee and you are working on a temporary assignment outside of the United States for more than 12 months, you will not be considered an Employee under the Policy unless we agree in Writing.

Employer means the Employer named on the cover page of this Certificate and includes any subsidiary or affiliated company named in the application.

Evidence of Insurability means a statement or records of your medical history upon which acceptance for insurance will be determined by us. In some cases, we may require that you submit to a paramedical or other physical examination or tests, at our expense, as part of the Evidence of Insurability. Evidence of Insurability must be satisfactory to us.

Fibromyalgia means a disorder that may be characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and/or mood issues.

Full-time Basis means, for the first 24 months, you have the capacity to perform the Material and Substantial Duties of your Regular Occupation for the number of hours you normally performed your Regular Occupation prior to your Disability. After 24 months, Full-time Basis means you have the capacity to perform Any Occupation for the number of hours you normally performed your Regular Occupation prior to your Disability.

If you normally performed your Regular Occupation in excess of 40 hours per week, we will consider you as being able to perform that requirement if you work or have the capacity to work 40 hours per week.

Gainful Occupation means employment that is, or can be expected, to provide you with an income of at least the Gainful Occupation Percentage shown in the Benefit Highlights.

Good Cause means documented physical or mental impairments which prevent you from participating in or completing the Rehabilitation Program. Good Cause may also mean a necessary medical program which prevents or interferes with your participation in or completion of the Rehabilitation Program.

Gross Benefit means your benefit before reductions for any Deductible Sources of Income or Disability Earnings.

Hospital means a facility licensed in the applicable jurisdiction that provides medical care and Treatment to sick and injured persons on an inpatient basis with 24 hour nursing service by or under the supervision of a Physician. Hospital does not include a rest home, a skilled nursing facility, an extended care facility, a place of convalescence, rehabilitative care, custodial care or a place primarily for the treatment of drug addiction or alcoholism.

Indexed Total Monthly Earnings means your Total Monthly Earnings prior to the date your Disability began, adjusted on the first of the month following 12 calendar months of Partial Disability benefit payments and each annual anniversary thereafter. Each adjustment to the Indexed Total Monthly Earnings is the lesser of 10% or the

current annual percentage increase in the Consumer Price Index for Wage Earners and Clerical Workers as published monthly by the U.S. Department of Labor. We reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the Consumer Price Index.

Late Entrant means you enroll for any insurance more than 31 days after you first become eligible to enroll in it.

Layoff means that you are temporarily not Actively at Work for a period of time your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Layoff.

Leave of Absence means that you are temporarily not Actively at Work for a period of time your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Leave of Absence.

Material and Substantial Duties means the essential tasks, functions, skills or responsibilities required by employers generally for the performance of your Regular Occupation. Material and Substantial Duties does not include any tasks, functions, skills or responsibilities that could be reasonably modified or omitted from your Regular Occupation.

Medically Necessary means the Treatment, services or supplies necessary and appropriate for the diagnosis or Treatment of an Accident or Sickness based upon generally accepted medical standards.

Mental Illness means any Sickness, disease or disorder, including those which are the result in any way of a genetic, chemical, organic or biological cause, which:

- is medically classified or considered, whether in whole or in part, to be a psychological, behavioral or emotional condition in accordance with the most recent Diagnostic Statistical Manual;
- is manifested by psychological distress or impaired social functioning, or both; and
- is treated by or dealt with, in whole or in part, through psychotherapeutic or sociotherapeutic methods or by medication which is intended to alter or affect emotions, behavior or thought content.

Mental Illness includes but is not limited to:

- anxiety and panic;
- somatoform disorders;
- mood disorders, including depression and bipolar disorder (manic depression);
- dissociative disorders and schizophrenia; and
- personality and eating disorders.

This listing is intended to present examples of Mental Illness and shall not be taken or construed as a limitation of the term as it is defined above.

Musculoskeletal and Connective Tissue Illness means any musculoskeletal and connective tissue disease or disorder, sprains and strains of joints and adjacent tissues, including but not limited to:

- cervical, thoracic and lumbosacral back and its surrounding soft tissue;
- carpal tunnel or repetitive motion syndrome;
- temporomandibular joint or craniomandibular joint disorder;
- myofascial pain; and
- scoliosis that does not require surgery.

Musculoskeletal and Connective Tissue Illness does not include:

- herniated, ruptured or bulging discs with neurological abnormalities that are documented by electromyogram, and computerized tomography or magnetic resonance imaging;
- scoliosis that requires surgery;
- tumors, malignancies, or vascular malformation;
- radiculopathies that are documented by electromyogram;
- spondylolisthesis, grade II or higher;
- myelopathies and myelitis;
- demyelinating diseases;
- traumatic spinal cord necrosis;
- osteopathies;

- rheumatoid or psoriatic arthritis; or
- lupus.

Non-deductible Sources of Income means Other Income that is not deducted from your Gross Benefit as described in the "Other Income" provisions. Non-deductible Sources of Income include:

- Income from:
  - 401(k) plans;
  - 403(b) plans;
  - profit sharing plans;
  - thrift plans;
  - tax sheltered annuities;
  - stock ownership plans;
  - non-qualified plans of deferred compensation;
  - pension plans for partners;
  - military pension plans;
  - credit disability insurance;
  - franchise disability income plans;
  - a retirement plan from another employer;
  - Individual Retirement Accounts (IRA);
  - vacation pay;
  - holiday pay;
  - any amount you receive under any individual or association disability income policy;
- any disability income benefits you receive from the Veterans Administration.

Other Income means those benefits or sources of income that are provided or available while you are receiving a benefit under the Policy. Other Income includes Deductible Sources of Income and Non-deductible Sources of Income. Other Income includes any benefits that would have been available to you had you applied for that benefit. Except for benefits payable under a Retirement Plan, Other Income must be provided as a result of the same Disability for which a benefit is payable.

Partial Disability and Partially Disabled means during the Elimination Period and the next 24 months you:

- are unable to perform one or more of the Material and Substantial Duties of your Regular Occupation on a Full-time Basis; and
- have Disability Earnings of less than 80% of your Indexed Total Monthly Earnings.

The Disability must be the material and substantial factor in causing the earnings loss.

After 24 months of receiving Total and Partial Disability benefits combined, Partial Disability and Partially Disabled means you:

- are unable to perform with reasonable continuity any Gainful Occupation for which you are or could become reasonably qualified for by education, training and experience; and
- have Disability Earnings of less than your Gainful Occupation Percentage shown in the Benefit Highlights.

The Disability must be the material and substantial factor in causing the earnings loss.

A Partial Disability must be caused by an Accident or Sickness and must commence following a period of Total Disability. You must be Totally Disabled during your Elimination Period.

Participation in a Riot, Rebellion or Insurrection, the words "Participation" and "Riot" in this phrase mean: Participation includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in your own defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including, but not limited to, police officers and firefighters.

Riot includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequence of such disorder.

2. DEFINITIONS

Period of Disability means the number of consecutive days that you are Disabled beginning with the first day you are Totally Disabled and under the Continuing Care of a Physician for the Accident or Sickness causing your Disability.

Physician means an individual who is operating within the scope of his or her license and is either:

- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and to prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by state or provincial law to have the same authority as a legally qualified medical doctor.

The Physician cannot be you, a business associate, or any family member. “Family member” means: (a) your Spouse or domestic partner and (b) the following relatives of you or your Spouse or domestic partner: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Policy means the group insurance policy under which this Certificate is issued.

Policyholder means the entity to which the Policy is issued.

Pre-existing Condition means during the 90 days prior to your effective date of insurance or the effective date of an increase in your amount of insurance, you:

- received medical Treatment, advice or care for the condition; or
- took prescribed drugs or medicines for the condition.

Prior Policy means the plan of disability income insurance provided through or sponsored by your Employer and under which you were insured on the day before November 1, 2016. Prior Policy includes an uninsured disability income plan of your Employer.

Proof means any medical, financial, or other information that we require to make a claim determination.

Regular Occupation means the occupation you are performing immediately prior to the first date your Period of Disability commences. This refers to your occupation as it is typically performed in the national economy rather than the duties required by a specific employer or at a specific location.

Rehabilitation Program means a Written agreement between you and us in which we agree to provide, arrange or authorize vocational, physical or psychiatric rehabilitation services and you agree to participate in the Rehabilitation Program.

