OCCUPATIONAL ACCIDENT – LEVEL 3
CERTIFICATE OF COVERAGE &
SUMMARY PLAN DESCRIPTION

SCHEDULE OF BENEFITS
OCCUPATIONAL ACCIDENT – LEVEL 3

DESCRIPTION OF BENEFIT	OCCUPATIONAL	NON-OCCUPATIONAL
ACCIDENTAL DEATH & DISMEMBERMENT		
Maximum Benefit Amount	$500,000 Principal Sum	$10,000 Principal Sum
Survivor's Benefit (Lump Sum)	$100,000 Death Lump Sum	$10,000 Death Lump Sum
Survivor's Benefit (Monthly Sum)	$5,000 per Month up to 80 Months	N/A
Incurral Period	52 Weeks	52 Weeks
Accidental Dismemberment	$5,000 per Month up to 100 Months	$10,000 Lump Sum
Severe Burn Benefit	$500,000	$10,000
Paralysis Benefit	$5,000 per Month up to 100 Months	$10,000 Lump Sum
ACCIDENTAL MEDICAL EXPENSE		
Maximum Benefit Amount	$1,000,000	Not Covered
Commencement Period	90 Days	N/A
Deductible	$0	N/A
Incurral Period	52 Weeks	N/A
Accidental Dental - Maximum Benefit	$1,000 per Injury / $10,000 Lifetime	N/A
Chiropractic Care / Occupational Therapy / Physical Therapy	No Sub Limit Applies	N/A
TEMPORARY TOTAL DISABILITY		
Maximum Benefit Amount	$1,500 Maximum / $150* Minimum per Week	Not Covered
Waiting Period	30 Days Retroactive	N/A
Commencement Period	90 Days	N/A
Duration – Maximum Benefit Period	104 Weeks	N/A
CONTINUOUS TOTAL DISABILITY		
Maximum Benefit Amount	$1,500 Maximum / $150* Minimum per Week	Not Covered
Waiting Period	104 Weeks	N/A
Duration – Maximum Benefit Period	Up to Age 65	N/A
ADDITIONAL BENEFIT RIDERS		
Hernia or Hemorrhoid or Occupational Disease or Cumulative Trauma	$10,000 per Injury Subject to a $40,000 Lifetime Maximum Maximum Benefit Period: 10 Weeks	
Certificate Combined Single Limit and Any One (1) Accident and Aggregate	$1,000,000	

*Subject to the lesser of 70% of Average Weekly Earnings or the Maximum Weekly Benefit Amount Shown

**Age will vary depending upon the Owner-Operator's DOB. If the Owner-Operator reaches SSRA before satisfying the waiting period, he/she will not qualify for Continuous Total Disability Benefits.

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IMPORTANT INFORMATION

This Plan Document describes the benefits available to a Covered Person under the named Plan, including eligibility requirements for coverage, the benefits provided, the conditions that must be met to qualify for Plan benefits, and other special Plan provisions. Although every effort has been made to make the description in this Plan Document as accurate as possible, this Plan Document does not include every relevant detail of the Plan. No representations are made regarding any additional or other coverage, nor are additional or other coverages available to a member unless specifically stated in this Plan Document**.** No benefits are available to a member which are not specifically identified in this Plan Document**.**

It is important that You read this Plan Document in its entirety, so that You can understand the details of the Plan. Many sections of the Plan Document are related to other sections of the document. You may not have all of the information You need by reading just one section, so it is important that you review all sections that apply to a specific topic. This Plan Document is designed to meet Your information needs and the disclosure requirement of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic Plan Document for the Plan. The Plan Document is the binding document for Plan Administration in any appeal process.

STATEMENT OF COVERAGE "DISCLAIMER"
The coverage described herein is NOT workers compensation insurance and does not satisfy the requirements under any state's workers compensation act.

DISCLAIMER

The coverage provided is Limited Benefit Supplemental Coverage. The coverage is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide. The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

LANGUAGE ACCESS SERVICES

We provide free:

- Aid to those with disabilities to help them communicate with us, such as sign language interpreters and written information in other formats (large print, audio, electronic formats, other).
- Language help for those whose first language is not English, such as Interpreters and member materials written in other languages.
- Assistance with filing claims and appeals in other languages.

For help, please call Member Services at **888-920-7526**.

Spanish (Español): Para obtener asistencia en Español, llame al 888- 920-7526.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-920-7526.
[Chinese (**中文**): **如果需要中文的帮助**，请拨打这个号码 888-920-7526.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888- 920-7526

PLAN ADMINISTRATION

Planstin Administration has been granted the authority to administer the Plan which includes, but is not limited to, claims processing and other technical services. Planstin Administration reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency, and making factual determinations.

The Plan shall be administered by Planstin Administration, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by Planstin Administration. It is the express intent of this Plan that Planstin Administration shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of Planstin Administration will be final and binding on all interested parties. Benefits will be paid under this Plan only if Planstin Administration, in its discretion, determines that the Covered Person is entitled to them.

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

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

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status, and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed items;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To perform all necessary reporting as required by 45 CFR § 148.220;
9. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
10. To perform each function necessary for or related to the Plan's administration.

COVERAGE TYPE

The total Aggregate Benefit payable under this policy for Accidental Death and Dismemberment, Accident Medical Expenses, Temporary Total Disability, Continuous Total Disability and Additional Benefit Riders benefits combined for an Occupational Accident per Covered Person per Covered Accident is as shown in the Schedule of Benefits. Benefit payments made under one coverage will reduce any benefits payable under any other coverage so that the total of all benefits payable will not exceed the aggregate benefit shown in the Schedule of Benefits.

This Occupational Accident Plan is secondary coverage. The Plan will pay benefits for actual medical expenses AFTER all payments from major medical plans, workers compensation coverage and auto and commercial drivers plans. These plans will operate as primary coverage. Medical care by a Licensed Physician must begin within thirty (30) days of a Covered Accident for any benefits to be payable under the policy.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

All injuries sustained by a Covered Person in any one Covered Accident shall be considered a single injury. If a Covered Person as a result of the same accident sustains more than one Loss, only one amount, the largest, will be paid. Any illness or injury for which a Covered Person has been examined, taken medication, had symptoms, or received medical treatment within 24 months prior to the effective date of this coverage is considered a pre-existing medical condition.

