Kier Construction Corporation

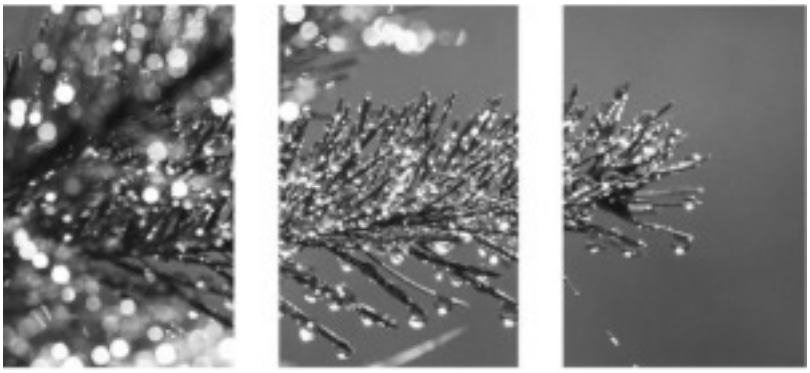
Plan Document and

Summary Plan Description

Employee Medical, Dental, Vision Benefit Plan

Original Effective January: 1, 2013

Last Restated January: 1, 2019



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I INTRODUCTION

PATIENT PROTECTION AND AFFORDABLE CARE ACT

NOTICE OF PLAN STATUS

This Plan is being treated as a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act) including amendments as they become effective.

This Plan Document and Summary Plan Description is a description of the Kier Construction Corporation Employee Benefit Plan Effective January 1, 2016 and restated January 1, 2019. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

The Plan Sponsor recognizes the full responsibility for the contents of the Summary Plan Description and that, while the Claims Administrator, its employees and/or subcontractors may have assisted in the preparation of the document, the Plan Sponsor is responsible for the final text and meaning. This document describes the intent with regard to the employee welfare plan.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, and timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

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

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of covered persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Plan Participants.

Special Eligibility Rules

Full-Time Employee Determinations

Due to federal health reform ("PPACA"), specific eligibility rules may apply to the medical coverage available under the Plan.

For the Plan Years in which the employer mandate under PPACA is in effect with respect to the Employer, the Employer intends to determine eligibility and offer medical coverage based on the guidelines in effect for the relevant plan year. All provisions herein shall be interpreted such that the Employer shall be in compliance with then-existing

rules and guidelines.
To participate in medical coverage under the Plan, an employee must be characterized by the Employer as a common law employee who is either:

1. Reasonably expected to work Full-Time, or,

2. Determined under such procedures as are established by the Employer to have been working Full-Time.

Subject to applicable law changes. "Full-Time" is defined as thirty (30) or more hours of service a week on average in a month. On a reasonable and consistent basis, an Employer may treat one hundred thirty (130) hours of service in a calendar month as the monthly equivalent of thirty (30) hours of service per week.

An Employer may determine each employee's Full-Time status for a calendar month by counting the employee's hours of service for that month. Alternatively, the Employer can opt to count the employee's hours of service for a specific period (the "Measurement Period") to determine whether the employee is Full-Time and must be offered medical coverage for a subsequent period (the "Stability Period").

Subject to any permissible transition rule, the Measurement Period shall be between three (3) and twelve (12) months long followed by a Stability Period of at least six (6) consecutive months but no shorter than the Measurement Period. To the extent permitted under federal law, the Employer may select different periods for various groups of employees. The Measurement Period and Stability Period may be separated by an Administrative Period of up to ninety (90) days.

The Employer shall track the hours of service for each part-time employee, variable hour employee and seasonal employee. An hour of service refers to each hour for which the employee is paid, or entitled to payment, from the Employer for the performance of duties and non-worked hours for which payment is made or due for vacation, holiday, illness, incapacity, layoff, jury duty, military duty, or leave of absence (other than compensation that constitutes income from sources outside of the United States). In the case of employees who are not paid on an hourly basis, the Employer may calculate hours of service using a days-worked equivalency (eight hours of service for each day for which the employee is entitled to pay for worked or non-worked time) or a weeks-worked equivalency (40 hours of service per week for each week for which the employee is entitled to pay for worked or non-worked time), unless the use of the equivalency would substantially understate the employee's hours of service.

If employee's total number of hours of service for a Measurement Period, divided by the number of months in the Measurement Period, equals at least 130, then the employee was fulltime during the Measurement Period and must be considered Full-Time during the Stability Period that follows.

Under the Affordable Care Act Safe Harbors, an employee can drop coverage due to a reduction in hours during a stability period that leads to an inability to pay the monthly employee premium contribution. As an employer, if an employee's payment is late, Employer must provide the employee with a 30-day grace period in order to make the payment. If the employee does not make the payment within the grace period, Employer is not required to provide coverage for the period for which the premium is not timely paid and may terminate coverage.

The employee's revocation of the election of coverage under the group health plan must correspond to the intended enrollment of the employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

A cafeteria plan may rely on the reasonable representation of an employee who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the employee and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan

1. The employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through the Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual enrollment period; and

2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee and any related individuals who cease coverage due to the revocation in a Qualifying Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

A cafeteria plan may rely on the reasonable representation on an employee who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the employee and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies, and the types of charges covered.

Cost Management Services. Explains prior authorization and the methods used to curb unnecessary and excessive charges.

> **The Cost Management Services section should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payments order when a person is covered under more than one Plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a covered person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

Women's Health and Cancer Rights

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

- All stages of reconstruction of the breast on which the mastectomy was performed;

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

- Prostheses; and

- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and Co-Insurance applicable to other medical and surgical benefits provided under this plan.

The Newborns' and Mothers' Health Protection Act (Newborns' Act)

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

Mental Health Parity Act

The Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), included in the Emergency Economic Stabilization Act of 2008, was signed into law on October 3, 2009. The MHPAEA requires that Plan mental health and substance use disorder benefit terms and conditions, including, but not limited to: financial limitations (e.g., co-payments, Co-Insurance, deductibles, out of pocket maximums), and treatment limitations (e.g., number and frequency of visits, days of coverage), must be at parity with (equal to or better than) Plan medical and surgical benefit terms and conditions. MHPAEA does not require large group health plans and their health insurance insurers to include mental health and substance use disorders benefits in their benefits package. The Mental Health Parity Act does not apply to employers with fewer than 51 employees.

CHIPRA

Under the Children's Health Insurance Program Reauthorization Act of 2009 **(CHIPRA),** group health plans and group health insurance issuers must offer new special enrollment opportunities. Effective April 1, 2009, plans and issuers must permit employees and dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

- Losing eligibility for coverage under a State Medicaid or CHIP program, or

- Becoming eligible for State premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined eligible for premium assistance.

II ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claim Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active, Full Time Employees of the Employer. A person is eligible for Employee coverage when he or she meets the eligibility criteria as established by their employer and identified on the Schedule of Benefits.

Eligibility Requirements for Employee Coverage. All Active, Full Time Employees of the Employer, who are residents of the United States, verifiable by documents accepted by the Department of Homeland Security's USCIS Form I-9.

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

1. A covered Employee's Spouse and children from birth to the limiting age of 26 as identified on the Schedule of Benefits. Spouse and children must primarily live in the United States in order to be eligible for coverage.

   The term **"Spouse"** shall mean an individual recognized as the covered Employee's husband or wife under the laws of the state in which the marriage was formalized and will not include common law marriage. This definition **does not** include domestic partners. The Plan Administrator may require documentation proving a legal marital relationship.

   The term "children" shall include natural children, adopted children, foster children or children placed with a covered Employee in anticipation of adoption. Step-children may also be included as long as their natural parent remains married to the Employee.

   If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

   The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

   Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. Coverage will become effective on the first pay period following the date of QMSCO order is received.

   A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

2. A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and is unmarried. The Plan Administrator and/or the Claims Administrator may require subsequent proof of the child's Total Disability and dependency.

   The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

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

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

If both parents are Employees, their children can be covered as Dependents of both parents. Coordination of benefits will apply.

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

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

If you fail to remove an ineligible dependent from the Plan, you will be responsible to repay the Plan the actual claims payments made by the Plan for any care or services received by the ineligible dependent after the loss of eligibility. The premiums paid will be refunded to You. By failing to remove an ineligible dependent, You may have committed health care fraud, though such situations are usually inadvertent mistakes.

FUNDING

Cost of the Plan: Kier Construction Corporation shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. Your employer may require you to sign a payroll deduction authorization form.

The level of any Employee contributions is set by the Employer. The Employer reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing and signing either a paper or electronic enrollment application. A newborn child must be enrolled in the plan within 31 days from birth. Notification of the birth along with appropriate enrollment documentation is the responsibility of the covered Employee including members who already have family coverage. Contact your human resources department within 31 days of the birth.

Enrollment Requirements for Newborn Children.

Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

TIMELY OR LATE ENROLLMENT

1. **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator and the Claims Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

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

Enrollees and their Dependents who did not enroll when initially eligible may only join during open enrollment unless they become eligible under Special Enrollment rights.