Retirement Plan means a program that provides retirement benefits to Employees and is not funded wholly by Employee contributions. Retirement Plan does not include:

- a profit-sharing plan;
- a thrift plan;
- a deferred compensation plan;
- a non-qualified pension plan;
- an Individual Retirement Account (IRA);
- a Tax Sheltered Annuity (TSA);
- a salary reduction plan (401(k), 403(b) or like plan);
- a Keogh plan (HR-10) with respect to Partners;
- an Employee Stock Ownership Plan (ESOP); or
- any amount rolled over or transferred to any other retirement plan as defined in Section 402 of the Internal Revenue Code.

Sickness means disease or illness, Mental Illness, Drug and Alcohol Illness, Chemical and Environmental Illness, Chronic Fatigue, Musculoskeletal and Connective Tissue Illness, Fibromyalgia or pregnancy. A Disability caused by a Sickness must:

- occur while covered under the Policy; and
- not otherwise be excluded under the Policy.

2. DEFINITIONS

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Spouse means any person who is a party to a marriage and under state, federal or provincial law is recognized as a spouse or civil union partner.

Total Disability and Totally Disabled means during the Elimination Period and the next 24 months you are unable to perform one or more of the Material and Substantial Duties of your Regular Occupation.

After 24 months of receiving Total and Partial Disability benefits combined, Total Disability and Totally Disabled means you are unable to perform with reasonable continuity any Gainful Occupation for which you are or could become reasonably qualified for by education, training and experience.

Total Disability must be caused by an Accident or Sickness and must commence while you are insured under the Policy. You must be Totally Disabled during your Elimination Period.

Treatment means a Physician's consultation, care or services; diagnostic measures; or the prescription, refill or taking of prescribed drugs or medicines.

We, Us, Our (we, us, our) means Sun Life Assurance Company of Canada.

Written or Writing means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

You, Your (you, your) means an Employee who is eligible for insurance under the Policy.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATIONS

When are you eligible for insurance?
You are initially eligible for insurance on the latest of:

- November 1, 2016;
- December 9, 2019 for All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina; or
- the first day of the month coincident with or next following the date your Eligibility Waiting Period ends; or
- the date you first are Actively at Work in an Eligible Class.

When must you enroll for insurance?
You must enroll within 31 days of the date you are initially eligible, otherwise you will be considered a Late Entrant.

If you decide later you want to enroll for insurance, Evidence of Insurability will be required.

When does your insurance start?
If you are not a Late Entrant, your insurance starts on the later of the date:

- you are eligible; or
- you enroll and agree to make any required contribution toward the cost of insurance; and

you are Actively at Work on that date.

If you are a Late Entrant, Evidence of Insurability is required for any amount of insurance. That amount will not start until we approve it in Writing, provided you are Actively at Work on that date.

If you are not Actively at Work, your insurance will not start until you resume being Actively at Work.

When can you make changes in your insurance?
You may request a change in your benefit elections at any time if you are covered under the Policy and Actively at Work.

Evidence of Insurability may be required for any change in insurance.

When does a change in your insurance start?
If you are Actively at Work, any increase in insurance or benefits will start on the date of change, for an increase in your Total Monthly Earnings.

If you are not Actively at Work on that date, any increase in insurance or benefits will not start until you resume being Actively at Work.

Whether or not you are Actively at Work, any decrease in insurance or benefits will start on the date of change, for a decrease in your Total Monthly Earnings.

Any change is subject to all the terms of the Policy.

When are you required to provide Evidence of Insurability?
You must provide Evidence of Insurability if you:

- enroll for insurance as a Late Entrant;
- discontinued coverage and subsequently re-enroll.

When does your insurance end?
Your insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your insurance or any part of your insurance; or
- the date you notify us in Writing to cancel your insurance; or
- the date you die.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATIONS

Your insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you enter active duty in any armed service;
- the date you retire;
- the date your class is no longer included for insurance; or
- the last day you are Actively at Work.

If your coverage has ended, can it be reinstated?
If your insurance ends for any reason other than you have voluntarily terminated it, then you may apply to reinstate your insurance within 12 months from the date it ended. To reinstate, you must apply within 31 days after you return to being Actively at Work in an Eligible Class. Reinstatement will be effective on the later of the date:

- you agree to make any required contribution toward the cost of your insurance; and
- you are Actively at Work.

A new Eligibility Waiting Period will not apply.

Your reinstated insurance will be subject to all the terms and provisions of the Policy.

4. BENEFIT PROVISIONS

What is the disability income benefit?
Disability income benefits are benefits paid to you to partially replace your income if you become Disabled while insured.

When do disability income benefits become payable?
We will pay you a benefit as calculated below, for a Period of Disability, subject to all the terms of the Policy if you:

- send Proof to us that you have become Disabled;
- are insured under the Policy at the time your Disability commences; and
- have completed your Elimination Period shown in the Benefit Highlights.

How is the benefit calculated for a Total Disability?
To determine the benefit we will pay each month you are Totally Disabled we will subtract all Deductible Sources of Income from the lesser of:

- the Benefit Percentage you elected multiplied by your Total Monthly Earnings; or
- the Maximum Benefit you elected.

The result is your Total Disability benefit.

The benefit payable will never be less than the Minimum Benefit shown in the Benefit Highlights.

How is the benefit calculated for a Partial Disability?
To determine the benefit we will pay for the first 12 months while you are Partially Disabled, add your Deductible Sources of Income and your Disability Earnings to your Gross Benefit for a Total Disability.

If the calculation above is more than 100% of your Indexed Total Monthly Earnings, subtract the amount in excess of 100% from your benefit for a Total Disability. The result is your benefit for a Partial Disability.

If the calculation above is 100% or less than your Indexed Total Monthly Earnings, your benefit for a Partial Disability is the same as your benefit for a Total Disability.

If you continue to be Partially Disabled after receiving Partial Disability benefits for 12 months, your Partial Disability benefit will be recalculated based on the higher result of the following proportionate loss formula and 50% benefit formula:

Proportionate Loss Formula

(A divided by B) multiplied by C

where:

A = your Indexed Total Monthly Earnings minus your Disability Earnings.
B = your Indexed Total Monthly Earnings.
C = your Total Disability benefit.

50% Benefit Formula

Your Total Disability benefit and reduce by 50% of your Disability Earnings.

When is the benefit paid?
The benefit will be paid as follows:

- benefits will be paid monthly following your Elimination Period as specified in the Benefit Highlights; and
- for each day for which a benefit is payable, the amount paid will be equal to 1/30th of the benefit.

What happens if you return to work and become Disabled again?
We will treat this new Disability as part of your prior Disability if you returned to work and were Actively at Work for less than:

- six months, if due to the same or related causes; or
- one day, if due to an entirely unrelated cause.

You will not have to complete a new Elimination Period.

Your benefit will be subject to the same terms and conditions as were applicable to the original Disability.

Your benefit will not continue if:
- your coverage under the Policy terminates;
- you become eligible for coverage under any other group disability income policy; or
- you refuse to complete a rehabilitative assessment or you cease to participate in a Rehabilitation Program without Good Cause.

If your new disability begins later than the time periods specified, you will need to complete a new Elimination Period.

When does your benefit end?
Your benefit will end on the earliest of the date:
- you do not submit to any medical examination or clinical assessment requested by us;
- we determine you are no longer Disabled, even if you choose not to work;
- you reach the end of your Maximum Benefit Duration;
- you do not provide Proof to us that you continue to be Disabled; or
- you do not provide Proof that your earnings loss is a direct result of your Disability.

In addition to the circumstances shown above, your benefit is subject to termination as otherwise stated under the terms and conditions of the Policy.

How is Other Income applied to your benefit?
The amount of Deductible Sources of Income you receive will be deducted from your Gross Benefit.

Are you required to apply for Other Income benefits?
If you are, or become eligible, for any Deductible Sources of Income, you must apply for that Other Income and make reasonable efforts to reapply for or appeal the denial of any application for that Other Income. Any assistance in that process is not an acknowledgement that you are Disabled or have an eligible claim for benefits.

What is the Right of Recovery obligation?
You must pursue all valid claims including, but not limited to, claims of negligence or wrong doing by any third-party, claims for restitution, constructive trust, equitable lien, breach of contract, and any other state or federal claims you may have against any third party responsible, in whole or in part, for any Accident, Sickness, or Disability for which any benefits have been paid or are payable under the Policy. You must immediately advise us of any action, claim or proceeding to recover such damages or income and any amount you recover and place any funds received in a constructive trust for payment to us. We reserve the right to pursue any and all claims not pursued by you, and you agree to assign all such claims to us upon our request.