ACCIDENTAL DEATH BENEFIT

If Injury to the Covered Person, directly caused by an Occupational Accident, results in the death of that Covered Person within the Incurral Period shown in the Schedule of Benefits, the Plan will pay a Survivor's Benefit, subject to the terms and conditions described in the Survivor's Benefit section below, and subject to any applicable deductible amount for the Accidental Covered Loss shown in the Schedule of Benefits. The Incurral Period starts on the date of the accident that caused such Injury.

The Plan shall have the right to develop a structured benefit distribution plan for the payment of any benefit(s) payable under this policy, whether through an annuity or otherwise. We do not need the consent or agreement of the Covered Person, beneficiary, or any other person to develop and implement such a plan. Upon the purchase of an annuity, the obligation to make any and all future payments under this policy will be transferred to the company issuing the annuity. It is agreed that, in that event, the Covered Person or Designated Beneficiary will rely solely on that company to satisfy any and all further obligations for such benefits under this policy and no further demands or claims can or will be made against the Plan for such benefits. If any person entitled to receive benefits is a minor or not competent to give a valid release, such benefits shall be paid to such person's legally appointed guardian or conservator.

Survivor's Benefit

If the Covered Person suffers accidental death such that an Accidental Death Benefit is payable under this Policy, the Plan will pay a monthly Survivor's Benefit to the surviving Spouse, up to the Principal Sum shown in the Schedule of Benefits. The Monthly Benefit Amount is determined by dividing the remainder of the Principal Sum after payment of any Lump Sum by the number of months shown in the Schedule of Benefits. If the Covered Person is not survived by a Spouse, or if the Covered Person's Spouse dies or remarries, the Plan will pay or continue to pay the Survivor's Benefit to the Covered Person's surviving Dependent Children, if any. If there is more than one surviving Dependent Child, the Survivor's Benefit will be distributed equally among the surviving Dependent Children. The payment of the monthly Survivor's Benefit will end on the earliest of the following dates:

1. The date the Spouse dies or remarries if there are no Dependent Children;
2. As to Each Dependent Child, the date that Dependent Child dies or is no longer within the definition of Dependent Child; or
3. The date the Principal Sum has been paid.

If the Covered Person is not survived by a Spouse or Dependent Child, the Plan will pay only the Accidental Death Benefit in accordance with the Claims provisions of this Policy.

ACCIDENTAL DISMEMBERMENT BENEFIT

Monthly Benefit

If Injury to the Covered Person, sustained as a result of an Occupational Accident, as defined below, results in any one of the Losses specified below, within the Policy Period shown in the Schedule of Benefits (as measured from the date of the Accident that caused such Injury), the Plan will pay a monthly benefit equal to the percentage of the Principal Sum shown below for that Loss, subject to any applicable deductible amount for the Accidental Dismemberment Covered Loss shown in the Schedule of Benefits.

Benefits will be payable in equal monthly payments up to the Maximum Benefit Period shown in the Schedule of Benefits, subject to the Maximum Monthly Benefit Amount shown in the Schedule of Benefits. The amount of the monthly benefit is determined by multiplying the applicable percentage of the Principal Sum by the Principal Sum, and then dividing that amount by the numbers of months in the Maximum Benefit Period.

The payment of the monthly benefit ceases on the earlier of:

1. The date the Covered Person dies; or
2. The date the total amount of monthly benefits paid equals the percentage of the Principal Sum shown below for that Loss.

For Loss of	Percentage of the Principal Sum
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing on Both Ears	100%
One Arm and One Leg	75%
One Hand or One Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Four Fingers of the Same Hand	25%
Hearing in One Ear	25%
Thumb and Index Finger of the Same Hand	25%
All Toes of the Same Foot	13%
One Thumb	10%
One Finger	2%
One Toe	1%

"Loss" of:

- A hand or foot means complete severance through or above the wrist or ankle joint.
- Sight of an eye means total and irrecoverable loss of the entire sight in that eye.
- Hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear.
- Speech means total and irrecoverable loss of the entire ability to speak.

- An arm or leg means complete severance through or above the shoulder or hip joint.
- Four fingers means complete severance through or above the metacarpophalangeal joint of all four digits.
- Thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.
- All toes means complete severance through or above the metatarsophalangeal joint of all five digits.
- One thumb means complete severance through or above the metacarpophalangeal joint of the digit.
- One finger means complete severance through or above the metacarpophalangeal joint of the digit.
- One toe means complete severance through or above the metatarsophalangeal joint of one digit.

Severe Burn Benefit

The Accidental Dismemberment Benefit has been expanded to include Severe Burn as a Covered Loss. If a Covered Person suffers an Injury that is a Severe Burn, the Plan will pay a benefit as described below. The benefit payable is based on the Maximum Percentage of Accidental Dismemberment Principal Sum shown below and with respect to the specified body area shown below:

Specified Body Area	**Maximum Percentage of Principal Sum**
Face and Neck and Head	99%
Hand and Forearm Below Elbow Joint (Right)	22.5%
Hand and Forearm Below Elbow Joint (Left)	22.5%
Upper Arm Below Shoulder Joint to Elbow Joint (Right)	13.5%
Upper Arm Below Shoulder Joint to Elbow Joint (Left)	13.5%
Torso Below Neck to Shoulder Joints and Hip Joints (Front)	36%
Torso Below Neck to Shoulder Joints and Hip Joints (Back)	36%
Thigh Below Hip Joint to Knee Joint (Right)	9%
Thigh Below Hip Joint to Knee Joint (Left)	9%
Foot and Lower Leg Below Knee Joint (Right)	27%
Foot and Lower Leg Below Knee Joint (Left)	27%

If only one of the Covered Person's specified body areas is Severely Burned in an accident and 100% of the surface of that specified body area is Severely Burned, the benefit payable is 100% of the Maximum Percentage of Principal Sum shown for that Specified Body Area. If only one of the Covered Person's Specified Body Areas is Severely Burned in an accident and less than 100% of the surface of that Specified Body Area is Severely Burned, the benefit payable is that same lesser percentage of the Maximum Percentage of Principal Sum shown above for that Specified Body Area.