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

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information, contact your Employer.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

1. **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

   a. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

   b. If required by the Plan Administrator and/or Claims Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

   c. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted; or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

   d. The Employee or Dependent requests enrollment in this Plan, coverage will be effective on the date of the qualifying event, no later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above.

   e. For purposes of these rules, a loss of eligibility occurs if:

      i. The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e. part-time employees).

      ii. The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the

number of hours of employment or contributions towards the coverage were terminated; or a spouse has an open enrollment period that would allow a change in elections during a designated open enrollment period.

iii. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

iv. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

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

2. Dependent beneficiaries. If:

a. The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

b. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

Then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

If the covered employee already has family coverage when he or she acquires a new dependent child (if the addition of a new child would not create a change in premium), then the new dependent child will be enrolled from birth, adoption or placement for adoption; however, a separate enrollment form for such a child is required and the claims administrator will pend claims until it is received. The separate enrollment form should be submitted within 31 days of the birth, adoption or placement for adoption. If the plan receives the enrollment form after 31 days from the date a covered employee acquires a new dependent, the plan will require medical underwriting by its reinsurance carrier for the child to be covered by the plan. If the reinsurance carrier rejects coverage for the child, they may not be added until the next open enrollment period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

1. In the case of marriage, the date of marriage;

2. In the case of a Dependent's birth, as of the date of birth; or

3. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan when the Employee satisfies all of the following:

1. The Eligibility Requirement as outlined in the Schedule of Benefits
2. The Active Employee Requirement and/or out of work due to FMLA.
3. The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants may request a certificate that shows the period of Creditable Coverage under this Plan.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

1. The date the Plan is terminated.
2. The day of the month identified in the Schedule of Benefits, when a covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
3. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Rescission of Coverage. The Plan reserves the right to rescind, terminate or modify coverage for any covered person because of the intentional, material misrepresentation or fraud by or on behalf of such covered Person. The Plan, (as required by PPACA), will provide a 30-day advance notice to each affected participant prior to rescinding coverage. The notice period is intended to provide participants an opportunity to explore their rights to contest the termination/rescission or to look for alternative coverage. However, in the case of divorce, if the Plan is not notified and the full COBRA premium is not paid by the employee or ex-spouse for coverage, termination of spouse coverage shall be retroactive to the date of divorce.

Continuation during Periods of Employer-Certified Disability or Leave of Absence. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer allows continuance to end, not to exceed 6 months.

For leave of absence: the date the Employer ends the continuance, not to exceed 6 months.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation during Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If your coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired within 13 weeks will not be required to satisfy all Eligibility and Enrollment Requirements and coverage will become effective on the date of rehire as a full-time employee. A terminated Employee who is rehired after 13 weeks will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

If the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period.

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

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

    a. The 24-month period beginning on the date on which the person's absence begins;

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

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

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

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage). For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA:

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

2. The date that the Employee's coverage under the Plan terminates for any reason including death. See the section entitled Continuation Coverage Rights under COBRA.

3. The date a covered Spouse loses coverage due to loss of dependency status. See the section entitled Continuation Coverage Rights under COBRA.

4. On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. See the section entitled Continuation Coverage Rights under COBRA.

5. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

6. The end of the month in which a dependent child reaches age 26.

III OPEN ENROLLMENT

Each year there is an open enrollment period in December. During the open enrollment period you may change your benefit elections under the plan and eligible employees who previously declined to enroll in the plan may apply for coverage.

Benefit choices made during the open enrollment period will become effective January 1st and remain in effect until the next open enrollment, unless there is a change in status or a Special Enrollment right.

Those who fail to make an election during open enrollment will automatically retain their present coverage elections. You will receive detailed information regarding open enrollment from your employer.

Elections cannot be changed until your employer's next open enrollment unless you have a change in status or special enrollment right.

IV SUMMARY OF BENEFITS

Verification of Eligibility: Contact Tall Tree Administrators 877-453-4201.

You may call this number to verify eligibility for Plan benefits **before** the charge is incurred or visit the website at www.talltreehealth.com.

MEDICAL BENEFITS

All benefits described in this Plan Document are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's and/or the Claims Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Customary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is contained in the Schedule of Benefits, available through your Plan Administrator.

Your plan utilizes Participating Provider Organization(s).

Contracted PPO networks that you may utilize are found on the Schedule of Benefits as well as your Identification card. You can find affiliated providers within those PPO networks by accessing their websites or contacting their customer service departments. The Tall Tree Administrators Customer Service Department can also assist you in locating providers. You may access providers affiliated with the national network when traveling outside of the state in which you reside.

This Plan has entered into an agreement with local and national PPO Provider Networks. Because the Participating Providers within those networks have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a covered person uses a Participating Provider, that covered person will receive a higher payment from the Plan than when a Non-Participating Provider is used. It is the covered person's choice as to which Provider to use.

> **Under the following circumstances, the higher in-network payment will be made for certain services provided by non-network providers:**

Rural Area

Treatment rendered while traveling or living (for purposes other than seeking medical care) "Out-of-Area" will be paid at the in-network level, subject to the deductible and the maximum out-of-pocket expense. "Out-of-Area" is defined as 30 miles or more from the nearest PPO hospital or physician in any of your available networks. If you travel for medical care and bypass a network provider to receive care from a Non-PPO provider, the benefits will be paid as Non-PPO.

Charges for services rendered by a Provider whose specific specialty is not available in the PPO area will be considered at the in-network level of benefits, subject to the deductible and maximum out of pocket expense.

Members must receive treatment at the nearest provider qualified to treat the medical condition in order for the care to be paid at the in-network level.

RAPS (Radiologist, Anesthesiologist, Pathologist)

The plan covers the services of any non-network Radiologist, Anesthesiologist, Pathologist or other ancillary providers under the network benefits, if services are performed at, or requested by a network facility, under the in-network level of Benefits.

Life Threatening

Covered Services for a life-threatening injury or illness for the first 72 hours or until medically stable as determined by a physician. After this time period, all additional services will be covered the same as any other Illness or Injury. Initial treatment for the life-threatening illness must commence within two (2) hours of the onset of symptoms, and Covered Services must be received by you at the nearest facility equipped to treat your condition.

Out of Country Care

Medical care incurred out of the United States that is not an approved out of country program will only be paid if the medical care is an urgent medical emergency and requires immediate medical treatment or a life-threatening condition, and benefits will be paid at the in-network level of benefits.

V MEDICAL BENEFITS

DEDUCTIBLES, CO-INSURANCES and CO-PAYMENTS PAYABLE BY PLAN PARTICIPANTS

Deductibles and co-payments are dollar amounts that the covered person must pay before the Plan pays for many of the Covered Charges.

The deductible is paid once per calendar year per covered person. Each calendar year a new deductible amount is required. However, exceptions may be listed in the Schedule of Benefits.

Co-insurance is the percent you pay to the maximum out of pocket.

A co-payment is the amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services and other services will not have any co-payments.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their calendar year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each calendar year, benefits will be paid for the Covered Charges of a covered person that are in excess of the deductible and any co-payments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each calendar year until the out of pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a covered person will be payable at 100% (except for the charges excluded) for the rest of the calendar year. Non-covered benefits and charges in excess of Usual and Customary are not applied to the out of pocket maximum. However, exceptions may be listed in the Schedule of Benefits.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the calendar year.

COVERED CHARGES

Covered charges are the Usual and Customary Charges that are incurred for the following items of service and supplies. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

1. **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

   Room charges made by a Hospital having only private rooms will be paid at the same benefit percentage for Inpatient Hospital Charges as identified on the Schedule of Benefits.

   Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

   The hospital or facility must be accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders.

   This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates and that provides treatment for Mental Health Disorders. There must be an

MD/psychiatrist on staff. Coverage does not include services provided at a group home. Treatment in a residential treatment facility may not be for the purpose of providing custodial care.

The covered person must be ill in more than one area of daily living to such an extent that he or she is rendered dysfunctional and requires the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the covered person's condition would deteriorate.

The covered person's Mental Health Disorder must be treatable in the Inpatient facility.

The covered person's Mental Health Disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM).

All Inpatient must be pre-certified otherwise benefits may be reduced or denied.

Facility and anesthesia charges for dental procedures needed when medically necessary. Actual dental procedures are to be considered under the dental plan.

2. **Coverage of Pregnancy.** The Maximum Allowed Amount for the care and treatment of Pregnancy are covered the same as any other Sickness.

   All females covered under the Plan are covered for maternity care, charges incurred for a newborn grandchild are not covered unless the grandchild is adopted by the employee

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

3. **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

   a. The patient is confined as a bed patient in the facility; and

   b. The confinement starts within 14 days of a Hospital confinement of at least 3 days; and

   c. The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

   Covered charges for a covered person's care in these facilities are payable as described in the Schedule of Benefits.

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

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

a. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Customary Charge that is allowed for the primary procedures; 50% of the Usual and Customary Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

b. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary Charge for each surgeon's

primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Customary percentage allowed for that procedure; and

c. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Customary allowance.