Is Other Income estimated?
We have the right to estimate the amount of any Deductible Sources of Income you are eligible to receive and to reduce your benefit by the estimated amount.

Until approval or denial is made, we will estimate the amount you would receive for any Deductible Sources of Income. That estimate will be considered your Deductible Sources of Income amount. When approval or denial is made, the benefits paid or payable will be adjusted as necessary. We will not estimate if:
- you have applied for the Other Income benefits; and
- you agree to appeal any denials of any Deductible Sources of Income benefits to all administrative levels we deem necessary; and
- you complete and sign the Sun Life Reimbursement Agreement.

4. BENEFIT PROVISIONS

What happens when the Other Income benefits have been awarded or have been denied?
You must notify us in Writing within 31 days of receiving notice of approval, denial or an adjustment in the amount of Deductible Sources of Income (other than for cost of living increases). If necessary we will make an adjustment to your benefit. If you have been underpaid, we will immediately make a lump sum payment to you of the amount that has been underpaid. If you have been overpaid, you must reimburse us the amount of the overpayment within 31 days of the award. We have the right to reduce or eliminate your future benefit payments until you have repaid the amount of the overpayment. During the overpayment reimbursement period, the Minimum Benefit will not apply.

What happens if you receive increases in your Other Income benefits?
After the first deduction for each of your Deductible Sources of Income benefits, we will not reduce your benefit payments due to cost of living increases you receive from any sources described as Deductible Sources of Income. This does not apply to any increase in earnings you receive from employment.

What is the Social Security Disability Income Assistance Program?
At your request, we will assist you (if appropriate) through the various levels of the Social Security claims process, including the application and appeals processes.

5. ADDITIONAL BENEFITS

You are insured for the additional benefits shown below provided you:

- are eligible for those benefits;
- are enrolled for those benefits; and
- have agreed to make the required contribution for those benefits.

These additional benefits are subject to all the terms and conditions of the Policy. In addition to the termination provisions shown in the Eligibility, Effective Dates and Terminations section, termination provisions specific to an additional benefit are shown in this section.

ACCIDENTAL DISMEMBERMENT/LOSS OF SIGHT BENEFIT

What is the Accidental Dismemberment/Loss of Sight (ADLOS) Benefit?
We will pay an ADLOS Benefit to you for the number of months specified for that loss, as shown below. We will pay the ADLOS Benefit if we receive Notice and Proof that while insured you:

- sustained an Accidental Bodily Injury; and
- incurred one of the following losses within 365 days of the date of the Accidental Bodily Injury.

If you incur more than one of the losses, shown below, from any one accident, only the loss with the greatest amount of months will be payable.

Type of Loss	Number of Benefit Payments
Loss of both hands	48 months
Loss of both feet	48 months
Loss of the entire sight of both eyes	48 months
Loss of one hand and the entire sight of one eye	48 months
Loss of one foot and the entire sight of one eye	48 months
Loss of one hand and one foot	24 months
Loss of the entire sight of one eye	12 months
Loss of thumb and index finger of the same hand	12 months

Loss of hand or foot means a total and permanent physical separation of the limb from the body, occurring at or above the wrist or ankle. Loss of sight means a total (i.e., 100%) and irrecoverable loss of sight. Loss of thumb and index finger means a total and permanent physical separation of the thumb and finger from the hand, occurring through or above the metacarpophalangeal joint. Regardless of the residual function level (i.e., 0%-100%), of a finger, hand or foot, if a limb is surgically reattached, no ADLOS benefit is payable.

How is the Accidental Dismemberment/Loss of Sight Benefit calculated?
To determine your benefit for the specific loss, multiply the number of benefit payments for that loss by the lesser of:

- your Gross Benefit; or
- the Maximum Benefit (shown in the Benefit Highlights).

This amount is not subject to reductions from Other Income.

No benefit is payable for Disability during any period we are paying a benefit for the specific loss under the ADLOS Benefit. If you are Disabled after the expiration of the benefit for the specific loss, a disability income benefit will be payable according to the terms of the Policy. Any period you have received an ADLOS Benefit for the specific loss will count towards satisfaction of the Maximum Benefit Duration and the Disability benefit period.

What happens if I die before receiving all the benefit payments?
If you die while receiving an ADLOS Benefit, the remaining amount of benefit payments, if any, will be payable in a lump sum to your estate. No ADLOS Benefit is payable beyond the number of months specified above.

For the purposes of this ADLOS Benefit:

Accidental Bodily Injury means bodily harm caused solely by an Accident.

5. ADDITIONAL BENEFITS

COBRA CONTINUANCE PREMIUM BENEFIT

What is the COBRA Continuance Premium Benefit?
We will pay you a COBRA Continuance Premium Benefit if you are receiving disability income benefits and you elect to continue your medical and/or dental insurance as permitted under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, including changes made by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

When are you eligible for the COBRA Continuance Premium Benefit?
You are eligible to receive the COBRA Continuance Premium Benefit if you:

- are receiving a benefit;
- have been Disabled for the greater of 180 consecutive days or your Elimination Period;
- have elected the COBRA continuance under the medical and/or dental insurance plan sponsored by your Employer; and
- provide us with Proof on a quarterly basis that you are making premium payments to your Employer for the COBRA continuance of medical and/or dental insurance.

What is the amount of the COBRA Continuance Premium Benefit?
The COBRA Continuance Premium Benefit is the lesser of:

- $400 per month; or
- the actual amount you pay to your Employer to continue your medical and/or dental insurance pursuant to COBRA.

When does your COBRA Continuance Premium Benefit end?
The COBRA Continuance Premium Benefit will end on the earliest of:

- the date you are no longer Disabled;
- the end of your Maximum Benefit Duration;
- the date your COBRA continuance under your Employer sponsored medical and/or dental plan ends;
- the date you fail to give us Proof that you are making premium payments to your Employer for the COBRA continuance of your medical and/or dental insurance; or
- the date 18 COBRA Continuance Premium Benefit payments have been made.

What happens when your COBRA Continuance Premium Benefit ends?
If you discontinue making premium payments to your Employer to continue your medical and/or dental insurance pursuant to COBRA, any amounts due to you or refundable to us will be calculated based on 1/30th of the monthly COBRA Continuance Premium Benefit for each day of a Period of Disability that is less than a full month.

REHABILITATION SERVICES

What are the rehabilitation services?
If you become Disabled, we may determine that you are a suitable candidate to receive vocational rehabilitation services. In order for you to be eligible for such services, you must have the functional capacity to successfully complete a Rehabilitation Program. These services include, but are not limited to:

- job modification;
- job placement;
- retraining; and
- other activities reasonably necessary to help you return to work.

We may require you to participate in a rehabilitation assessment or a Rehabilitation Program at our expense. We will work with you, your Employer, your Physician and others, as appropriate, to develop a Rehabilitation Program.

Eligibility for vocational rehabilitation services is based on your education, training, experience and physical/mental capabilities. We will determine whether you are eligible for vocational rehabilitation services.

The Rehabilitation Program may, at our sole discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you are participating in the Rehabilitation Program.

5. ADDITIONAL BENEFITS

What happens to your benefit if you participate in a Rehabilitation Program?
If you participate in a Rehabilitation Program, you will receive the greater of:

- the Benefit Percentage (as shown in the Benefit Highlights), multiplied by 1.10, multiplied by your Total Monthly Earnings, reduced by your Disability Earnings and Deductible Sources of Income; or
- your current benefit multiplied by 1.10.

This increased amount will end on the earliest of:

- the date you complete the Rehabilitation Program;
- the date you cease to participate in the Rehabilitation Program without Good Cause;
- the date your benefits cease; or
- 12 months after your Rehabilitation Program began.

What happens if you refuse rehabilitation services?
If you refuse to participate in your rehabilitation efforts or you refuse to participate or cease to participate in a Rehabilitation Program without Good Cause, your benefits will end.

SURVIVOR BENEFIT

What happens to your benefit if you die?
If you die while insured under the Policy, we will pay a lump sum benefit to your Eligible Survivor provided:

- you were Disabled prior to your death;
- you completed your Elimination Period; and
- we receive Proof of your death.

How is the Survivor Benefit determined?
If the above conditions are met, we will pay your Eligible Survivor 3 times your Gross Benefit for the month prior to your death.

Only one lump sum will be paid regardless of the number of Eligible Survivors. If there is more than one Eligible Survivor, the lump sum will be paid in equal shares to those persons.

If you do not have an Eligible Survivor, the Survivor Benefit will be payable to your estate.