For example: The Maximum Percentage of Principal Sum shown for the "Foot and Lower Leg Below Knee Joint (Right)" Specified Body Area is 27%. If 100% of the surface of that Specified Body Area is Severely Burned, the benefit payable is 100% of 27%, or 27%, of the Principal Sum. If 50% of that surface is Severely Burned, the benefit payable is 50% of 27%, or 13.5%, of the Principal Sum. If 1/3 of that surface is Severely Burned, the benefit payable is 1/3 of 27%, or 9%, of the Principal Sum.

If more than one of the Covered Person's Specified Body Areas is Severely Burned as a result of the same accident, the benefit payable is the lesser of:

1. The sum of the benefit amounts calculated separately, according to the above rules, with respect to each such Specified Body Area; or
2. 100% of the Principal Sum.

The determination of whether or not a Specified Body Area is Severely Burned, and what proportion of its surface is Severely Burned, must be made by a Licensed Physician. The Plan has the right, at its own expense, to have the determination verified by a Licensed Physician of the Plan's choice.

Paralysis Benefit

If Injury to the Covered Person results in any type of paralysis specified below, within the Policy Period shown in the Schedule of Benefits (as measured from the date of the Accident that caused such Injury), the Plan will pay a monthly benefit equal to the Percentage of the Accidental Dismemberment Principal Sum shown below for that type of paralysis, subject to any applicable deductible amount for the paralysis Covered Loss shown in the Schedule of Benefits. Benefits will be payable in equal monthly payments, up to the Maximum Benefit Period shown in the Schedule, subject to the Maximum Monthly Benefit Amount. The monthly benefit is determined by multiplying the applicable Percentage of the Principal Sum by the Principal Sum, and then dividing that amount by the number of months in the Maximum Benefit Period. The payment of the month benefit ceases on the earliest of:

1. The date the Covered Person is no longer paralyzed,
2. The date the Covered Person dies, or
3. The date the total amount of monthly benefits paid equals the Percentage of the Principal Sum shown below for that Type of Paralysis:

Type of Paralysis	**Percentage of the Principal Sum**
Quadriplegia	100%
Paraplegia	50%
Hemiplegia	50%
Uniplegia	25%

As used in this policy, neither Quadriplegia, Paraplegia, Hemiplegia, Uniplegia, nor paralysis includes paresis. Paralysis benefits for more than one type of paralysis may not be combined. If a Covered Person sustains more than one type of paralysis as a result of the same Accident, the only paralysis benefit payable under this policy will be the largest single paralysis benefit that applies.

EXPOSURE & DISAPPEARANCE

If, by reason of an Occupational Accident, a Covered Person is unavoidably exposed to the elements and as a result of such exposure suffers a loss which is otherwise covered under this Policy, the loss will be considered a Covered Loss under the terms of this Policy. If the body of a Covered Person has not been found within one (1) year after the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which that Covered Person was an occupant, then it will be deemed, subject to all other terms and provisions of this Policy, that the Covered Person has suffered Accidental Death within the meaning of this Plan. If, within seven (7) years, the Covered Person is later found living, all benefits paid must be immediately refunded to the Plan.

AUTOPSY

Upon receipt of a claim for a deceased Claimant for any condition, accident, or injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

ACCIDENTAL MEDICAL EXPENSE BENEFIT

All Injuries sustained by a Covered Person in any one Accident shall be considered a single Injury. Any illness or injury for which a Covered Person has been examined, taken medication, had symptoms, or received medical treatment within 24 months prior to the effective date of this coverage is considered a pre-existing medical condition

If a Covered Person suffers an Occupational Injury that, during the effective period of this policy shown in the Schedule of Benefits, requires him or her to be treated by a Licensed Physician, the Plan, will pay the Usual and Customary Charges incurred for Medically Necessary Covered Accident Medical Services received due to that Injury, up to the Maximum Benefit Amount and Incurral Period shown in the Schedule of Benefits per Covered Person for all Injuries caused by a single Accident, subject to any applicable deductible amount.

The Incurral Period starts on the date of the accident that caused such Injury. The deductible amount, if applicable, for the Accident Medical Expense Benefit is the deductible amount shown in the Schedule of Benefits, if any, which must be met separately for each Accident from the Usual and Customary Charges for Medically Necessary Covered Accident Medical Services incurred due to Injuries sustained by the Covered Person in that Accident.

Medical Expense Benefits are only payable in excess of the coverage limits of any other traditional insurance products that cover the Covered Persons. Benefits will be reduced by benefits payable under any such traditional insurance products. If there is no other valid traditional insurance, the Plan will pay eligible expenses incurred which are subject to all the terms, conditions, and limitations of the policy.

Covered Persons must be under the continuous care of a Licensed Physician to receive benefits. First medical expenses must be incurred within thirty (30) days of the covered Accident for benefits to be payable under the policy. Covered medical expenses must be incurred within Incurral period as shown in the Schedule of Benefits. All medical expenses must be invoiced within ninety (90) days of the date of service.

In addition to the exclusions set forth herein, Usual and Customary Charges for Covered Accident Medical Services do not include, and benefits are not payable with respect to, any expense for or resulting from the following:

1. Repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing Durable Medical Equipment, unless for the purpose of modifying the item because Injury has caused further impairment in the underlying bodily condition;
2. New or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums;
3. New eyeglasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless Occupational Injury has caused impairment of

sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because Injury has caused further impairment of sight;

4. New hearing aids or hearing examinations, unless Injury has caused impairment of hearing-, or repair or replacement of existing hearing aids, unless for the purpose of modifying the item because Occupational Injury has caused further impairment of hearing;
5. Rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Plan's sole judgment, Accident Medical Expense Benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Plan may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Accident Medical Expense Benefit in lieu of such rental expense);
6. Custodial Services; or
7. Personal Comfort or Convenience Items.

We will not pay for such items.

TEMPORARY TOTAL DISABILITY BENEFIT

All Injuries sustained by a Covered Person in any one Accident shall be considered a single Injury. If a Covered Person as a result of the same Accident sustains more than one Loss, only one amount, the largest, will be paid. Any illness or injury for which a Covered Person has been examined, taken medication, had symptoms, or received medical treatment within 24 months prior to the effective date of this coverage is considered a pre-existing medical condition.