5. **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

   a. Inpatient Nursing Care. Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

   b. Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

6. **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

   Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

   A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

7. **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the covered person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

   Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

   Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

8. **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

   a. Ambulance. Local Medically Necessary professional land or air transport service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator and/or the Claims Administrator finds a longer trip was Medically Necessary.

   b. Ambulatory services including dialysis treatment, respiration therapy, radiation and chemotherapy.

   c. Anesthetic, oxygen, blood and blood derivatives that are not donated or replaced, intravenous injections and solutions. Administration of these items is included. Anesthesia for dental procedures performed in a medical facility due to anxiety or medical necessity will be covered.

d. **Birth Control Devices.** Contraceptive devices, patches and implants. Post conception drugs are not covered.

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

f. **Chemotherapy or Radiation.** Treatment with radioactive substances. The materials and services of technicians are included.

g. Initial **contact lenses** or **glasses** required following cataract surgery.

h. **Day Treatment.** Means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers an alternative to Inpatient treatment.

i. **Durable medical equipment:** including expenses related to necessary repairs and maintenance. A statement is required from the prescribing physician describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased. Replacement equipment will be covered if the replacement equipment is required due to a change in the patient's physical condition; or purchase of new equipment will be less expensive than repair of existing equipment. For purposes of this Plan, durable medical equipment includes diabetic pumps and related supplies. Purchase of durable medical equipment is not a covered expense unless (1) the Plan Administrator determines that purchase of the equipment should be less expensive than rental, based on the physician's statement of expected duration of the patient's need as well as the rental costs versus the purchase costs, or (2) rental by the Plan is not possible. Such equipment will not be covered under the Plan if it could be useful to a person in the absence of an illness or injury and could not be purchased without a physician's prescription.

j. **Educational classes**. Services related to diabetic instructional classes.

k. **Genetic testing.** To detect suspected genetic abnormalities in an unborn child for a mother over age 34. Also included is the BRCA testing to identify hereditary gene for breast/ovarian cancer with or without being previously diagnosed. All other genetic testing is excluded from coverage, unless medically necessary. Genetic testing is only for women at high risk of BRCA gene mutation: (must meet at least one of the requirements.

- Only for women (men not covered)
- Testing only covers BRCA1 and BRCA2. In other words, panel testing or testing for genes outside BRCA1/BRCA2 not covered / multi-gene testing (MGT) not covered.
- Testing only if certain criteria are met per NCCN guidelines:
- A family member with a *BRCA1/2* gene mutation (or other inherited gene mutation linked to breast cancer)
- A personal history of breast cancer at age 45 or younger
- A personal history of triple negative breast cancer (breast cancer that is estrogen receptor-negative, progesterone receptor-negative and HER2-negative) diagnosed at age 60 or younger
- Ashkenazi Jewish heritage **and** a personal history of breast cancer
- A personal history of breast cancer at age 46-50 **and** a close family member (parent, sibling, child, grandparent, grandchild, uncle, aunt, nephew, niece or first cousin) diagnosed with breast cancer or aggressive prostate cancer at any age
- A personal history of breast cancer at any age **and** a close family member diagnosed with breast cancer at age 50 or younger

- A personal history of breast cancer at any age **and** 2 or more close family members diagnosed with breast cancer at any age
- A personal history of breast cancer at any age **and** a close family member diagnosed with pancreatic cancer or metastatic prostate cancer at any age
- A close family member diagnosed with breast cancer at age 45 or younger
- A personal or family history of ovarian cancer, pancreatic cancer, aggressive prostate cancer or metastatic prostate cancer
- A personal or family history of male breast cancer

l. Hospice Care. For plan participants with a life expectancy of six (6) months or less. Hospice Care includes: confinement in a hospital to include ancillary charges and room and board; services, supplies and treatment provided by hospice to a covered person's home; Physicians and nursing care; physical or speech therapy and counseling provided through hospice. Bereavement counseling is available for up to 6 months.

m. Laboratory services.

n. Mastectomy. Prophylactic mastectomy when medically necessary for reduction of risk of breast cancer in high-risk women.

o. Mental Health and Substance Abuse Treatment. The Plan provides coverage for treatment of psychiatric illnesses or diseases. These include drug addiction and alcoholism. The illnesses or diseases that qualify as mental conditions are listed in the latest edition, at the time you receive treatment, of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), including attention deficit disorder and attention deficit hyperactive disorder.

Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent DSM for the new diagnosis.

The Plan covers medically necessary services to diagnose and/or treat mental conditions. This coverage includes:

- Biologically-based mental conditions. "Biologically-based mental conditions" means: schizophrenia; schizoaffective disorder; major depressive disorder (including screening for depression in both adults and children); bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; eating disorders; post-traumatic stress disorders; substance abuse disorders (drug addiction and alcoholism); and any biologically-based mental conditions that appear in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

- Non-biologically-based mental conditions subject to the limitations stated below and elsewhere in this plan document.

No benefits are provided for: psychiatric services for a condition that is not a mental condition; residential or other care that is Custodial care; and services and/or programs that are not medically necessary to treat your mental condition. Some examples of services and programs that are not covered by this health plan are: services that are performed in educational, vocational, or recreational settings; and "outward bound-type," "wilderness," "camp," or "ranch" programs. These types of non-covered programs may be in residential or non-residential settings. They may include therapeutic elements and/or clinical staff services as well as vocational, educational, problem solving, and/or recreational activities. These programs may have educational accreditation. The staff may include some licensed mental health providers who may provide some therapy. No benefits are provided for any services furnished along with one of these non-covered

programs. For example, no benefits are provided for therapy and/or psychotherapy furnished along with one of these non-covered programs.

Inpatient Services

To receive coverage for inpatient services for a mental condition, you and your provider must receive prior authorization before you enter a general or mental hospital or substance abuse treatment facility for inpatient care. When inpatient care is approved, the Plan provides coverage for as many days as are medically necessary for you. This coverage includes: semi-private room and board psychiatric care that is furnished for you by a physician (who is a specialist in psychiatry), or by a psychologist, or by a clinical specialist in psychiatric and mental health nursing, or by another mental health provider.

Intermediate Treatments

There may be times when you will need medically necessary care that is more intensive than typical outpatient care. But, you do not need 24-hour inpatient hospital care. This "intermediate" care may include (but is not limited to):

- Acute residential treatment. Your coverage for this treatment is considered to be an inpatient benefit. During the inpatient pre-service review process, the Claims Administrator will assess your specific health care needs. The least intensive type of setting that is required for your mental condition will be approved.

- Partial hospital programs or intensive outpatient programs.

Outpatient Services

This health plan covers outpatient covered services to diagnose and/or treat mental conditions when the services are furnished for you by a mental health provider. This coverage is provided for as many visits as are medically necessary for your mental condition.

p. Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

i. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

ii. Emergency repair due to Injury to sound natural teeth.

iii. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

iv. Excision of benign bony growths of the jaw and hard palate.

v. External incision and drainage of cellulitis.

vi. Incision of sensory sinuses, salivary glands or ducts.

vii. Removal of impacted teeth if not covered under a Dental Plan.

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

q. **Occupational therapy** by a licensed occupational therapist.

r. **Organ Transplant Coverage.** Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational."

Reimbursement rate is identified on the Schedule of Benefits.

Plan covers a Plan Participant's charges for a donor.

Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

i. The transplant must be performed to replace an organ or tissue

ii. If the organ or tissue donor is a covered person and the recipient is not, then the Plan will cover donor organ or tissue charges for evaluating the organ or tissue or removing the organ or tissue from the donor.

iii. Transportation charges will be considered.

iv. Post donation care will also be covered.

s. The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which 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 Sickness.

t. **Physical therapy** by a licensed physical therapist.

u. **Prescription Drugs** (as defined).

v. **Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefit or Appendix A.

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

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

w. The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

x. **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

i. Reconstruction of the breast on which a mastectomy has been performed,

ii. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

iii. Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

y. **Residential Treatment Facilities.** Inpatient and outpatient services associated with Mental Health, Chemical Dependency and Substance Abuse when medically necessary. Services are not covered for custodial care or behavioral health care.

z. **Routine Clinical Trials.** Charges for routine patient costs for qualified individuals who participate in an approved clinical trial.