For the purposes of this Survivor Benefit:

Eligible Survivor means your Spouse. If you do not have a Spouse at the time of your death, your children who are under age 25 are your Eligible Survivors.

WAIVER OF PREMIUM

Are you required to pay premiums while you are Disabled?
We will waive the premium payments for your insurance under the Policy beginning the first of the month following completion of your Elimination Period. The waiver will continue as long as benefits are payable under the Policy. If the Policy is in force when your Disability ends, you will remain insured if you return to an Actively at Work status in an Eligible Class and premium payments for your insurance under the Policy are made on the first of the month following the date you are no longer Disabled.

6. EXCLUSIONS AND LIMITATIONS

What are the exclusions?
No benefit is payable to you under the Policy for any Period of Disability or other loss for which benefits are payable that is caused by, contributed to in any way or resulting from:

- intentionally self-inflicted injuries;
- war or any act of war or your active duty in any armed service during a time of war (this does not include acts of terrorism);
- a Pre-existing Condition; except:
  - if your Disability begins later than 12 months after your effective date or later than 12 months after the effective date of any increase in your amount of insurance.
  - for cost of living, contract, or periodic salary review increases;
- your active Participation in a Riot, Rebellion or Insurrection;
- your committing or attempting to commit an assault, felony, or other criminal act.

What are the limitations?
No benefit is payable to you for any Period of Disability or other loss:

- while you are not under the Continuing Care of a Physician for the Accident or Sickness causing your Disability, unless you have reached your maximum point of recovery and are still Disabled;
- for any period you do not submit to any medical examination or clinical assessment requested by us; or
- for any Period of disability during which you are incarcerated.

Is a limited benefit payable for a Disability due to Mental Illness?
If a Period of Disability is caused by, contributed to in any way or resulting from Mental Illness, the benefit will be paid for not more than 24 months if you are under the Continuing Care of a specialist in psychiatric care. Benefits will be paid beyond 24 months if:

- you are Confined in a Hospital or institution licensed to provide psychiatric Treatment; or
- you continue to be Disabled when discharged from a Hospital or institution licensed to provide psychiatric Treatment, then we will continue your benefits for up to 90 days. If you become reconfined during the 90 day period and remain Confined for at least 14 consecutive days, we will continue your benefit payments during your reconfinement. Upon discharge, you will be eligible for up to an additional 90 days of benefits if you continue to be Disabled.

Is a limited benefit payable for a Disability due to Drug and Alcohol Illness?
If a Period of Disability is caused by, contributed to in any way or resulting from Drug and Alcohol Illness, the benefit will be paid for not more than 24 months if you are actively supervised by a Physician or rehabilitation counselor and are receiving continuing Treatment from a rehabilitation center or a designated institution approved by us. Benefits will be paid beyond 24 months if you are Confined in a Hospital or institution licensed to provide Drug or Alcohol Treatment.

Is a limited benefit payable for a Disability due to other conditions?
If a Period of Disability is caused by, contributed to in any way or resulting from Chemical and Environmental Illness or Chronic Fatigue or Musculoskeletal and Connective Tissue Illness, or Fibromyalgia, the benefit will be paid for not more than 24 months. Benefits will be paid beyond 24 months if you are Confined in a Hospital or institution.

Is a limited benefit payable if you are living outside the United States or Canada?
If you are residing outside of the United States or Canada during a Period of Disability, the benefit will be paid for not more than 12 months. You will be considered to be residing outside the United States or Canada if you have been outside of the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefit payments. Benefits after the first 12 months are payable only if you return to the United States or Canada for 6 consecutive months. This Limitation does not apply if your Disability begins while you are Actively at Work or on vacation outside of the United States or Canada and you return as soon as you are physically able to do so.

7. CLAIMS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us Written notice and Proof of claim on our form within the time limits specified. Your Employer has the notice and Proof of claim forms.

NOTICE OF CLAIM

When does Written notice of claim have to be submitted?
Written notice of claim must be given to us:

- for a disability, no later than 30 days before the end of your Elimination Period or within 30 days after the termination of the Policy, if earlier; or
- for any Additional Benefit, as stated in the Additional Benefit provision, or in the absence of a requirement, as soon as reasonably possible.

If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

When we receive Written notice of claim, we will send the forms for Proof of claim. If you do not receive the forms within 15 days after Written notice of claim is sent, you may send Proof of claim to us without waiting to receive the claim forms.

PROOF OF CLAIM

When does Written Proof of claim have to be submitted?
Proof of claim must be given to us:

- for a disability, no later than 90 days after the end of your Elimination Period; or
- for any Additional Benefit, as stated in the Additional Benefit provision, or in the absence of a requirement, as soon as reasonably possible.

If requested Proof is not provided, your claim will be denied.

If Proof cannot be given within the time limit, Proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time Proof is otherwise required unless you are legally incompetent.

What is considered Proof of claim?
Proof of claim must consist of at least the following information:

- a description of the loss or disability;
- the date the loss or disability or expense occurred;
- the cause of the loss or disability or expense;
- evidence demonstrating the disability and should include at least Hospital records, Physician records, psychiatric records, x-rays, narrative reports, or lab, toxicology or other diagnostic testing materials as appropriate for the disabling condition;
- police reports;
- incidence reports from your Employer;
- payroll records from your Employer; and
- copies of your wage or earnings statements.

We may require as part of the Proof, authorizations to obtain medical and non-medical information.

Proof of your continued Disability and regular and Continuing Care must be given to us within 30 days of the request for Proof.

Proof must be satisfactory to us.

PAYMENT OF BENEFITS

When are benefits payable?
Benefits are payable within 30 days of the date we receive Proof of the claim.

7. CLAIMS

Benefits are based on the coverage that is in force on the date you are Disabled or the expense was incurred. Any change to the Policy will not affect a payable claim that occurs prior to the change.

When will a decision on your claim be made?
We will send you a Written notice of decision on your claim within a reasonable time after we receive the claim but not later than 45 days after receipt of the claim. If we cannot make a decision within 45 days after receiving your claim, we will request a 30 day extension as permitted by U.S. Department of Labor regulations. If we cannot render a decision within the extension period, we will request an additional 30 day extension. Any request for extension will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond and provide the requested information. You will have 45 days to provide the specified information.

What if your claim is denied?
If we deny all or any part of your claim, you will receive a Written notice of denial stating:
- the specific reason(s) for the denial;
- the specific Policy provision(s) on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- your right to bring a civil action under ERISA, §502(a)), if applicable, following an adverse determination on review; and
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request.

Can you request a review of a claim denial?
If all or part of your claim is denied, you may request in Writing a review of the denial within 180 days after receiving notice of denial.

You may submit Written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

We will review the claim on receipt of the Written request for review, and will notify you of our decision within a reasonable time but not later than 45 days after the request has been received. If an extension of time is required to process the claim, we will notify you in Writing of the special circumstances requiring the extension and the date by which we expect to make a determination on review. The extension cannot exceed a period of 45 days from the end of the initial period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have at least 45 days to provide the specified information.

What if your claim is denied on review?
If we deny all or any part of your claim on review, you will receive a Written notice of denial stating:
- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;

- your right to bring a civil action under ERISA, §502(a), if applicable;
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request; and
- 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."

To whom are benefits payable?
Survivor Benefits are payable to your Eligible Survivor as defined in the Additional Benefits section of the Certificate. All other benefits payable during your lifetime are payable to you except in the following situations:

- you are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons;
- due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described above; or
- you die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay benefits as defined in the Benefit Provisions section of the Certificate.

If we do not pay you and claim is not made by the appropriate person designated above, we may, at our option, make payments under either or both Methods A or B below. Any decision to pay any benefits, prior to the appointment of the appropriate person designated (as shown above), is solely at our discretion, and we may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

Method A: We may pay up to the sum of $5,000 to any individual or entity we determine has incurred or paid expenses as a result of funeral services provided to or on your behalf. If we pay such a benefit, we will not have to pay that benefit amount again and the total benefit due under the Policy shall be reduced by the amount paid under this provision.

Method B: We may pay the whole or any part of such benefit:

- to your Spouse, up to a cumulative amount of $5,000; or
- if you have no Spouse, up to a cumulative amount of $5,000 to any one or more of the following relatives in the following order of priority:
  - first, your child or children;
  - then, your mother or father.

8. INSURANCE CONTINUATION

Are there any conditions under which your insurance can continue?
If you are absent due to Accident or Sickness, your insurance will be continued during:

- the Elimination Period; and
- any period the premium is being waived under the Policy.