If Injury to the Covered Person results in Temporary Total Disability within the period between the date of Injury and the policy anniversary/termination date and if the Covered Person is under age 65 on the day the Temporary Total Disability begins, the Plan will pay the Temporary Total Disability Benefit specified below, subject to satisfaction of any applicable Waiting Period shown in the Schedule of Benefits.

The Waiting Period starts on the date of the Accident that caused such Injury. After the Waiting Period has been satisfied, the Temporary Total Disability Benefit shall be payable, 30 days retroactively from the date the disability began, provided the Covered Person remains Temporarily Totally Disabled.

The Temporary Total Disability Benefit with respect to each week of a Covered Person's Temporary Total Disability during a Single Period of Total Disability is equal to the lesser of:

1. 70% of the Covered Person's Average Weekly Earnings; or
2. The Maximum Weekly Benefit Amount shown in the Schedule of Benefits.

The Temporary Total Disability Benefit shall cease on the earliest of the following:

1. The date the Covered Person is no longer Temporarily Totally Disabled;
2. The date the Covered Person dies;
3. The date the Covered Person attains age 65; or
4. The date the Maximum Benefit Period shown in the Schedule of Benefits has been reached.

The Temporary Total Disability Benefit with respect to less than a full Benefit Week of Temporary Total Disability equals 1/7th of the weekly benefit for each day of Temporary Total Disability.

CONTINUOUS TOTAL DISABILITY BENEFIT

All Injuries sustained by a Covered Person in any one Accident shall be considered a single Injury. If a Covered Person as a result of the same Accident sustains more than one Loss, only one amount, the largest, will be paid. Any illness or injury for which a Covered Person has been examined, taken medication, had symptoms, or received medical treatment within 24 months prior to the effective date of this coverage is considered a pre-existing medical condition

If Injury to the Covered Person, resulting in Temporary Total Disability, subsequently results in Continuous Total Disability, the Plan will pay the Continuous Total Disability Benefit specified below, provided:

1. Benefits payable for a Temporary Total Disability Covered Loss ceased solely because the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached, but the Covered Person remains disabled; and
2. The Covered Person is under age 65 on the day after the Maximum Benefit Period shown in the Schedule for Temporary Total Disability has been reached; and
3. The Covered Person has been granted a Social Security Disability Award for his or her disability; and
4. The Covered Person's disability is reasonably expected to continue without interruption until the Covered Person dies.

The Continuous Total Disability Benefit with respect to each month of a Covered Person's Continuous Total Disability is equal to four and three-tenths (4.3) times the weekly benefit for Temporary Total Disability, *less the Covered Person's primary Social Security Disability Award*.

The Continuous Total Disability Benefit with respect to less than a full Benefit Week of Continuous Total Disability equals 1/ 7th of the weekly Benefit for Temporary Total Disability for each day of Continuous Total Disability.

Benefits payable under the Temporary Total Disability Benefit before the Maximum Benefit Period shown in the Schedule of Benefits for Temporary Total Disability has been reached, will not be considered a continuous Total Disability Benefit.

The Continuous Total Disability Benefit shall cease on the earliest of the following dates:

1. The date the Covered Person is no longer Continuously Totally Disabled;
2. The date the Covered Person dies;
3. The date the Covered Person's Social Security Disability Award ceases;
4. The date the Covered Person attains age 65, the date the Maximum Benefit Period shown in the Schedule of Benefits for Continuous Total Disability has been reached.

NON-OCCUPATIONAL COVERAGE

All Injuries sustained by a Covered Person in any one Accident shall be considered a single Injury. If a Covered Person as a result of the same Accident sustains more than one Loss, only one amount, the largest, will be paid. Any illness or injury for which a Covered Person has been examined, taken medication, had symptoms, or received medical treatment within 24 months prior to the effective date of this coverage is considered a pre-existing medical condition

Accidental Death Benefit - See Page 6
Accidental Dismemberment Benefit – See Page 7

Non-Occupational Coverage references in this Policy refers to an Injury or Accident, where applicable, are hereby deemed to include Non-Occupational Injury and Non-Occupational Accident, respectively. Benefits shall be payable only for those Covered Losses listed in the Schedule of Benefits under Non-Occupational Accident Benefits and shall be subject to the Non-Occupational Accident Benefit limitations shown therein.

Non-Occupational means, with respect to an activity, Accident, incident, circumstance, or condition involving a Covered Person, that it is not proximately caused by the Covered Person's performing Occupational Services.

Non-Occupational Injury means physical Injury caused by a Non-Occupational Accident occurring while this policy is in force as to the person whose injury is the basis of claim and resulting directly and independently of all other causes in a Covered Loss.

GENERAL LIMITATIONS AND EXCLUSIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services. This Plan does not cover loss directly or indirectly contributed to or resulting from any one or more of the following:

1. Administrative costs that are solely for and/or applicable to administrative costs of completing claim forms or reports for providing records wherever allowed by applicable law and/or regulation.
2. Cancelled and/or Broken Appointment fees billed by the provider or facility.
3. Any state's workers' compensation act.
4. Charges for services billed after the termination date of the Plan.
5. Suicide, intentionally self-inflicted injuries; gunshot wounds which are either intentionally self-inflicted or the result of an attack provoked by the Covered Person; except that benefits will be payable when such Injuries are inflicted on a Covered Person by another person while the other person is committing a felony; and benefits will be payable for injuries resulting from an unprovoked attack on the Covered Person.
6. Notwithstanding anything to the contrary contained herein this Plan does not cover Loss or damage directly or indirectly occasioned by, happening through or in consequence of War/Riot, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition or destruction of or damage to property by or under the order of any government or public or local authority.
7. Sickness, disease, bodily infirmity or bacterial or viral infection, regardless of how contracted. This exclusion does not include bacterial infection that is the natural and foreseeable result of an accidental external cut or wound, or accidental food poisoning.
8. Intoxication or being under the influence of a controlled substance unless prescribed by and taken under the supervision of a Licensed Physician;
    a. For the purpose of this exclusion, intoxication means: a person is deemed to be intoxicated if the level of Alcohol in his blood equals or exceeds the amount where a person is presumed, under the law of the locale in which the Injury is sustained, to be under the influence of alcohol or intoxicating liquor, regardless of whether or not the Covered Person is operating a motor vehicle when the Injury is sustained;
    b. For the purpose of this exclusion, under the influence means: a person is deemed to be under the influence of a narcotic, barbiturate, or hallucinatory drug, as defined in the law of the locale in which the Injury is sustained, unless prescribed by a Licensed Physician and taken in accordance with the prescribed dosage, regardless of whether or not the Covered Person is operating a motor vehicle when the Injury is sustained;
    c. The insurer shall not be liable for any loss sustained or contracted in consequence of the Covered Person's being intoxicated or under the influence of any controlled substance unless administered on the advice of a Licensed Physician.
9. This Plan does not cover claims in any way caused or contributed to by nuclear reaction, nuclear radiation, or radioactive contamination.