For purposes of this benefit, the following provisions apply:

i. **Approved Clinical Trial:** Shall mean a Phase I, II, III or IV clinical trial that is conducted in relation to the prevention, diagnosis or treatment of cancer or other life-threatening diseases or conditions. The trial must be approved or sponsored by one of a number of federal agencies, including the National Institutes of Health, the Centers for Medicare and Medicaid Services and the Food and Drug Administration (FDA). This list is not all-inclusive.

ii. **Life Threatening Condition:** Shall mean any disease from which the likelihood of death is probable, unless the course of the disease is interrupted.

iii. **Qualified Individual:** Shall mean a Participant who is eligible to participate in an "approved clinical trial" and either the Participant's Physician has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

iv. **Routine Patient Costs:** Routine patient costs include Medically Necessary items and services provided for the purpose of the trial, including doctor services, diagnostic and laboratory tests and other services that would otherwise be covered under the Plan for participant that is not enrolled in a clinical trial. Routine patient costs do not include:

1. The actual drug, device or equipment that is the object of the trial;

2. Services solely to satisfy data collection and analysis that are not used in direct clinical management of the patient; or

3. Services that are clearly inconsistent with accepted standards of care for a particular diagnosis.

aa. **Sleep Disorders**. Care and treatment for sleep disorders.

bb. **Speech therapy:** Performed by a licensed speech therapist when services are restorative or rehabilitative and necessary due to illness or injury or to correct a congenital defect. Speech therapy for developmental delay will not be considered eligible.

cc. **Spinal Manipulation/Chiropractic services:** by a licensed M.D., D.O. or D.C.

dd. **Sterilization** procedures.

ee. **Substance Abuse and Chemical Dependency.** Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

ff. **Surgical dressings.** Splints, casts and other devices used in the reduction of fractures and dislocations.

gg. **TMJ / Orthognathic**. Treatment is covered.

hh. **Well Newborn Nursery/Physician Care**.

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

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a covered person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Customary Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

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

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

Charges for Routine Physician Care. The benefit is limited to the Usual and Customary Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

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

ii. Diagnostic **x-rays**.

DISCLAIMER

THE PLAN ADMINISTRATOR WILL HAVE THE DISCRETION TO DETERMINE IF A SERVICE IS A COVERED BENEFIT, WHEN IT IS NOT SPECIFICALLY PROVIDED FOR IN THE PLAN. QUOTED BENEFITS ARE NOT A GUARANTEE OF PAYMENT. BENEFITS ARE DETERMINED WHEN A CLAIM IS RECEIVED. FINAL PAYMENT DETERMINATION IS MADE IN ACCORDANCE WITH PLAN DETERMINATIONS AND INTERPRETATION OF ALL PLAN PROVISIONS.

VI COST MANAGEMENT SERVICES

Cost Management Services are provided by American Health Holding: 866-363-0957

PRIOR AUTHORIZATION

The physician, patient or family member are required to receive prior authorization for certain services identified in the Schedule of Benefits. This call must be made at least 7 business days in advance of services being rendered or within 2 business days after an emergency. Failure to obtain prior authorization may result in a reduction or denial of benefits.

Prior authorization is not a guarantee of payment. Benefits are subject to all eligibility, plan provisions and limitations in force at the time services are rendered.

CASE MANAGEMENT

Case Management. The goal of the Case Management team is to be actively involved in assisting clients who are receiving significant services for catastrophic illnesses or injuries and provide support and information to assist with optimal access to appropriate and timely service thereby improving health outcomes and quality of care while optimally controlling health care costs. Case Management services are provided by registered nurses and/or licensed clinical social workers.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

1. Personal support to the patient;
2. Contacting the family to offer assistance and support;
3. Monitoring Hospital or Skilled Nursing Facility;
4. Determining alternative care options; and
5. Assisting in obtaining necessary equipment and services.

As part of the Case Management process, benefits may be modified by the Plan Administrator on an individual exception basis to permit a benefit not otherwise provided for by the plan, if the Plan Administrator determines, in its sole discretion, that such modification is medically necessary and is more cost-effective than the benefit to which you or your eligible dependents would otherwise be entitled. The Plan Administrator also reserves the right to limit payment for services to those amounts which would have been charged had the service been provided in the most cost-effective setting in which the service could safely have been provided.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and 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.

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other covered person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

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 Plan Administrator and/or the Claims Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator and/or the Claims Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

VII DEFINED TERMS

The following terms have special meanings when used in this Plan.

Active Employee: Is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis as defined in the Schedule of Benefits.

Allowed Amount: for services provided by a participating provider is the contracted amount of payment to which the provider has agreed. For services provided by a non-participating provider, the amount determined by the Plan to be the average amount contracted by the Plan with participating providers in the same geographic area.

Ambulatory Surgical Center: Is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Assignment of Benefits: means all expenses reimbursable under the Plan will be paid to the covered Employee except when:

1. The provider participates in the PPO Network and claims are automatically assigned to the provider of service.

2. Assignments of benefits to hospitals, physicians or other providers of service will be honored.

3. The Plan may pay benefits directly to providers of service unless the covered person requests otherwise, in writing, with the time limits for filing a proof of loss.

4. The Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Birthing Center: means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name: means a trade name medication.

Calendar Year: means January 1st through December 31st of the same year.

Chemical Dependency & Substance Abuse: means any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:
1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);

b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);

c. Craving or a strong desire or urge to use a substance; or

d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with Spouse about consequences of intoxication, physical fights).

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Child: means a natural child, a stepchild, child who is adopted by the employee or placed with the employee for adoption prior to age 18 or a child for whom the employee or covered dependent is required to provide coverage due to a Medical Child Support Order.

CHIP: Children's Health Insurance Program.

CHIPRA: Children's Reauthorization Act of 2009 (as amended) that provides a special enrollment right.

Claims Administrator: Tall Tree Administrators has been hired as the Third-Party Claims Administrator by the Plan Administrator to perform claims processing and other specified administrative services in relation to the plan. The Claims Administrator is not an insurer of the health benefits and is not a fiduciary of the Plan and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Claim Administrator is not responsible for financing and does not guarantee the availability of benefits under this Plan.

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

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Customary amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Customary charge, in accord with the terms of this Plan Document.

Clean Claim: Is a claim filed within the timely filing provisions of the Plan, containing all necessary information to process the expense according to the Plan provisions.

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

Cosmetic Dentistry: means dentally unnecessary procedures.

Covered Charge(s): means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person: Is an Employee or Dependent who is covered under this Plan.

Creditable Coverage: includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care: Custodial care is a type of care that is not covered by this Plan. Custodial care means any of the following:

- Care that is given primarily by medically-trained personnel for a member who shows no significant improvement response despite extended or repeated treatment; or
- Care that is given for a condition that is not likely to improve, even if the member receives attention of medically-trained personnel; or
- Care that is given for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute level of care; or
- Care that is given for the purpose of meeting personal needs which could be provided by persons without medical training, such as assistance with mobility, dressing, bathing, eating and preparation of special diets, and taking medications.

Day Treatment. Means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers alternative to Inpatient treatment.

Dentist: Is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment: means equipment which:

1. Can withstand repeated use.
2. Is primarily and customarily used to serve a medical purpose.
3. Is prescribed by a physician.
4. Generally, is not useful to a person in the absence of an Illness or Injury.
5. Is appropriate for use in the home.

Emergency Services: Is treatment required in an emergency room, ambulance charges or other treatment due to a sudden, serious, unexpected and acute onset of an illness or injury where a delay in treatment would cause irreversible deterioration resulting in a threat to a patient's life or a body part, or an organ not returning to full, normal function.

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

Employer: is Kier Construction Corporation. The Employer is a distinctive legal entity and is separate from the Kier Construction Corporation Plan.

Enrollment Date: Is the first day of coverage after any waiting period if applicable.

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

Essential Health Benefit: means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric services, including oral and vision care, if applicable.

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

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

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

2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

3. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

4. If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

FMLA: Family and Medical Leave Act of 1993 as amended.

Formulary: means a list of prescription medications compiled by the third-party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic Drug: means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information: means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

GINA: The **Genetic Information Nondiscrimination Act of 2008** enacted May 21, 2008, is an Act of Congress in the United States designed to prohibit the use of genetic information in health insurance and employment. The Act prohibits

group health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future.

Habilitative Services: Healthcare services that are treating a medical illness or injury that helps a person keep, learn, or improve skills & functioning for daily living which may include physical therapy occupational therapy and speech therapy.

HIPAA: The federal Health Insurance Portability and Accountability Act (HIPAA) require that medical plan grant credit for prior coverage called creditable coverage. Under HIPAA, your creditable coverage from this plan may reduce the exclusion period, if any, for a pre-existing medical condition under a new health plan. The law requires that each employee and dependent for whom coverage terminates for any reason be provided with a certificate indicating the length of time an individual was covered under the health plan. Tall Tree Administrators will issue you a certificate to provide you with evidence of your medical plan coverage shortly after your coverage termination date. You may also find a copy of this on the Tall Tree Administrators website, www.talltreehealth.com. Check with your new plan administrator to see if you need to provide this certificate. This certificate may also be required to buy a private insurance policy. When you receive this certificate, keep it in a safe place until you are ready to use it.

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

Home Health Care Plan: must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies: includes: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency: Is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan: Is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies: are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit: Is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital: Is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; Det Nortske Veritas DNV or other State licensure, is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

Illness: means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Incurred: means the date a service is actually performed.

Injury: means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit: is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee: means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

Maximum Allowable Fee for a covered expense is the lesser of one of the following:

1. The actual billed amount charged by the provider for covered services;
2. The allowable charge specified under the terms of the Plan.
3. The negotiated rate established in a contractual arrangement with a Provider.
4. The Usual, Customary amount.

Note: The bill you receive for services from non-participating providers may be significantly higher than the maximum allowable fee. In addition to deductibles, co-payments and Co-Insurance, you are responsible for the difference between the maximum allowable fee and the amount the provider bills you for the services. Any amount you pay to the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges and charges for services not performed.