While the Policy is in force and subject to the conditions stated in the Policy, your Employer may continue your insurance that was in force on the date immediately before the date you ceased to be Actively at Work by paying the required premium to us for any of the following reasons and durations:

- Layoff – up to 2 months
- Leave of Absence – up to 2 months
- Vacation - based on your Employer's policy, not to exceed 3 months.

You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance pursuant to the Family and Medical Leave Act of 1993, as amended or continue coverage pursuant to a state required continuation period (if any). You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance coverage pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended. You should contact your Employer for more details.

9. CONTINUITY OF COVERAGE

What happens if your Employer replaces other insurance with the Policy?
If your Employer replaces insurance provided by the Prior Policy with the insurance provided by the Policy, Continuity of Coverage benefits as stated in this section may be available to you. These benefits will be available as long as the insurance and level of benefits under the Prior Policy were substantially similar to the insurance provided by the Policy.

What if you are not Actively at Work when your Employer replaces your Prior Policy with the Policy?
You will be covered under the Policy if you are not Actively at Work on November 1, 2016* and:

- you were insured under the Prior Policy on the day before November 1, 2016*;
- you are a member of an Eligible Class;
- premiums for you are paid up to date; and
- you are not receiving or eligible to receive benefits under the Prior Policy.

If you become Disabled and were never Actively at Work while covered under the Policy, any benefit payable will be the lesser of:

- the monthly benefit payable under the Policy; or
- the monthly benefit payable under the Prior Policy had it remained in force.

Does the Eligibility Waiting Period apply when your Employer replaces the Prior Policy with the Policy?
We will apply any period of time satisfied under the Prior Policy to meet the requirements of the Eligibility Waiting Period toward the satisfaction of the period of time required by the Policy's Eligibility Waiting Period.

What if you had a Pre-existing Condition prior to your coverage under the Policy?
You will be given credit under any Pre-existing Condition exclusion under the Policy for the time you were insured under the Prior Policy. The credit will apply to the extent that the previous coverage or level of benefits was substantially similar to level of benefits under the Policy.

Are Disabilities due to a Pre-existing Condition covered?
Benefits may be payable if, on or after November 1, 2016*, you become Disabled due to a Pre-Existing Condition provided you were:

- Insured under the Prior Policy on the day before November 1, 2016*; and
- Actively at Work and insured under the Policy on November 1, 2016*.

Any benefit payable will be determined as follows:

- if you have satisfied the Pre-Existing Condition requirement, the benefit will be based on the Policy's benefit provision.
- if you cannot satisfy the Pre-Existing Condition requirement, the Prior Policy's pre-existing condition provision will be applied and
    - if you would have satisfied the Prior Plan's pre-existing condition requirement, considering time insured under both policies, any benefit payable will be the lesser of:
        - the benefit payable under the Policy; or
        - the benefit payable under the Prior Policy had it remained in force.
    - if you cannot satisfy the Pre-Existing Condition requirement or if the pre-existing condition requirement under the Prior Policy would apply, no benefit will be paid.

*December 9, 2019 for All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina

10. GENERAL PROVISIONS

AGENCY

Can the Policyholder, Employer or third party administrator act as our agent?
For all purposes of the Policy, the Policyholder, Employer or third party administrator acts on its own behalf or as your agent. Under no circumstances will the Policyholder, Employer or third party administrator be deemed our agent.

ALTERATION

Who can alter the Policy?
The only persons with the authority to alter or modify the Policy or to waive any of its provisions are our president, actuary, secretary or one of our vice presidents and any such changes must be in Writing.

ASSIGNMENT

Can benefit payments be assigned?
You cannot assign any interest in the Policy unless we agree in Writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by us will discharge our liabilities under the Policy, to the extent of such payments.

CLERICAL ERROR

What happens when there is a clerical error in the administration of the Policy?
Clerical errors in the administration of the Policy or delays in keeping records for the Policy whether by us, the Policyholder, or the Employer:

- will not terminate insurance that would otherwise have been effective.
- will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error, subject to the "Limit of Premium Refunds" section.

This provision does not apply to benefit administration errors by the Policyholder or the Employer which result in an Employee:

- not enrolling for insurance within required time limits;
- failing to request increased amounts of insurance within required time limits;
- failing to provide any required Evidence of Insurability; or
- failing to exercise any available Insurance Continuation options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of the Policy conflicts with any applicable law, the provision will be automatically amended to meet the minimum requirements of the law, unless otherwise pre-empted by federal law.

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under the Policy?
Payment made under the terms of the Policy will, to the extent of such payment, release us from all further obligations under the Policy. We will not be obligated to see to the application of such payment.

10. GENERAL PROVISIONS

EXAMINATION

What are our examination rights?
We, at our expense, have the right to have any person, whose Disability is the basis of a claim:

- examined by a Physician, other health professional or vocational expert of our choice; and/or
- interviewed by an authorized representative.

This right may be used as often as we determine necessary. Unless authorized by the examining Physician, the examination may not be recorded nor may another person be present during the examination.

INCONTESTABILITY

What is the Incontestability provision?
Except for non-payment of premium, fraud or any claims incurred within two years of the effective date of your initial, increased, additional or reinstated insurance, no statement made by you relating to insurability for such insurance will be used to contest the validity of that insurance after the insurance has been in force for a period of two years during your lifetime. The statement must be contained in a form Signed by you.

This provision shall not preclude the assertion at any time of a defense to a claim based upon your eligibility for insurance.

INSURER'S AUTHORITY

What is our authority?
Sun Life has discretionary authority to make all final determinations regarding claims for benefits under the Policy. This discretionary authority includes, but is not limited to, the right to determine eligibility for benefits and the amount of any benefits due, and to construe the terms of the Policy.

Any decision made by us in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing such a decision shall uphold it unless the claimant proves that it was arbitrary and capricious.

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?
No legal action may start:

- until 60 days after Proof of claim has been given; nor
- more than 3 years after the time Proof of claim is required.

The claimant must exhaust all internal appeal/administrative remedies prior to filing any legal proceeding. If the claimant fails to exhaust all administrative remedies prior to initiating any legal action, we shall be entitled to legal fees in defense of the action. For claims subject to ERISA, if a claimant files state law causes of action that are later determined by a court to be preempted by ERISA, we shall be entitled to legal fees in defense of those causes of action.

Any decision made by us, including review of denial of claims, is conclusive and binding on all parties. Any court reviewing our determination shall uphold such determination unless the claimant proves Sun Life's claim determination is without any rational basis. In any legal proceedings, the Court is limited in its review to the administrative record compiled by Sun Life prior to its final claim determination.

LIMIT OF PREMIUM REFUNDS

Is there a limit on premium refunds?
Whether premiums were paid in error or otherwise, we will refund only that part of the excess premium that was paid during the 12-month period that preceded the date we learned of such overpayment.

10. GENERAL PROVISIONS

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of the Policy?
If relevant facts about the Employer or Employee relating to this insurance are determined not to be accurate:

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the actual facts will decide whether, and in what amount, and for what duration insurance is valid under the Policy.

NON-PARTICIPATING

Does the Policy participate in dividends?
The Policy is non-participating and will not share in any profits or surplus earnings of Sun Life Assurance Company of Canada, and, therefore, no dividends are payable.

PREMIUM PAYMENTS AS EVIDENCE OF INSURANCE

Does the payment of premiums guarantee coverage under the Policy?
The receipt of premiums by us is not a guarantee of insurance. Eligibility for benefits will be determined at the time of claim submission and in order to receive the benefit under the Policy all Policy requirements must be satisfied.

If we determine that you are not eligible for coverage, you should contact your Employer regarding the refund of premiums due, if any.

REIMBURSEMENT

What if a benefit is underpaid or overpaid?
Reimbursement will be made to us for any overpayments that we may make due to any reason. You must repay us within 60 days unless we agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If we have underpaid a benefit for any reason, we will make a lump sum payment for that amount.

Interest does not accrue on any underpaid or overpaid benefit unless required under the applicable law.

STATEMENTS

Are statements warranties?
In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by you in enrolling for insurance under the Policy will be used to reduce or deny a claim unless a copy of your Written application for insurance is or has been given to you or to your Eligible Survivors, if any, or your estate representative.

TIME PERIODS

What time periods apply to this Certificate?
For the purpose of effective dates and termination dates under this Certificate, all days begin at 12:00 midnight and end at 11:59:59 PM at the Policyholder’s location.