10. Any Injury arising out of a Union “stop work” action.
11. Any loss for which benefits are payable under Medicare laws, or similar law.
12. Treatment provided by a Hospital or institution that would not charge a person in the absence of the insurance under the policy or that is owned or operated by the state or national government or agency thereof. This does not apply to a tax supported institution of the State of Texas that would not charge a non-indigent person.
13. The Covered Person engaging in or taking part in:
    a. Naval, military or air force service or operations;
    b. Skin diving involving the aid of breathing apparatus, rock climbing or mountaineering normally involving the use of ropes or guides, pot holing, hang gliding, parachuting, hunting on horseback, or driving or riding in any kind of race.
    c. Driving or riding on motorcycles or motor scooters.
14. Eye exams, eyeglasses, and hearing aids.
15. Prosthetic or orthopedic appliances unless required for the replacement of natural parts of the body.
16. Dental treatment, except as provided under Accident Medical Expense.
17. Hernia or hemorrhoids, except as provided under Additional Benefit Riders.
18. Cosmetic, plastic, or restorative surgery, unless medically necessary for the treatment of covered injuries. “Medically Necessary” means the treatment, service, or supply is (a) prescribed by the Covered Person’s Licensed Physician for Injury; and (b) appropriate, according to conventional medical practices, to the Injury.
19. Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting therefrom:
    a. While being used for any racing, test, or experimental purposes; or
    b. While the Covered Person is operating, learning to operate, or serving as a member of the crew thereof; or
    c. While being operated by or for or under the direction of any military authority, other than transport type aircraft operated by the Military Air Command (MAC) of the United States of America or the similar air transport service of any other country; or
    d. Which vehicle or device, if a civil aircraft, does not have a valid United States air worthiness certificate, or its foreign equivalent of an unlimited classification, or
    e. While being operated by a person who does not hold a valid pilot certificate or rating authorizing him/her to operate it.
20. Professional services, supplies, or Hospitalization for rest cures, convalescent, domiciliary or sanitaria care or custodial care. Custodial Care means that type of care whenever furnished by and by whatever name called, which is designed primarily to assist an individual in meeting his/her activities of daily living.
21. Services or supplies which are not recommended and approved by the attending Licensed Physician.
22. Charges related to ingestion or injection of narcotics of hallucinogens, or any gas or fumes, taken or inhaled voluntarily or by voluntary poisoning.
23. Deliberate exposure to exceptional danger (except in an attempt to save human life).
24. Non-prescription medicines, vitamins, food, nutritional supplements, health club memberships or exercise equipment, even if prescribed or administered by a Licensed Physician.

25. Charges for necessary services and supplies in excess of the Maximum Allowable Charge.
26. Services and supplies not reasonably necessary. To be "reasonably necessary", service or supply must be ordered by a Licensed Physician and be commonly and customarily recognized throughout the medical profession as appropriate in the treatment of the diagnosed accident or Injury. It must neither be educational nor experimental in nature, nor provided primarily for research. Also, the length of the Hospital confinement and the Hospital's services and supplies will be "reasonably necessary" only to the extent reasonably related to the treatment of the condition involved and not allowable, as determined by the Administrator, to the patient's scholastic, educational or vocational training.
27. Charges for services relating to treatment, which is experimental or investigational, when not a recognized, generally accepted medical procedure.
28. Registered and/or private duty nursing care services.
29. Charges incurred as the result of an Injury suffered in a fight where the Covered Person is the aggressor, or during the commitment of or attempted commitment of a crime by the Covered Person.
30. Occupational therapy except as related to rehabilitation from an Accident to restore basic functions.
31. Insect stings or spider bites.
32. Massage therapy.
33. Interpreters fees.
34. Psychological or psychiatric treatment.
35. Repetitive or Cumulative Trauma (conditions which impair the normal physiological function of the body over an extended period of time, but which do not arise as the result of a single trauma).
36. Weapons of mass destruction.
37. Terrorism. It is agreed that, regardless of any contributory cause(s), this insurance does not cover any claim(s) in any way caused or contributed to by any act of terrorism. For the purpose of this exclusion an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of person whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological, or ethnic purposes or reasons including the intention to influence any government and/or put the public, or any section of the public in fear.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide benefits other than those provided under the terms of the Plan.

ELIGIBILITY, EFFECTIVE DATE & TERMINATION DATE

ELIGIBILITY

A person who is eligible may elect coverage under the Plan by completing an enrollment form approved by Us. Verification of eligibility may be required. The date coverage begins depends on the Plan Effective Date and the date of enrollment. You will be covered under the Plan on the following dates:

1. On the date the Employer's Plan first becomes effective, provided You
    a. Are eligible for coverage on that date,
    b. Are employed on a full-time basis (30 hours/week +) or a Contractor
    c. Enroll for coverage during the open enrollment period.
2. On the date You first become eligible for coverage, provided You
    a. Are Currently Performing Services as a Contractor
    b. Enroll for coverage on or before the date You first become eligible for coverage.
3. On the first day of the calendar month following Your enrollment date, provided You
    a. Are Currently Performing Services for the Employer,
    b. Enroll for coverage within 60 days after You first become eligible for coverage.
4. On the date provided in accordance with a Special Enrollment Period.

EFFECTIVE DATE OF COVERAGE

1. Enrollments received within the first 14 days of the month can have an effective date of the 1st day of the same month.
2. Enrollments received after the 15th of the month will not become effective until the 1st day of the following month.