Medical Care Facility: means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency: means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically or Dentally Necessary: means care and treatment that is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. Treatments, procedures, services or supplies that the Plan Administrator determines, in the exercise of its discretion:

1. Are expected to be clear clinical benefit to the patient; and
2. Are appropriate for the care and treatment of the injury or illness in question; and
3. Conform to standards of good medical practice as supported by applicable medical and scientific literature.

A treatment, procedure, service or supply must meet all of the criteria listed above to be considered medically necessary and to be eligible for coverage under this Plan. In addition, the fact that a health care provider has prescribed, ordered or recommended a treatment, procedure, service or supply does not, in itself, mean that it is medically necessary as defined above.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medical Record Review: is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, the Plan Administrator may determine the Maximum Allowable Charge and or the Usual and Customary according to the medical record review and audit results.

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

Mental Illness: means any disease or condition, regardless of whether the cause is organic, this is classified as a Mental Health Disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Mental Health and Addiction Equity Parity Act (MHPAEA): is legislation signed into United States law on September 26, 1996, as amended in 2008, that requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. The Mental Health Parity Act does not require a Plan to offer Mental Health Benefits.

Morbid Obesity: Is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the covered person.

No-Fault Auto Insurance: is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services: is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy: means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician or Provider: means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Acupuncturist Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Naturopath, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan: means Kier Construction Corporation, Employee Benefit Plan Effective January 1, 2016 and restated January 1, 2019, which is a benefits plan for Eligible Employees of Kier Construction Corporation and is described in this document.

Plan Administrator: means Kier Construction Corporation.

Plan Participant: means any Employee or Dependent who is covered under this Plan.

Plan Sponsor: means Kier Construction Corporation.

Plan Year: is the 12-month Fiscal period beginning on January 1st and ending December 31st.

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

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

Preventive Medicine or **Preventive Care:** means measures taken to prevent diseases or injuries rather than curing them or treating their symptoms. Preventive services will be compliant with Section 2713 of the Patient Protection Affordable Care Act (PPACA). See Appendix A for details. **Residential Treatment Facility:** means a licensed facility which provides 24-hour continuous, individually-planned programs of therapeutic treatment and medical care for people with mental health, chemical dependency, or substance abuse issues. Custodial care is not a covered benefit.

Residential Treatment Facility: means a licensed facility which provides 24-hour continuous, individually-planned programs of therapeutic treatment and medical care for people with mental health, chemical dependency, or substance abuse issues. Custodial care is not a covered benefit.

Schedule of Benefits: means a specified dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled benefits are based upon covered expenses not otherwise limited or excluded under the terms of the Plan. A complete listing of the Schedule of Benefit may be obtained on the web site at: www.talltreehealth.com or free of charge on request to the Plan Administrator.

Sickness: is a person's Illness, disease or Pregnancy (including complications).

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

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

2. Its services are provided for compensation and under the full-time supervision of a Physician.

3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

4. It maintains a complete medical record on each patient.

5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, individuals with intellectual disabilities as defined by Rosa's Law, Custodial or educational care or care of Mental Disorders.

7. It is approved and licensed by Medicare.

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

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

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);

b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);

c. Craving or a strong desire or urge to use a substance; or

d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with Spouse about consequences of intoxication, physical fights).

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Spinal Manipulation/Chiropractic Care: means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Total Disability (Totally Disabled): means, in the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Usual and Customary Charge: Usual and Customary Charges are also referred to as Maximum Allowable Charges. Usual and Customary (U&C) shall mean covered expenses which are identified by the Claim Administrator, taking into consideration the fee(s) which the Provider charges the majority of patients for the service or supply, the cost to the Provider customarily accepts as payment for the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates customarily accepted. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling, multiple procedures, or any audit results identified.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age, and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Maximum Allowable Charge and or the Usual and Customary charge is for any procedure, service, or supply.

Usual and Customary charges and or Maximum Allowable Fee may, at the Claims Administrator's discretion and alternatively be determined and established by using normative data such as, but not limited to, PPO network discount, Medicare cost to charge ratios, average wholesale price (AWP) and/or manufacturer's retail pricing (MRP) for supplies and devices.

Unbundling: the practice of using numerous procedure codes to identify procedures that normally are covered by a single code.

Waiting Period is the time between when a benefit eligible employee is hired and when the coverage becomes active.

VIII PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.
All exclusions related to Dental are shown in the Dental Plan.

The following medical services are not a covered benefit unless otherwise stated in the Schedule of Benefits.

1. **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

2. **Adoption.** Any charges associated with Adoption.

3. **Alcohol or drugs.** Services, supplies, care or treatment to a covered person for an Injury or Sickness which occurred as a result of that covered person's illegal use of alcohol or drugs. A person will be conclusively presumed to be under the influence of alcohol or drugs and such influence will be conclusively presumed to be a cause of the illness, condition, accident or injury for the purposes of this exclusion if either the person's blood alcohol level was equal to or greater than the legal limit for driving in the state where the accident occurred, or if a blood, urine, or other medically reliable test determines that there was any amount of illegal drugs in the person's system at the time of the cause or occurrence of the illness, condition, or accident. The presence of alcohol or drugs may be determined by tests performed by or for law enforcement authorities, by tests performed in the course of treating the person, or by other reliable means. The plan sponsor in its sole discretion shall determine whether a claim is excluded under these rules and there need not be a determination or action by any other person or party as to criminal fault. Expenses will be covered for Injured covered persons other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition. Screening and counseling to reduce alcohol misuse will be covered under preventive care.

4. **Autism, Any charges associated with the care and treatment of** Autism.

5. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

6. **Cosmetic Procedures.** A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and /or functions of the body which are lost or impaired due to an illness or injury.

7. **Counseling Services**. Counseling for educational, social, occupational, religious or other maladjustments. Counseling for treatment of a gambling addiction. Sensitivity or stress management training, self-help training unless specifically stated in the Schedule of Benefits. Counseling services mandated by the PPACA are covered as specifically stated in the Schedule of Benefits.

8. **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

9. **Educational or vocational testing.** Services for educational or vocational testing or training, except in regards to education and training for diabetic management.

10. **Error**. This Plan reserves the right to recover any payments made by this Plan that were: Made in error; or. Made to you or any party on your behalf where this Plan determines the payment to you or any party is greater than the amount payable under this Plan, or This Plan has the right to recover against you if this Plan has paid you or any other party on your behalf.

11. **Exams or Treatment Required by Third Party**. Physical, psychiatric, and psychological exams or treatments and related services that are required by third parties. For example, exams and tests that are required for recreational activities, employment, insurance, and school; court-ordered exams and services, except when they are medically necessary services.

12. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Maximum Allowable Charge.

13. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

14. **Experimental.** Care and treatment that is either Experimental or Investigational.

    a. A treatment, procedure, device or drug that the plan administrator determines, in the exercise of its discretion:

    b. Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law; or

    c. Is shown by reliable evidence to be the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or

    d. Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

    e. "Reliable evidence" includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

    f. A treatment, procedure, device or drug that meets any of the criteria listed above is considered experimental/investigational and is not eligible for coverage under this plan.

15. **Eye care.** Radial keratotomy, Lasik surgery or other eye surgery to correct refractive disorders. Also, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

16. **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease) and foot inserts. Arch supports, or orthopedic shoes will be covered if medically necessary.

17. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

18. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

19. **Hair loss.** Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. Wigs will be covered after chemotherapy only.

20. **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are, but not limited to skydiving, auto racing and bungee jumping. Final determination as to what constitutes a hazardous activity will be made by the Plan Administrator.

21. **Hearing aids, including cochlear implants and hearing examinations.** Charges for services including exams and supplies in connection with hearing aids or cochlear implants.

22. **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of active participation in an Illegal Act, or active participation in a riot or public disturbance. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

    Services received as a result of illness or injury caused or contributed to by the covered person committing or attempting to commit any of the following or engaging in conduct which would amount to any of the following if a charge had been made, regardless, in either case, of whether a charge was filed, or guilt was determined:

    a. A felony;

    b. Any illegal occupation;

    c. A misdemeanor or other offense involving theft, fighting, disorderly conduct, or other breach of the peace; or

    d. A misdemeanor or other offense involving the use of alcohol or drugs, including, but not limited to any crime or offense involving driving or being in actual physical control of a motor vehicle or any other means of conveyance propelled in part or in whole by an engine or motor, for example, a boat or ATV, while under the influence of alcohol or drugs.

23. **Illegal drugs or medications.** Services, supplies, care or treatment to a covered person for Injury or Sickness resulting from that covered person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured covered persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

24. **Impotence.** Care, treatment, services, supplies in connection with treatment for impotence.

25. **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization, unless listed as covered in the Schedule of Medical Benefits.

26. **Marital, pre-marital, or family counseling.** Care and treatment for marital or pre-marital counseling, or family counseling.

27. **Medically Necessary**. Services must meet the definition of Medical Necessity to be a covered benefit.