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Basic Long Term Disability Income Insurance Certificate
Non-Participating

Employee Group Benefits

Clemens Food Group

Short Term Disability Plan

SUMMARY PLAN DESCRIPTION

PLAN EFFECTIVE DATE:

Note: This summary plan description is a sample only. It was not tailored to the employer's short term disability plan even though some of the provisions of this sample document may be consistent with the employer's short term disability plan. Any plan provisions and summary plan description must be approved by the employer and should be created with the assistance of legal counsel. The employer is the plan fiduciary.

The plan is a self-funded welfare benefit plan ("Plan") providing short term disability benefits ("STD") to eligible participants under the terms and conditions of the Plan. The Plan is administered by Janney Montgomery Scott LLC ("Company"). Sun Life Assurance Company of Canada ("Sun Life") provides certain non-fiduciary claim processing services to the Plan. The Plan is not insured by Sun Life and Sun Life has not issued any insurance policy that would fund benefits under the Plan nor is Sun Life responsible for the payment of any benefits under the Plan. All benefits are funded by the Company through contributions to a trust. The description of Eligible Classes in the Benefit Highlights will help you determine what benefits apply to you.

This booklet is a summary plan description ("SPD"), intended to provide a summarized explanation of the current Plan benefits. However, the Master Plan Document is the document that more fully describes the terms and conditions of the Plan. If the terms of the booklet and the Master Plan Document differ, the Master Plan Document will govern. A complete copy of the Master Plan Document is in the possession of the Company and is available for your review. In the event of any changes in benefits or Plan provisions, you will be provided with a new SPD or a supplement (known as a summary of material modifications) that describes any changes.

Possession of this SPD does not necessarily mean you are insured under the Plan. The requirements for becoming eligible for coverage under the Plan and the dates your coverage begins or ceases are explained within this SPD.

This SPD uses terms and phrases that are listed in the Definitions Section.

For information, call Clemens Family at 215-368-2500.

THE PLAN MAY BE AMENDED OR TERMINATED BY Clemens Family AT ANY TIME AND FOR ANY REASON.

READ THIS DOCUMENT CAREFULLY

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BENEFIT HIGHLIGHTS

SHORT TERM DISABILITY COVERAGE AND BENEFITS

ELIGIBLE CLASSES OF EMPLOYEES

Each full-time employee regularly working 30 or more hours per week including alien and H1B visa employees

CLASSIFICATION OF ELIGIBLE EMPLOYEES

Class 1 – Exempt and Non-exempt employees other than Benefit Level 65-75.

Class 2 – Exempt and Non-exempt salaried employees Benefit Level 65 - 75

AMOUNT OF INSURANCE

Class 1 60% of Basic Weekly Earnings
Class 2 66 2/3% of Basic Weekly Earnings

Elimination Period

(The period of time you need to be continuously Totally Disabled before STD benefits are payable)

14 days for Injury

14 for Sickness and Total Disability that begins later than 72 hours after an accident

Maximum Benefit Period

(The longest period of time the Company will pay you an STD benefit while you are Totally or Partially Disabled)

13 weeks

Total Weekly Earnings

BENEFIT HIGHLIGHTS

Your basic weekly earnings immediately before the first date your Total Disability begins. Total Weekly Earnings does not include commissions, bonuses, overtime pay or any other extra compensation.

WAITING PERIOD

(The period of time you must be employed in an Eligible Class before you can apply for benefits)

All Eligible former Employees of Maxwell Farms, Maxwell Milling and Maxwell Foods located in Indiana and North Carolina hired prior to December 9, 2019
None

All Other Eligible Employees
Until the first of the month coincident with or next following 60 days of employment.

CONTRIBUTIONS

The cost of your Short Term Disability coverage is paid for entirely by Clemens Food Group through contributions to a trust fund.

The following Questions and Answers will help you to better understand your benefits.

Please read them carefully and refer any questions to the Company. If you have any questions about a claim for STD benefits, you may call the Sun Life Group Customer Service Center toll free at 1-800-247-6875.

ELIGIBILITY AND EFFECTIVE DATES OF EMPLOYEE STD COVERAGE

When am I covered under the Plan?

If you are in an Eligible Class shown in the Benefit Highlights, you are eligible on the latest of:

- 1st of the month following 60 days;

When does my coverage start?

Your coverage under the Plan starts on the date you are eligible, if you are Actively at Work on that date.

What if I am not Actively at Work on that date?

If you are not Actively at Work on the date your coverage would normally start, your coverage under the Plan will not start until you are Actively at Work.

When do changes in my amount of coverage occur?

If your amount of coverage increases due to a change in your salary, your increase will take effect immediately upon the date of change, as long as you are Actively at Work on that date.

If your amount of coverage decreases due to a change in your salary, the decrease will take effect immediately upon the date of change.

If you are not Actively at Work on the date an increase in your coverage would normally start, the increase in your coverage will not start until you are Actively at Work.

TERMINATION OF EMPLOYEE STD COVERAGE

When does my coverage under the Plan cease?

Your coverage ceases on the earliest of:
- the date the Plan terminates.
- the date you are no longer in an Eligible Class.
- the date your class of employment is no longer included for coverage under the Plan.
- the date you retire.
- the date you request in writing to terminate your coverage.
- the date you enter active duty in any armed service during a time of war (declared or undeclared).
- the date your employment terminates.
- the date you cease to be Actively at Work.

Are there any conditions under which my coverage can continue?

Yes.

Your coverage will continue during any Elimination Period under the Plan**.**

If you are on temporary layoff, leave of absence or vacation, your coverage may continue under the following circumstances: [Insert] You also may be eligible to continue your insurance coverage pursuant to the Family and Medical Leave Act of 1993or pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA). You should contact the Company for more details.

BENEFIT PROVISIONS

SHORT TERM DISABILITY BENEFITS

What is the Short Term Disability Benefit?

Short Term Disability Benefits ("STD") partially replace your income if you become Totally or Partially Disabled while covered under the Plan.

When do STD benefits become payable?

The Company will pay a weekly STD benefit after the end of your Elimination Period, if the Company receives proof that you are:

- Totally Disabled due to an Injury or Sickness; or
- Partially Disabled due to the same Injury or Sickness that caused Total Disability, within 14 days of the end of the period during which you received Total Disability Benefits; and
- under the regular and continuing care of a Physician who provides appropriate treatment by means of examination and testing in accordance with your disabling condition; and
- not engaged in any occupation or employment for wage or profit other than Partial Disability employment with the Company.

What conditions must be met for STD benefits to continue?

The Company will pay you an STD benefit, up to the Maximum Benefit Period, if you provide ongoing proof that you continue to be Totally or Partially Disabled and you still require the regular and continuing care of a Physician. You need to provide proof when the Company asks for it, but the proof is at your expense.

How is the STD benefit calculated?

If you are Totally Disabled, your weekly STD benefit will be calculated based on the Total Disability Benefit formula. If you are Partially Disabled, your weekly STD benefit will be calculated based on the Partial Disability Benefit formula. You need to provide the Company with proof of your weekly earnings on a monthly basis.

BENEFIT PROVISIONS

SHORT TERM DISABILITY BENEFITS

What is the Total Disability Benefit formula?

To determine your Total Disability Benefit:

1. Your Total Weekly Earnings multiplied by the Benefit Percentage (shown in the Benefit Highlights).

2. Subtract Other Income Benefits from the amount determined in Step 1.

An amount equal to 1/7 of the net weekly benefit is payable for each day of Total or Partial Disability that is less than a full week.

What is the Partial Disability Benefit formula?

To determine your Partial Disability Benefit:

1. calculate the STD benefit you would receive if you were Totally Disabled; then

   add your earnings from employment plus your income received from Other Income Benefits to your Total Disability Benefit.

2. if this sum is more than 100% of your Total Weekly Earnings, subtract the amount in excess of 100% from your Total Disability Benefit. This result is your Partial Disability Benefit; or

   if the sum is less than 100% of your Total Weekly Earnings, your Total Disability Benefit is your Partial Disability Benefit.

A Total Disability Benefit will be paid if you are earning 20% or less of your Total Weekly Earnings.

What are Other Income Benefits?

Other Income Benefits are those benefits provided or available to you while your weekly STD benefit is payable. Any Other Income Benefits that are payable as a result of a disability must be provided to you as a result of the same Total Disability payable under the Plan. Other Income Benefits include:

BENEFIT PROVISIONS

SHORT TERM DISABILITY BENEFITS

1. The amount you are eligible for under:
   a. Unemployment Compensation Law; or
   b. Compulsory Benefit Act or Law; or
   c. any other act or law of like intent.