TERMINATION DATES OF INDIVIDUAL COVERAGE

The coverage of any Covered Person for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. The day of the month in, or with respect to which, he or she requests that such coverage be terminated, on the condition that such request is made on or before such date, unless prohibited by law.
3. The date of the expiration of the last period for which the Covered Person has contributed, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The date of the month in which the Covered Person is no longer eligible for such coverage under the Plan.
5. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of a Covered Person, or upon the Covered Person gaining knowledge of the submission, as determined by Planstin Administration in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of a Covered Person, or upon the Covered Person gaining

knowledge of the submission, as determined by Planstin Administration in its discretion, consistent with applicable laws and/or rules regarding such rescission.

TERMINATING THE PLAN

This Plan was established for the exclusive benefit of the Covered Person's with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may upon written consent from Planstin Administration, 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). All amendments to this Plan shall become effective as of the date established by the Plan Sponsor subject to approval by Planstin Administration. If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Covered Persons will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration and will not inure to the benefit of the Employer.

BENEFICIARY DESIGNATION

A completed valid Beneficiary Form, prescribed by Planstin Administration, must be received by Planstin Administration while you are still alive. The most recent valid beneficiary form on file will cancel all previous beneficiary designations.

If the beneficiary is a minor or otherwise not competent to give a valid release, a guardian or the authorized person designated to act on behalf of the minor must provide appropriate documentation designating them to act on their behalf. If documentation is not received, Planstin Administration will hold the funds at simple interest until the minor is of age and requests the payment.

Because a named beneficiary may die or you may divorce and remarry, please review your beneficiaries on a regular basis to make sure they are current.

If you need to change your beneficiaries, please contact our Member Services team at (888) 920-7526.

SUMMARY OF MATERIAL MODIFICATION (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to deductibles, eligibility or the addition or deletion of coverage. Planstin Administration shall notify all Covered Persons of any plan amendment considered a material modification by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective. If said material modification is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed enough notification to satisfy the Plan's Summary of Material Modifications requirements.

SUMMARY OF MATERIAL REDUCTION (SMR)

A Summary of Material Reduction (SMR) is a type of SMM. A material reduction generally means any modification that would be considered by the average Covered Person to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in deductibles or copayments.

Planstin Administration shall notify all eligible Covered Persons of any plan amendment considered a material reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction.

Eligible Covered Persons and Beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Covered Person. The 60-day period for furnishing a summary of Material Reduction does not apply to any Covered Person covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days. If said material reduction is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed enough notification to satisfy the Plan's Summary of Material Reduction requirements. Material reduction disclosure provisions are subject to the requirements of 45 CFR § 148.220 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

CLAIM PROVISIONS

INTRODUCTION

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim. Full and final authority to adjudicate claims and make determinations as to their pay ability by and under the Plan belongs to and resides solely with Planstin Administration. Planstin Administration shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan and all applicable laws. The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the people involved in making these decisions. Benefits will be payable to a Covered Person, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered. Full and final authority to adjudicate claims and make determinations as to their pay ability by and under the Plan belongs to and resides solely with Planstin Administration. Planstin Administration shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan and all applicable laws.

NOTICE OF CLAIM

Written or electronic notice of an Accidental Injury (claim) must be given to the insurer (the Plan) within 30 days after the occurrence of any Loss covered by the Covered Person, or as soon as thereafter as is reasonably possible. Notice given by or on behalf of the Claimant to the insurer (the Plan) or to any authorized agent of the insurer (the Plan), with information sufficient to identify the covered person, shall be deemed notice to the insurer (the Plan).

PROOF OF LOSS

Written proof of loss must be furnished to the insurer, in case of claim for loss for which this Plan provides any periodic payment contingent upon continuing loss, within 60 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 60 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

When the Plan receives written or electronic proof of loss, the Plan may require additional information. The Covered Person must furnish all items the Plan decides are necessary to determine the Plan's liability in accordance with the "Right to Collect Information" provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to the Plan.

RIGHT TO COLLECT INFORMATION

A Covered Person must cooperate and assist the Plan by obtaining the following information within 45 days of the Plan's request. Charges will be denied if the Plan is unable to determine liability because a Covered Person, Licensed Healthcare Practitioner, facility, or other individual or entity failed to do any of the following:

1. Authorize the release of all medical records to the Plan and other information as requested.
2. Provide the Plan with information requested about pending claims, other insurance coverage or proof of Creditable Coverage.
3. Provide the Plan with information that is accurate and complete.
4. Provide reasonable cooperation to any requests made by the Plan.

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this section.

PAYMENT OF BENEFITS

The Plan will pay medical claims when coded according to the latest editions of the Current Procedural Terminology (CPT) manual or International Classification of Diseases (ICD) manual. The Plan will not pay for charges that are billed separately as professional services when the procedure requires only a technical component, charges that are billed incorrectly or billed separately but are an integral part of another billed service, as determined by Planstin Administration, other claims that are improperly billed, or duplicates of previously received or processed claims. Planstin Administration reserves the right to review any and all claims for eligibility for coverage at the time each claim is submitted. You may request a review by calling or writing to the Plan.

Any amount the Plan pays in good faith will release the Plan from further liability for that amount. Payment by the Plan does not constitute any assumption of liability for coverage of an Accident or Injury. It also does not constitute any assumption of liability for further coverage. Any benefit paid in error may be recovered from the Covered Person or the person or entity receiving the incorrect payment. The Plan may offset the overpayment against future benefit payments.

TIMELY REDEMPTION OF PAYMENT

If any claims payment check remains uncashed after 12 months from the date the check was issued, or if a payment issued by other means is unredeemed after 12 months from the date the payment was issued, the claim shall be deemed denied upon the expiration of the 12-month period.

RIGHTS OF ADMINISTRATION

The Plan maintains Our ability to determine Our rights and obligations under this Plan, including without limitation the eligibility for and amount of any benefits payable.

CLAIMS INVOLVING FRAUD OR MISREPRESENTATION

Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person's representative. If the benefits are paid under the Plan and it is later shown that the claims for these benefits involve fraud or misrepresentation, the Plan will be entitled to a refund from the Covered Person, the Beneficiary, or the person receiving payment.