28. **Mental Health Disorder.** Any charges associated with care and treatment of a Mental Disorder. Screening for depression in both adults and children will be covered under preventive care.

29. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

30. **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

31. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

32. **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the covered person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

33. **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan, including, but not limited to pregnancy charges for a non-Plan Participant, even when acting as a surrogate for a Plan Participant.

34. **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals; unless specifically listed as covered in the Schedule of Medical Benefits. Medically Necessary non-surgical charges for Morbid Obesity will not be covered. Nutritional counseling will be covered under preventive care.

35. **Occupational.** Care and treatment of an Injury or Sickness that is occupational. Occupational means that it arises from work for wage or profit including self-employment

36. **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds. Compression stockings will be covered if medically necessary and prescribed by a physician.

37. **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

38. **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the covered person's physical condition to make the original device no longer functional.

39. **Sales Tax.**

40. **Self-Inflicted.** Any loss due to an intentionally self-inflicted injury. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

41. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

42. **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical and/or psychiatric treatment.

43. **Sexual Dysfunction**. Behavioral treatment or drug therapy for sexual dysfunction and sexual function regardless if cause of dysfunction is due to physical or psychological reasons.

44. **Smoking / tobacco cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, Counseling for tobacco use is covered under preventive care.

45. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

46. Surrogate pregnancy services. Services incurred in connection with an agreement to act as a surrogate mother. This exclusion includes pregnancy-related charges incurred by a Plan Participant who is acting as a surrogate mother, as well as pregnancy-related charges incurred by a non-Plan Participant who is acting as a surrogate for a Plan Participant.

47. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance and air transport charges as defined as a Covered Charge.

48. **Vision Therapy Services.** Services incurred to treat vision therapy is not covered.

49. **War.** Any loss that is due to a declared or undeclared act of war. Including nuclear reaction or the release of nuclear energy. (This exclusion will not apply if the loss is sustained within 90 days of the initial incident. To be covered under the Plan, the loss must be caused by fire, heat, explosion or other physical trauma that is a result of the release of nuclear energy and the covered person must be within a 25-mile radius of the release site at the time of the release or within 24 hours of the start of the release.

50. **Workers Compensation**. Injury or illness that is covered by any Workers Compensation or Occupational Disease law.

IX PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan to charge covered persons reduced fees for covered Prescription Drugs. RxEdo is the administrator of the pharmacy drug plan.

Members are required to use participating pharmacies. A list of the participating pharmacies may be obtained by accessing the RxEdo web site at: www.rxedo.com. You may also call their customer service number at 888-879-7336. Claim forms are available from your plan administrator if you require reimbursement for a prescription.

Co-payments

The Co-payment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The co-payment amount is not a covered charge under the Medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

Drug Tiers

1. Generics – medications that are the equivalent of brand name medication.

2. Formulary Brand – brand name medications that are considered to be preferred products.

3. Non-formulary Brands – brand name medications that are not on the formulary or preferred product listing.

4. Specialty Medications – medications used to treat chronic and complex medical conditions. These medications generally require patient specific dosing and close clinical monitoring. These medications are available through RxEdo Specialty Pharmacy.

Prior Authorization/Specialty Pharmacy

Drugs in excess of $1500 will require pre-authorization prior to dispensing.

Specialty Drugs will require pre-authorization and purchase through a Specialty Pharmacy.

Coordination of Pharmacy Benefits is not allowed.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the Schedule of Benefits.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, MedVantx, the mail order pharmacy, is able to offer covered persons significant savings on their prescriptions.

Covered Prescription Drugs

1. All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives and all other methods of birth control, but excludes any drugs stated as not covered under this Plan.

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

3. Insulin and other diabetic supplies when prescribed by a Physician.

Limits To This Benefit

This benefit applies only when a covered person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a Physician.

2. Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

1. **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

2. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

3. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

4. **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

5. **Experimental.** Experimental drugs and medicines, even though a charge is made to the covered person.

6. **FDA.** Any drug not approved by the Food and Drug Administration.

7. **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

8. **Hair Loss products.**

9. **Impotence.** A charge for impotence medication is not covered.

10. **Infant Formulas.** Whether medically necessary or not.

11. **Infertility.** A charge for infertility medication.

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

13. **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

14. **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

15. **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

16. **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

17. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

18. **Vitamins.** Except prenatal, unless medically necessary for treatment of a covered medical illness.

X DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a calendar year, a covered person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their calendar year deductibles, the deductibles of all members of the Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each calendar year benefits will be paid to a covered person for the dental charges Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

The Dental Plan is an indemnity plan. You may receive care from any Dental provider. Dental Charges reimbursed according to the Maximum allowable charges.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Benefit payment for a covered person will be made as described in the Schedule of Benefits.

COVERED DENTAL SERVICES

Benefit payment for a covered person will be made as described in the Schedule of Benefits.

DENTAL PLAN EXCLUSIONS

A charge for the following is not covered:

1. **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
2. **Broken appointments.** Charges for broken or missed dental appointments.
3. **Cosmetic services** of any kind.
4. **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
5. **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

6. **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

7. **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

8. **No listing.** Services which are not included in the list of covered dental services.

9. **Orthodontia.** Orthodontic treatment and orthognathic surgery, unless specifically listed as covered in the Schedule of Dental Benefits.

10. **Personalization.** Personalization of dentures.

11. **Replacement.** Replacement of lost or stolen appliances.

12. **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

XI VISION BENEFITS

Vision care benefits apply when vision care charges are incurred by a covered person for services that are recommended and approved by a Physician, Optometrist or Ophthalmologist.

BENEFIT PAYMENT

Benefit payment for a covered person will be made as described in the Schedule of Benefits.

VISION CARE CHARGES

Vision charges are the maximum allowed amount for the vision care services and supplies shown in the Vision Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care service or supply.

VISION PLAN EXCLUSIONS

No benefits will be payable for the following:

1. **Before covered**. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

2. **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

3. **No prescription.** Charges for lenses ordered without a prescription.

4. **Orthoptics.** Charges for orthoptics (eye muscle exercises).

5. **Sunglasses.** Charges for non-prescription safety goggles or sunglasses, including prescription type.

6. **Training.** Charges for vision training or subnormal vision aids.

XII HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Claims Administrator decides at its discretion that a covered person is entitled to them.

Filing Post-Service Claims

In order to file a post-service claim, you or your authorized representative must submit the claim in writing, on standard claim forms or an itemized statement containing the required information.

All claims must be received by the plan within a 12-month period from the date of the expense and must include the following information:

1. Plan participant's name, Social Security number or Unique ID number and address;
2. Patient's name, Social Security number and address if different from the participant's;
3. Provider's name, tax identification number, address, degree and signature;
4. Date(s) of service;
5. Diagnosis;
6. Procedure codes (describes the treatment or services rendered);
7. Assignment of benefits, signed (if payment is to be made to the provider);
8. Release of information statement, signed;
9. Coordination of benefits (COB) information if another plan is the primary payor; and
10. Sufficient medical information to determine whether and to what extent the expense is a covered benefit under the plan.

Claims for covered services should be sent electronically or manually by your provider to:

Tall Tree Administrators
P.O. Box 1807
Draper, UT 84020
877-453-4201

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within a 12-month period from the date the expense was incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

1. It is not reasonably possible to submit the claim in that time; and
2. The claim is submitted within one year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim or if the claim is received by Medicare or Medicaid; in which case, the claims would be paid in the current plan year and covered under the current year's stop loss contract and provisions.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Claims Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	60 days per benefit appeal

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse determination.

2. Reference to the specific Plan provisions on which the determination was based.

3. A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

4. A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's

right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.

5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. "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."

6. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

7. If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

XIII APPEALS

General Information Regarding the Internal and External Claims Appeals

1. 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.)

2. The Plan shall provide to the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.

3. The Plan's decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, will not be based upon the likelihood that the individual will support the denial of benefits.

Internal Appeals Process
When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. Was relied upon in making the benefit determination;

2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

3. Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

4. Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Appeal of Adverse Benefit Determination

Following notification of the adverse benefit determination, the Claim Administrator and/or the Plan Administrator shall provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. If the claimant wishes to appeal an adverse benefit determination, the claimant must submit a request for review by the Plan within 180 days after receipt of the notification of the adverse benefit determination. Such request may include written comments, documents, records and other information relating to the Claim.

Review of the request for review shall be conducted by the Named Fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The Named Fiduciary shall not afford deference to the initial adverse benefit determination and shall take into account all comments, documents, records and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination. Where deciding the appeal is based in whole or in part on medical judgment, the Named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such consulting health care professional shall be one who was not involved in the initial adverse benefit determination, nor a subordinate of such individual.

After review by the Named Fiduciary, the Plan Administrator shall provide written or electronic notification to the claimant of the determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review. Such notification shall set forth:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific plan provisions on which the benefit determination is based;

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

4. A statement of the claimant's right to bring an action under section 502(a) of ERISA;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

6. If the Plan Fiduciary obtained advice from medical or vocational experts in connection with the adverse benefit determination, the identification of such experts, without regard to whether the advice was relied upon in making the benefit determination;

7. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

8. 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.