2. Any labor management trustee, union or employee benefit plans that are funded in whole or in part by the Company.

3. Any disability income benefits you are eligible for under:
   a. any other group insurance plan of the Company;
   b. any governmental retirement system as a result of your job with the Company.

4. The amount you receive from any accumulated sick leave.

5. Any formal salary continuation paid to you by the Company which causes your weekly STD benefit, plus Other Income Benefits and any salary continuation to be more than 100% of your Total Weekly Earnings. The amount in excess of 100% of your Total Weekly Earnings will be used as a reduction of the STD benefit otherwise payable under the Plan.

Other Income Benefits will include any amount described above which would have been available to you had you applied for that benefit.

What if I receive payment of Other Income Benefits in a lump sum?

If you receive a lump sum payment for any Other Income Benefits, the Company will prorate the lump sum on a weekly basis over the time period specified for the lump sum payment. If no time period is stated, the lump sum payment will be prorated on a weekly basis over your expected lifetime as determined by the Company.

What happens if I receive increases in my Other Income Benefits?

After the first deduction for each of your Other Income Benefits, the Company will not reduce your weekly STD benefit payments due to cost of living increases. This does not apply to any increase in earnings you receive from employment.

BENEFIT PROVISIONS

SHORT TERM DISABILITY BENEFITS

Are any of my Other Income Benefit estimated?

The Company will estimate the amount of any Other Income Benefits if they have not yet been awarded or denied or if they have been denied and are being appealed. This estimate will be used to reduce the amount of your weekly STD benefit payments. However, the estimate will not be used if, within 15 days of becoming Totally or Partially Disabled, you meet both of the following conditions:

- you have applied for the Other Income Benefit; and
- you complete and sign a Reimbursement Agreement. This Agreement states that you promise to reimburse the Company any overpayment caused by an award of Other Income Benefits.

What happens when the Other Income Benefits have been awarded or have been denied?

You must notify the Company of the amount of Other Income Benefit when it is approved or adjusted (other than cost of living increases) or if it has been denied on final appeal. The Company will make an adjustment to the Net Weekly Benefit when the Company receives written notice of the amount of the Other Income Benefit or when it has been denied. Written Notice must be sent within 31 days after receipt of the Other Income Benefit award or denial.

If after the Company makes an adjustment your Net Weekly Benefit has been underpaid, the Company will make a lump sum payment to you of the amount that has been underpaid.

If after the Company makes an adjustment your Net Weekly Benefit has been overpaid, you must reimburse the Company the amount of the overpayment within 31 days of the award. The Company has the option to reduce or eliminate future STD benefit payments instead of requiring reimbursement in a lump sum. During the overpayment reimbursement period the minimum weekly benefit will not apply.

BENEFIT PROVISIONS

SHORT TERM DISABILITY BENEFITS

When does my weekly STD benefit cease?

Your weekly STD benefit will cease on the earliest of:
- the date you are no longer Totally or Partially Disabled;
- the date you die;
- the end of your Maximum Benefit Period;
- the date you do not provide proof that you continue to be Totally Disabled or Partially Disabled as requested; or
- the date your Partial Disability employment earnings are more than 80% of your Total Weekly Earnings;
- the date the Company determines, in its discretion, that you are able to perform all of the material and substantial duties of your own occupation, even if you choose not to work;
- the date the Company determines, in its discretion, that you are able to perform at least some of the material and substantial duties of your own occupation and you are not working at all; or
- if you are working, the date the Company determines, in its discretion, that you are able to perform at least some of the material and substantial duties of your own occupation but are not working to your capacity.

What happens if I return to work and become Totally Disabled again?

The Company will treat this new Total Disability as part of your prior Total Disability if you return to work and are Actively at Work for less than:
- two consecutive weeks, if due to the same or related causes;
- one day, if due to an entirely unrelated cause.

You will not have to complete a new Elimination Period.

Your weekly STD benefit will be subject to the same terms and conditions applicable to the original Total Disability.

Your weekly STD benefit will not continue if:
- you become eligible for benefits under any other group STD policy; or
- the Plan terminates.

If your new Total Disability begins later than the time periods specified, you will need to complete a new Elimination Period.

BENEFIT PROVISIONS

SHORT TERM DISABILITY BENEFITS

What are the Limitations?

No STD benefit will be payable to you for any Total or Partial Disability during any of the following periods:

- any period you are no longer under the regular and continuing care of a Physician providing appropriate treatment by means of examination and testing in accordance with your disabling condition, unless you have reached your maximum point of recovery and are still Totally or Partially Disabled.

- any period you do not submit to any medical Examination requested by the Company.

- any period you engage in any occupation or employment for wage or profit other than Partial Disability employment with the Company.

- any period of your Total or Partial Disability that is due to Mental Illness (mental, nervous, psychological, emotional diseases, or behavioral disorders of any type), unless you are under the continuing care of a specialist in psychiatric care.

- any period of your Total or Partial Disability that is due to Drug and Alcohol Illness (an illness which results from the abuse of alcohol, drugs or derivatives), unless you are actively supervised by a Physician or Rehabilitation Counselor and are receiving continuing treatment from a rehabilitation center or a designated institution approved by the Company.

BENEFIT PROVISIONS

SHORT TERM DISABILITY BENEFITS

What are the Exclusions?

No STD benefit is payable for any Total or Partial Disability that is due to:

- intentionally self-inflicted injuries;
- your active participation in a riot, rebellion or insurrection;
- a war, declared or undeclared, or any act of war;
- your committing or attempting to commit an assault, felony or other illegal act;
- Injury or Sickness for which you are entitled to benefits under any Workers' Compensation, Occupational Disease or similar law;
- Injury or Sickness sustained while you are doing any act or thing pertaining to any occupation for wage or profit.

CLAIM PROVISIONS

How is a claim submitted?

To submit a claim, you or someone on your behalf must send the Company written Notice and Proof of Claim within the time limits specified. The Company has the Notice and Proof of Claim forms.

When does written Notice of Claim have to be submitted?

Written notice of claim must be given to the Company no later than 30 days after you cease to be Actively at Work.

If notice cannot be given within the applicable time period, the Company must be notified as soon as it is reasonably possible.

When the Company has received written notice of claim, the Company will send the forms for proof of claim. If the forms are not received within 15 days after written notice of claim is sent, proof of claim may be sent to the Company without waiting to receive the proof of claim forms.

When does written Proof of Claim have to be submitted?

Proof of claim must be given to the Company no later than 90 days after the end of your Elimination Period.

If proof cannot be given within these time limits, proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time proof is otherwise required unless the individual is legally incompetent.

What is considered Proof of Claim?

Proof of Claim must consist of at least the following information:
- a description of the disability;
- the date the disability occurred; and
- the cause of the disability.

Proof of Claim may include, but is not limited to, police accident reports, autopsy reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials as required.

Proof of Claim for disability must include evidence demonstrating the disability including, but not limited to, hospital records, Physician records, Psychiatric records, x-rays, narrative reports, or other diagnostic testing materials as appropriate for the disabling condition.

CLAIM PROVISIONS

Proof must be satisfactory to the Company.

The Company may require as part of the Proof, authorizations to obtain medical and non-medical information.

Proof of your continued disability and regular and continuous care by a Physician must be given to the Company within 45 days of the request for proof.

When are benefits payable?

Benefits are payable when the Company receives Proof of Claim that is satisfactory to the Company.

[Note to Employers: The following claim procedures are designed to coordinate with requirements applicable to ERISA benefit plans. If your short term disability plan is not governed by ERISA, these requirements may not apply and/or different requirements may apply.]

When will a decision on my claim be made?

The Company will send you a written notice of decision on your claim within a reasonable time after the Company receives the claim but not later than 45 days after receipt of the claim. If the Company cannot make a decision within 45 days after receiving your claim, the Company will request a 30-day extension as permitted by U.S. Department of Labor regulations. If the Company cannot render a decision within the extension period, the Company will request an additional 30-day extension. Any request for extension will specifically explain:

1. the standards on which entitlement to benefits is based;
2. the unresolved issues that prevent a decision on the claim; and
3. the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date the Company sends notice of the extension to you until the date on which you respond to the request for additional information. You will have at least 45 days to provide the specified information.

What if my claim is denied?