A claim will not be honored if the Covered Person or the provider of the charges will not or cannot provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly files a fraudulent claim,

claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

CLAIM PROVISIONS DEFINITIONS

For purposes of this section, in addition to any specific terms that are defined under the general Definitions section of this Plan, the following terms have the meanings given below:

Claim Involving Urgent Care. Any claim for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations (1) could seriously jeopardize the Covered Person's life or health or the Covered Person's ability to regain maximum function or (2) in the opinion of a Licensed Healthcare Practitioner who has knowledge of the Covered Person's medical condition, which subjects the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

Pre-Service Claim. Any claim for a benefit with respect to which the terms of the Summary Plan Description (SPD) condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Post-Service Claim. Any claim for a benefit that is not a Pre-Service Claim.

Concurrent Claims. If a Claimant requires an on-going course of treatment over a period or via several treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

Adverse Benefit Determination. Any denial of a benefit, reduction of a benefit, termination of a benefit, or failure to pay (in whole or in part) for a benefit. This term includes any benefit denial, benefit reduction, benefit termination, or failure to pay, that:

a. Is based upon a determination of a Covered Person's or beneficiary's eligibility to participate in the Plan,
b. Results from the usage of any Utilization Review Process, or

c. Fails to cover an item or service for which benefits are otherwise provided based upon a determination that the item or services is an Experimental or Investigational Service or is not Medically Necessary or appropriate.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Urgent Care. In the case of a Claim involving Urgent Care, the Plan will notify the Covered Person or the Covered Person's authorized representative of the benefit determination as soon as possible, considering the medical exigencies, but no later than 72 hours after receipt of the claim by the Plan. If the Covered Person or the Covered Person's authorized representative does not provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan, the Plan will notify the Covered Person or the Covered Person's authorized representative as soon as possible, but no later than 24 hours after receipt of the claim by the Plan.

The notice will describe the specific information necessary to complete the claim. In such a case, the Covered Person will be allowed a reasonable amount of time, not less than 48 hours, to provide the specified information. The Plan will notify the Covered Person or the Covered Person's authorized representative of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

1. The Plan's receipt of the specified information, or
2. The end of the period afforded the Covered Person or the Covered Person's authorized representative to provide the specified additional information.

Pre-Service Claims. In the case of a Pre-Service Claim, the Plan will notify the Covered Person or the Covered Person's authorized representative of the benefit determination within a reasonable time period, but no later than 15 days after receipt of the claim by the Plan. The Plan may extend the period of review once, for up to 15 days, in a case where the Plan determines that extension is needed due to matters beyond its control.

Post-Service Claims. In the case of a Post-Service Claim, the Plan will notify the Covered Person or the Covered Person's authorized representative of the benefit determination within a reasonable time period, but no later than 30 days after receipt of the claim by the Plan. The Plan may extend the period of review once, for up to 15 days, in a case where the Plan determines that extension is needed due to matters beyond its control.

MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATION

The notification of any Adverse Benefit Determination will be provided to the Covered Person or the Covered Person's authorized representative and will include the following information:

1. The specific reason or reasons for the Adverse Benefit Determination.
2. The specific Plan provisions on which the Adverse Benefit Determination is based.
3. The Plan's review procedures and the time limits applicable to such procedures, including a statement of the Covered Person's right to bring a civil action under section 502(a) of ERISA following an appeal.

4. If the Adverse Benefit Determination is based upon Medical Necessity, or experimental treatment, or similar exclusion or limit, the Covered Person will be furnished with an explanation of the scientific or clinical judgment for the Adverse Benefit Determination.
5. In the case of an Adverse Benefit Determination concerning a Claim involving Urgent Care, the Covered Person will be furnished with a description of the applicable expedited review process.

PROCEDURES TO APPEAL AN ADVERSE BENEFIT DETERMINATION

1. The Covered Person or the Covered Person's authorized representative has 180 days following receipt of an Adverse Benefit Determination within which to appeal the determination. the Covered Person or the Covered Person's authorized representative must submit a written request for an appeal to Planstin Administration.
2. All comments, documents, records, and other information submitted by the Covered Person or the Covered Person's authorized representative relating to the claim will be reviewed without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
3. The appeal will be conducted by an appropriately 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 will conduct a completely new review, not considering the initial determination.
4. In deciding an appeal that is based (in whole or in part) on a medical judgment, the appropriately named fiduciary will consult with a healthcare professional who has training and experience in the field of medicine involved in the medical judgment.
5. Upon request, the Covered Person or the Covered Person's authorized representative will be provided the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination.

Appeals for Adverse Benefit Determinations may be sent to Planstin Administration as follows:

- Email: claims@planstin.com
- Fax: (435) 631-9478
- Mail: Planstin Administration
  1506 S. Silicon Way, Suite 2B
  St. George, UT 84770

MANNER AND CONTECT OF NOTIFICATION OF APPEAL DECISION

The notification of any decision concerning an appeal of an Adverse Benefit Determination will be provided to the Covered Person or the Covered Person's authorized representative and include the following information:

1. The specific reason or reasons for the appeal decision.
2. Reference to the specific Plan provisions on which the appeal decision is based.
3. A statement describing any voluntary external review procedures and the Covered Person's right to obtain information about such procedures, and their right to bring a civil action under section 502(a) of ERISA.

4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the appeal decision, the Covered Person or the Covered Person's authorized representative will be provided with the information used in making the appeal decision.

TIMING OF NOTIFICATION OF APPEAL DECISION

After an Adverse Benefit Determination is reviewed, You the Covered Person or the Covered Person's authorized representative will receive notice of the appeal decision.

For an appeal of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, the Covered Person or the Covered Person's authorized representative will receive the appeal decision within 72 hours of the Plan's receipt of the Covered Person's request for appeal.

For an appeal of an Adverse Benefit Determination concerning a Pre-Service Claim, the Covered Person or the Covered Person's authorized representative will receive the appeal decision within 30 days of the Plan's receipt of the Covered Person's request for appeal.

For an appeal of an Adverse Benefit Determination concerning a Post-Service Claim, the Covered Person or the Covered Person's authorized representative will receive the appeal decision within 30 days of the Plan's receipt of the Covered Person's request for appeal.