The ultimate decision on appeal shall be made by the Plan Administrator, pursuant to its discretionary authority to interpret the Plan, resolve disputes and make final benefit determinations.

Standard External Review

The Public Health Service Act (PHS Act) stipulates that claimants may request a standard external review upon receipt of a notice of adverse benefit determination. Standard external review is external review that is not considered expedited.

1. **Request for External Review.** Claimants requesting a standard external review must file a request within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. **Preliminary Review.**

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

        i. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

        ii. The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan, (e.g.; worker classification or similar determination);

        iii. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

        iv. The claimant has provided all the information and forms required to process an external review.

    b. Within one business day after completion of the preliminary review, the Plan shall issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA)). If the request is not complete, such notification shall describe the information or material needed to make the request complete and the Plan shall allow the claimant to perfect the request for external review with the four-month filing period or within the 48-hour period following the receipt of notification, whichever is later.

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

    a. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

    b. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assignment IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

c. Within five business days after the date of assignment of the IRO, the Plan shall provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the document and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

d. Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan shall not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan shall provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

e. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulation under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

i. The claimant's medical records;

ii. The attending health care professional's recommendation;

iii. Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimants, or the claimant's treating provider;

iv. The terms of the claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

v. Appropriate practice guidelines, which must include applicable evidence based standard and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

vi. Any application clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

vii. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

i. The assigned IRO's decision notice will contain: A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of services, the health care providers, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standard, considered in reaching its decision;

iv. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standard that were relied on in making its decision;

v. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the claimant;

vi. A statement that judicial review may be available to the claimant; and

vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistant or ombudsman establish under PHS Act section 2793.

g. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

4. **Reversal of Plan's decision.** Upon receipt of a notice of a final external decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

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

   a. An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulation would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

      i. A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Plan shall determine whether the request meets the reviewability requirements for standard external review. The Plan shall immediately send a notice to the claimant of its eligibility determination.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Plan shall assign an IRO pursuant to the requirements set forth for standard external review. The Plan shall provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   a. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de

novo and is not bound by any decisions or conclusion reached during the Plan's internal claims and appeals process.

4. **Notice of final external review decision.** The Plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph C.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and the Plan.

XIV COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans including Medicare are paying. When a covered person is covered by this Plan and another plan, or the covered person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The Plan that pays first according to the rules will pay as if there were no other plan involved. When this Plan is secondary, it will reimburse, subject to all Plan provisions, the balance of the remaining eligible expenses, not to exceed normal Plan liability if this plan had been primary.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.

2. Group practice and other group prepayment plans.

3. Federal government plans or programs. This includes Medicare.

4. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

5. Auto Insurance as required by State law including but not limited to No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

6. Homeowners Insurance.

Allowable Charge. For a charge to be allowable it must be a covered expense under the terms of the Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary, and the covered person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the covered person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

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

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:

    a. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

b. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

c. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

d. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

e. When a child's parents are divorced or legally separated, these rules will apply:

i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

iii. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

f. When a dependent child is covered under their parents plan and a spouses plan these rules will apply:

i. The benefits of the benefit plan of the policy holder whose birthday falls earlier in a year are determined before those of the benefit plan of the policy holder whose birthday falls later in that year.

ii. If both policy holders have the same birthday, the benefits of the benefit plan which has covered the policy holder for the longer time are determined before those of the benefit plan which covers the other policy holder.

iii. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan.

iv. In the event the dependent child's coverage under the spouses' plan began on the same date as the dependent child's coverage under either or both parents' plans, the order if benefits shall be determined by applying the birthday rule.

g. Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the covered person's health care expenses, the benefits of the plan which covers the covered person as a dependent spouse shall be considered primary to coverage as a child.

i. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a calendar year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A covered person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Claims Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the covered person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

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

XV THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The covered person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the covered person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting or requesting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the covered person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the covered person has against any Third Party, or insurer, whether or not the covered person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the covered person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a covered person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the covered person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a covered person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the covered person to the payments of those benefits.

The covered person:

1. Automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

2. Must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The covered person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a covered person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting or requesting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the covered person may have to recover payments from any responsible third party. Further, accepting or requesting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the covered person's Third-Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the covered person. Also, the Plan's right to Subrogation still applies if the Recovery received by the covered person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the covered person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the covered person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a covered person if a covered person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the covered person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the covered person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar

reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.
Defined terms: "covered person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the covered person (including his attorney or agent) by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the covered person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the covered person is covered. This right of Refund also applies when a covered person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Claims Administrator and/or Plan Administrator. The Claims Administrator and/or Plan Administrator have the right to request reports and approve of all settlements.

XVI CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the Kier Construction Corporation Employee Benefit Plan Effective January 1, 2016 and restated January 1, 2019 (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator and Plan Sponsor is Kier Construction Corporation. The Claims Administrator is Tall Tree Administrators. COBRA continuation coverage for the Plan is managed by Tall Tree Administrators, 11550 South 700 East, Ste. 200, Draper, UT 84020, 801-274-8100. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

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

The term "covered Employee" includes full time active employees, eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

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

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

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

1. The death of a covered Employee.

2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment. Employees who are terminated due to gross misconduct (i.e.: theft physical violence, severe harassment, or other reasons that may result in criminal charges), are not eligible for COBRA.

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

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

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

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

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

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. You should consider that you may qualify for special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

There may be other coverage options available for you and your family. You may buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Claims Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. The end of employment or reduction of hours of employment,
2. Death of the employee,
3. Commencement of a proceeding in bankruptcy with respect to the employer, or
4. Enrollment of the employee in any part of Medicare.

IMPORTANT:

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

NOTICE PROCEDURES:

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

Tall Tree Administrators
11550 South 700 East Ste 200
Draper, UT 84020
877-453-4201
Fax: 801-274-8900

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

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

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

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

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

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

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

1. The last day of the applicable maximum coverage period.

2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.

5. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

    a. 29 months after the date of the Qualifying Event, or

    b. The first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

    c. The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

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

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

    a. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

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

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

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

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

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

Does the Plan require payment for COBRA continuation coverage?
For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?
Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?
Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

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

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator and the Claims Administrator.

XVII RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Kier Construction Corporation Employee Benefit Plan Effective January 1, 2016 and last restated January 1, 2019 is the benefit plan of Kier Construction Corporation, also called the Plan Sponsor. The Plan is to be administered by the "Plan" Administrator in accordance with the provisions of ERISA. This Plan acts under the Federal provisions of ERISA and as such federal law pre-empts state law. An individual or company may be appointed by Kier Construction Corporation to be Plan Administrator. If the relationship with the Plan Administrator is terminated, Kier Construction Corporation shall appoint a new Plan Administrator as soon as reasonably possible. If no other plan administrator is appointed, Kier Construction Corporation shall be the Plan Administrator.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, is paid to render advice to the Plan and has discretionary authority or responsibility in the management or administration of the Plan.

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

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

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

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

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

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

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

THE CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

1. **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

   The Health Information Technology for Economic & Clinical Health (HITECH) Act legislation created in 2009, establishes adaption of Electronic health record to be included in the HIPAA Privacy Act.

2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

3. **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

   a. **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

b. Use and Disclosure Restricted. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

c. Resolution of Issues of Noncompliance. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

i. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

ii. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

iii. Mitigating any harm caused by the breach, to the extent practicable; and

iv. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

d. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

e. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

f. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

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

j. Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

XVIII FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Employer. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deductions in accordance with IRS Section 125.

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

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

> Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
>
> Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
>
> Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.
>
> Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to notice of the reason for the denial, the provisions of the Plan or Summary Plan Description on which the denial was based, any information required to perfect the claim, and the procedure for appealing the denial.

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

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

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

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

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

XIX GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the claims administration is provided through Tall Tree Administrators, the Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees.

PLAN NAME:

Kier Construction Corporation Employee Benefit Plan
3710 Quincy Ave
Ogden, UT 84403
801-627-1414

PLAN NUMBER: 501

EMPLOYER TAX ID NUMBER: 87-0435003

EMPLOYEE BENEFIT PLAN EFFECTIVE DATE: January 1, 2016 and last restated January 1, 2019

PLAN RENEWS EVERY: January

EMPLOYER INFORMATION:

Kier Construction Corporation
3710 Quincy Ave
Ogden, UT 84403
801-627-1414

PLAN ADMINISTRATOR AND PLAN SPONSOR:

Kier Construction Corporation
3710 Quincy Ave
Ogden, UT 84403
801-627-1414

CLAIMS AND COBRA ADMINISTRATOR:

Tall Tree Administrators
11550 South 700 East Ste 200
Draper, UT 84020
801-274-8100

FIDUCIARY:

Kier Construction Corporation
3710 Quincy Ave
Ogden, UT 84403
801-627-1414

BY THIS SIGNATURE the Kier Construction Corporation Employee Benefit Plan Effective January 1, 2016 and last restated January 1, 2019is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Kier Construction Corporation on or as of the day and year first below written.