If the Company denies all or any part of your claim, you will receive a written notice of denial setting forth:

1. the specific reason or reasons for the denial;
2. the specific Plan provisions on which the denial is based;

3. your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
4. a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
5. a description of the appeal procedures and time limits;
6. your right to bring a civil action under ERISA, §502(a) following an adverse determination on review;
7. the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request; and
8. the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

CLAIM PROVISIONS

Can I request a review of a claim denial?

If all or part of your claim is denied, you may request in writing a review of the denial within 180 days after receiving notice of denial.

You may submit written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

The Company will review the claim on receipt of the written request for review, and will notify you of the Company's decision within a reasonable time but not later than 45 days after the request has been received. If an extension of time is required to process the claim, the Company will notify you in writing of the special circumstances requiring the extension and the date by which The Company expects to make a determination on review. The extension cannot exceed a period of 45 days from the end of the initial review period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date The Company sends notice of the extension to you until the date on which you respond to the request for additional information. You will have at least 45 days to provide the specified information.

What if my claim is denied on review?

If The Company denies all or any part of your claim on review, you will receive a written notice of denial setting forth:

1. the specific reason or reasons for the denial;
2. the specific Plan provisions on which the denial is based;
3. your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
4. your right to bring a civil action under ERISA, §502(a);
5. the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request;
6. 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."; and
7. the identity of any medical or vocational experts whose advice was obtained in connection with the appeal, regardless of whether the advice was relied upon to deny the appeal.

CLAIM PROVISIONS

Who are benefits payable to?

Benefits payable during your lifetime are payable to you.

If a benefit is payable to your estate, if you are a minor, or you are not competent, the Company has the right to pay an amount of the benefit up to $5,000 to any of your relatives that the Company considers entitled to those benefits. If the Company pays benefits in good faith to a relative, the Company will not have to pay those benefits again.

Who has discretionary authority under the Plan?

The Company has full, final, and conclusive discretion to determine eligibility for benefits and to interpret the terms of the Plan. Benefits are payable under the Plan only if the Company determines, in its discretion, that an individual is entitled to benefits. The Company's determinations and interpretations may only be overturned by a court if the Company's determinations and/or interpretations are arbitrary and capricious or an abuse of discretion.

DEFINITIONS

What are The Company's examination rights?

The Company, at its own expense, has the right to have any person, whose Injury or Sickness is the basis of a claim:
- examined by a Physician, other health professional or vocational expert of its choice; and/or
- interviewed by an authorized Company representative.

This right may be used as often as reasonably required. If you refuse to be examined and/or interviewed, the Company may terminate or deny your claim for benefits, in its discretion.

What are the time limits for legal proceedings?

No legal action may start:
- until 60 days after Proof of Claim has been given; nor
- more than 1 year after the time Proof of Claim is required.

Do these group benefits affect Workers' Compensation?

The Plan is not in lieu of, and does not affect, any requirement for worker's compensation coverage or benefits.

These are some of the general terms you need to know.

Actively at Work means that you perform all the regular duties of your job for a full work day scheduled by the Company at the Company's normal place of business or a site where the Company's business requires you to travel.

You are considered Actively at Work on any day that is not your regular scheduled work day (e.g., you are on vacation or holiday) as long as you were Actively at Work on your immediately preceding scheduled work day, and you:
- are not hospital confined; or
- are not disabled due to an injury or sickness.

You are considered Actively at Work if you usually perform the regular duties of your job at your home as long as you can perform all the regular duties of your job for a full work day and could do so at your Employer's normal place of business, if required, and you:
- are not hospital confined; or
- are not disabled due to an injury or sickness.

DEFINITIONS

Eligibility Date means the date or dates you become eligible for insurance under the Plan. Classes eligible for insurance are shown in the Benefit Highlights.

Employee (You) means a person who is employed by the Company, scheduled to work at least the number of hours shown in the Benefit Highlights, and paid regular earnings.

Injury means bodily impairment resulting directly from an accident and independently of disease. Any Injury must occur and Disability must begin while you are covered under the Plan.

Physician means an individual who is operating within the scope of his license and is either:

- licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- legally qualified as a medical practitioner

The Physician cannot be you, your spouse or the parents, brothers, sisters or children of you or your spouse.

Pregnancy means childbirth, miscarriage, abortion or any disease resulting from or aggravated by the pregnancy.

Sickness means illness, disease or pregnancy. A Disability, because of Sickness, must begin while you are covered under the Plan.

Waiting Period means the length of time immediately before your Eligibility Date during which you must be employed in an Eligible Class. Any period of time before the Plan Effective Date that you were Actively at Work for the Company as a full-time Employee will count towards completion of your Waiting Period. The Waiting Period is shown in the Benefit Highlights.

DEFINITIONS

Elimination Period means a period of continuous days of your Total Disability when no STD benefit is payable. Your Elimination Period is shown in the Benefit Highlights and begins on your first day of Total Disability.

Gross Weekly Benefit means your weekly STD benefit before any reduction of Other Income Benefits.

Maximum Weekly Benefit means the largest amount payable weekly to you. The Maximum Weekly Benefit is shown in the Benefit Highlights.

Partial Disability or Partially Disabled means because of your Injury or Sickness which caused your Total Disability, you continue to be unable to perform all of the material and substantial duties of your own occupation on a full-time basis, but you are:

- performing at least one of the material and substantial duties of your own occupation or another occupation on a part-time or full-time basis; and
- earning less than 80% of your Total Weekly Earnings due to your same Injury or Sickness that caused your Total Disability.

Partial Disability must begin within 14 days after your Total Disability benefits cease and you must have received at least one Total Disability Benefit. Partial Disability employment must be for the Company. Partial Disability employment cannot be for any other employer or self-employment.

The loss of your professional or occupational license, or your inability to obtain or qualify for a license for any reason does not, in itself, constitute Partial Disability.

To qualify for benefits, you must satisfy your Elimination Period with the required number of days of Total Disability. Your Elimination Period cannot be satisfied with days of Partial Disability.

If you are not working, you are not entitled to any benefits under the Plan if the Company determines, in its discretion, that you are able to perform at least some of the material and substantial duties of your own occupation. If you are working, you are not entitled to any benefits under the Plan if the Company determines, in its discretion, that you are not working to your capacity.

DEFINITIONS

Total Disability or Totally Disabled means because of your Injury or Sickness, you are unable to perform all of the material and substantial duties of your own occupation and you are not engaged in any occupation for wage or profit.

The loss of your professional or occupational license or your inability to obtain or qualify for a license for any reason does not, in itself, constitute Total Disability.

To qualify for benefits, you must satisfy your Elimination Period with the required number of days of Total Disability.

Clemens Food Group has been established to provide welfare benefits for its employees. Specifically, the Plan provides short term disability benefits to participants under the terms and conditions of the Plan.

PLAN INFORMATION

1. The name of the plan is: Clemens Food Group

2. The Plan Number is 501.

3. The End of the Plan Year is: 05/01/2015

~~7.~~4. The Plan Sponsor is: Clemens Food Group
2700 Clemens Road
Hatfield, PA 19440

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5. The Employer Identification Number (EIN) is: 75-2990438

6. The Claims Administrator is: Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

The Claims Administrator is delegated certain administrative duties under the plan. The Claims Administrator is not an insurer of benefits under the Plan, has not issued any insurance policy to fund benefits under the Plan, and is not otherwise liable for any benefits under the Plan.

7. The Plan Administrator is: Clemens Food Group
2700 Clemens Road
Hatfield, PA 19440

The Plan Administrator controls and manages the operation and administration of the Plan, and it has full discretionary authority in fulfilling its duties.

~~7.~~8. Agent for Service of Legal Processes: Clemens Food Group
2700 Clemens Road
Hatfield, PA 19440

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9. Authority to Amend and Terminate: Clemens Food Group acting through its Board of Directors or any properly authorized delegate, hereby reserves the right at any time, without prior notice and without consent of anyone, to modify or amend any or all of the Plan for any reason. This reservation of rights includes the right to require, change, or discontinue any contributions required of participants toward the cost of the benefit. In exercising its authority, Clemens Food Group will comply with the requirements of any applicable law, to the extent that such law is not preempted by the Employee Retirement Income Security Act of 1974, as amended.

10. Sources of Contributions and Benefits Paid: Benefits are paid from the Plan. Benefits are funded by the Company through contributions to a trust.

11. Statement of ERISA Rights: As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if one is required by law. The law may require the Plan Administrator to furnish each participant with a copy of the summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan (if one is required), and do not receive them within 30 days, you may file suit in 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. If it should happen that plan fiduciaries misuse the Plan's money (if the plan has any 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 Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance an Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.