By _____
Kier Construction Corporation

Margo L. Cudmore, HR Director
Printed Name and Title

11/9/2018
Date

XX APPENDIX A

PREVENTATIVE MEDICAL BENEFITS

BENEFIT PAYMENT

Each calendar year, benefits will be paid for the Covered Charges of a Covered person. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the PPO allowed amount.

COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for covered services, which are described below. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

a. Preventive Care. Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefit.

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

c. Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

d. Birth Control Devices. Contraceptive prescription drugs, devices, patches, and implants are covered for women. Post conception drugs are not covered.

e. Genetic BRCA counseling and testing to identify hereditary gene for breast/ovarian cancer. All other genetic counseling is excluded from coverage.

f. Laboratory for Covered Preventive Services**.**

g. Sterilization procedures for women, including physician, facility and anesthesia.

h. X-rays for covered Preventive services.

COVERED PREVENTIVE SERVICES FOR ADULTS

1. **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked

2. **Alcohol Misuse** screening and counseling

3. **Aspirin**. A low-dose aspirin for prevention of cardiovascular disease and colorectal cancer in adults aged 50-59 years who meet all of the following criteria:

    a. Have a 10-year cardiovascular risk of 10% or greater

    b. Aren't at increased risk for bleeding

    c. Have a life expectancy of at least 10 years

    d. Are willing to take low-dose aspirin daily for at least 10 years

4. **Blood Pressure** screening for all adults
5. **Cholesterol screening** for adults of certain ages or at higher risk
6. **Colorectal Cancer** screening for adults starting at age 50 and continuing until age 75
7. **Depression screening** for adults. Screening for depression in the general adult population, including pregnant and postpartum women.
8. **Type 2 Diabetes screening** for adults with high blood pressure
9. **Diet counseling** for adults at higher risk for chronic disease
10. **Hepatitis B Screening** for adults at high risk
11. **Hepatitis C Screening** for adults at high risk
12. **HIV screening** for all adults at higher risk
13. **Immunization vaccines** for adults--doses, recommended ages, and recommended populations vary:
    a. Hepatitis A
    b. Hepatitis B
    c. Herpes Zoster (Shingles)
    d. Human Papillomavirus
    e. Influenza (Flu Shot)
    f. Measles, Mumps, Rubella
    g. Meningococcal
    h. Pneumococcal
    i. Tetanus, Diphtheria, Pertussis
    j. Varicella
14. **Latent Tuberculosis Infection.** Screening for latent tuberculosis infection (LTBI) in populations at increased risk
15. **Lung Cancer Screening** for adults 55-80 who are at high risk
16. **Obesity screening** and counseling for all adults
17. **Sexually Transmitted Infection** (STI) prevention counseling for adults at higher risk

18. **Statin.** Adults aged 40-75 years with no history of cardiovascular disease (CVD) use a low- to moderate-dose statin for the prevention of CVD events and mortality when they have one or more cardiovascular disease risk factors, and a calculated 10-year CVD event risk of 10% or greater; screening for cardiac risk may include assessment of blood pressure, smoking status, screening for lipid disorders and use of ACC/AHA CVD to estimate 10-yr risk.

19. **Syphilis screening** for all adults at higher risk

20. **Tobacco Use** screening for all adults and cessation interventions for tobacco users

21. **Vitamin D Supplement** for Adults over age 65

COVERED PREVENTIVE SERVICES FOR WOMEN

1. **Bacteriuria** urinary tract or other infection screening for pregnant women

2. **BRCA** genetic counseling and testing for women at higher risk

3. **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40 through age 74. Women at increased risk for breast cancer should undergo mammography periodically. Imaging tests, biopsies, or other interventions are required to be considered an integral part of Screening.

4. **Breast Cancer Chemoprevention** counseling for women at higher risk

5. **Breastfeeding**: Providing interventions during pregnancy and after birth to support breastfeeding. Under the health care reform law, lactation support and counseling, as well as costs for renting breast feeding equipment for each child's birth, are covered at no cost-share when using participating providers. We believe some members may prefer to purchase a breast pump rather than rent hospital grade equipment. To offer a range of choices, your plan will cover the purchase of a personal, double electric breast pump at no cost to the member.

6. **Cervical Cancer** screening for any of the following:

    a. For ages 21-29, PAP smear every 3 years

    b. For ages 30-65, with cytology and human papillomavirus testing (HPV) with Pap smear every 5 years or a regular cytology alone (without HPV testing) every 3 years

    c. Women with an average risk shouldn't be screened more than once every 3 years

7. **Chlamydia Infection** screening for younger women and other women at higher risk

8. **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. Counseling and follow-up care are included with this benefit.

9. **Depression Screening.** Screening for depression in the general adult population, including pregnant and postpartum women.

10. **Domestic and interpersonal violence** screening and counseling for all women

11. **Folic Acid.** All women who are planning or capable of pregnancy take a daily supplement containing 0.4-0.8mg.

12. **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes should be screened prior to 24 weeks of gestation

13. **Gonorrhea** screening for all women at higher risk

14. **Hepatitis B** screening for pregnant women at their first prenatal visit

15. **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women

16. **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older

17. **Interpersonal and Domestic Violence Screening.** Annual screening for women to obtain a referral to initial intervention services, which include counseling, education, harm reduction strategies and referral to appropriate supportive services.

18. **Osteoporosis** screening for women over age 60 depending on risk factors

19. **Preeclampsia.** Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

20. **Raloxifene** and **Tamoxifen** when prescribed

21. **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk

22. **Sexually Transmitted Infections (STI) and Sexually Transmitted Diseases (STD)** counseling for sexually active women

23. **Syphilis** screening for all pregnant women or other women at increased risk

24. **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users

25. **Urinary Tract or other Infection Screening** for pregnant women

26. **Well-woman visits** to obtain recommended preventive services for women under 65 (Includes prenatal visits but not lab work done in association with the visit, high risk pregnancy prenatal is also excluded. lab work paid at normal benefit level)

COVERED PREVENTIVE SERVICES FOR CHILDREN

2. **Alcohol and Drug Use** assessments for adolescents

3. **Autism** screening for children at 18 and 24 months

4. **Behavioral** assessments for children of all ages
   Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

5. **Blood Pressure** screening for children
   Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

6. **Cervical Dysplasia** screening for sexually active females

7. **Congenital Hypothyroidism** screening for newborns

8. **Contraception.** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. Counseling and follow-up care are included with this benefit.

9. **Depression.** Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.

10. **Developmental** screening for children under age 3, and surveillance throughout childhood

11. **Dyslipidemia** screening for children at higher risk of lipid disorders
    Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

12. **Fluoride Chemoprevention** supplements for children without fluoride in their water source

13. **Gonorrhea** preventive medication for the eyes of all newborns

14. **Hearing** screening for all newborns

15. **Height, Weight and Body Mass Index** measurements for children
    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

16. **Hematocrit or Hemoglobin** screening for children

17. **Hemoglobinopathies** or sickle cell screening for newborns

18. **HIV** screening for adolescents at higher risk

19. **Hypothyroidism Screening** for newborns

20. **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:

    a. Acellular Pertussis

b. Diphtheria, Tetanus, Pertussis

c. Haemophilus influenza type B

d. Hemophilia

e. Hepatitis A

f. Hepatitis B

g. Human Papillomavirus

h. Inactivated Poliovirus

i. Influenza (Flu Shot)

j. Measles, Mumps, Rubella

k. Meningococcal

l. Meningococcal B vaccine

m. Pneumococcal

n. Rotavirus

o. Varicella

21. **Interpersonal and Domestic Violence Screening.** Annual screening for women to obtain a referral to initial intervention services, which include counseling, education, harm reduction strategies and referral to appropriate supportive services.

22. **Iron** supplements for children ages 6 to 12 months at risk for anemia

23. **Lead** screening for children at risk of exposure

24. **Medical History** for all children throughout development
    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

25. **Obesity.** Screening for obesity in children and adolescents six years and older and offer to refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.

26. **Oral Health** risk assessment for young children
    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.

27. **Phenylketonuria (PKU)** screening for this genetic disorder in newborns

28. **Sexually Transmitted Infection (STI) and Sexually Transmitted Diseases (STD)** prevention counseling and screening for adolescents at higher risk

29. **Syphilis screening** for all adolescents at higher risk

30. **Tuberculin** testing for children at higher risk of tuberculosis
    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

31. **Vision** screening at least once in all children ages three to five years to detect amblyopia or its risk factors.

DISCLAIMER

THE PLAN ADMINISTRATOR WILL HAVE THE DISCRETION TO DETERMINE IF A SERVICE IS A COVERED BENEFIT, WHEN IT IS NOT SPECIFICALLY PROVIDED FOR IN THE PLAN. QUOTED BENEFITS ARE NOT A GUARANTEE OF PAYMENT. BENEFITS ARE DETERMINED WHEN A CLAIM IS RECEIVED. FINAL PAYMENT DETERMINATION IS MADE IN ACCORDANCE WITH PLAN DETERMINATIONS AND INTERPRETATION OF ALL PLAN PROVISIONS.