CONCURRENT CARE DECISIONS

If the Covered Person is undergoing a course of treatment and the Plan notifies them that the Plan intends to reduce or terminate the benefits for that course of treatment before the end of the period of time or number of treatments that were previously approved, the Covered Person's has the right to appeal. The Plan must give the Covered Person enough advance notice to allow the Covered Person to appeal before the termination or reduction takes effect.

APPEAL RIGHTS

The Covered Person may appeal any coverage or claim determination made by the Plan to deny, reduce, or terminate the provision or payment for healthcare services under the Plan. The Covered Person must submit a written request for an appeal to the Planstin Administration. Appeals must be submitted in accordance with the Plan's appeal policy and required timeframes, as set forth in the Plan's Procedures to Appeal an Adverse Benefit Determination section. The internal appeals process includes 2 levels of appeal.

When the Plan has made an Adverse Benefit Determination based on a judgment as to Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness of the healthcare service, and the Covered Person has exhausted the internal appeal process, the Covered Person has the right to have the Plan's decision reviewed by an independent review organization external to Planstin Administration. A request for an external independent review must be submitted within 4 months from the date the Covered Person received notice of the Adverse Benefit Determination through the Plan's internal appeal process. Except when a Covered Person's life or health would be seriously jeopardized, the Covered Person must first exhaust the Plan's internal appeal process before the Plan will grant a request for an external independent review.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from Planstin Administration.

The Plan will permit, in a medically urgent situation, such as a Claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless Planstin Administration is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is separate from a provider accepting an Assignment of Benefits, requiring a release of information, or requesting completion a similar form. An Assignment of Benefits by a Claimant shall not be recognized as a designation of the provider as an authorized representative.

RECOVERY PROVISIONS

OVERPAYMENT

If a benefit is paid under this Plan and it is later shown that a lesser amount should have been paid, the Plan will be entitled to recover the excess amount from the Covered Person, the beneficiary, or the provider of the medical treatment, services, or supplies. The Plan may offset the overpayment against future benefit payments. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan may recover that incorrect payment, whether or not it was made due to the third-party administrators or Plan Administrator's (or its designees) own error, from the person to whom it was made or from any other appropriate party.

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

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

SUBROGATION RIGHT

Subrogation is the process by which the Plan seeks reimbursement from another person or entity for a claim the Plan has already paid. When benefits are paid on a Covered Person's behalf under this Plan, Planstin Administration is subrogated to all rights of recovery a Covered Person has against any person, entity, or other insurance coverage. This includes, but is not limited to, recoveries against (a) a third party; (b) any liability coverage for a third party; and/or (c) other insurance that a Covered Person has, including uninsured or underinsured motorist coverage.

This subrogation right extends to the proceeds of any settlement or judgment but is limited to the amount of benefits the Plan has paid. A Covered Person must:

1. Do nothing to prejudice or hinder any right of recovery;
2. Execute and deliver any instruments and papers that may be required by the Plan; and
3. Cooperate with the Plan to assist Us in securing Planstin Administration's subrogation rights.

If a Covered Person brings a lawsuit or other proceeding to recover damages in connection with an Accident or Injury for which the Plan has paid benefits, the Covered Person or the Covered Person's authorized representative must provide the Plan with copies of all pleadings, notices, and other documents and papers that are related to Planstin Administration's subrogation right under this Plan. The Plan reserves the right to intervene in any proceeding in which a Covered Person is a party to the extent that such intervention is reasonably necessary to protect Planstin Administration's subrogation right.

Upon recovery of any portion of Planstin Administration's subrogation interest by way of settlement or judgment, the Plan will not be required, under any circumstances, to pay a fee to the Covered Person's attorney or share in any costs incurred by the Covered Person and/or the Covered Person's attorney in bringing about the settlement or judgment. If the Plan engages an attorney or other agent(s) for the purpose of enforcing Planstin Administration's subrogation right, the Plan will be entitled to an award of their costs, including without limitation reasonable attorneys' fees associated with all trial and appellate proceedings.

A Covered Person is not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this Plan. If the Plan is precluded from exercising Planstin Administration's subrogation right, we may exercise our "Right to Reimbursement" provision in this Plan.

RIGHT TO REIMBURSEMENT

When benefits under paid by the Plan, we have the right to recover an amount equal to the amount the Plan paid if the Covered Person:

1. Seeks recourse against any person, entity, or other insurance coverage by suit, settlement, judgment, or otherwise, and
2. Recovers payment, in whole or in part, from any person, entity, or other insurance coverage for the benefits that the Plan previously paid.

This right to reimbursement extends to the proceeds of any settlement or judgment. This includes, but is not limited to, recoveries against (1) a third party; (2) any liability coverage for a third party; and/or (3) other insurance that a Covered Person has, including uninsured or underinsured motorist coverage.

Reimbursement to the Plan will not exceed either the amount of benefits that the Plan paid that the Covered Person recovered from any other person, entity, or other insurance coverage or the amount recovered from any other person, entity, or other insurance coverage as payment for the same Accident or Injury, whichever is less.

The Covered Person must reimburse the Plan for any payments that were made prior to a determination as to whether an Accident or an Injury is work-related at the time that the Covered Person receives payment for the Accident or Injury from another source. The Covered Person must agree to:

1. Notify the Plan of any workers' compensation claim that a Covered Person makes;
2. Reimburse the Plan even when workers' compensation benefits are provided by means of a settlement or compromise; and

3. Cooperate with the Plan to assist the Plan in securing our right to reimbursement.

The Covered Person must provide the Plan with timely written notification in the event that he or she suffers an Accident or an Injury in which a third party might be responsible, and the Covered Person seeks recourse against any person, entity, or other insurance coverage by suit, settlement, judgment, or otherwise. Such a notice must inform the Plan of:

1. The nature of the Accident or Injury;
2. The names, addresses, and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages suffered by the Covered Person;
3. A description of the Accident or occurrence that the Covered Person reasonably believes was responsible for the Accident or Injury at issue and the approximate date(s) upon which such Accident or occurrence happened; and
4. The name of any legal counsel retained by a Covered Person in connection with any such Accident or occurrence.

If a Covered Person brings a lawsuit or other proceeding to recover damages in connection with any such Accident or occurrence, the Covered Person or the Covered Person's attorney must provide Planstin Administration with copies of all pleadings, notices, and other documents and papers that are related to Planstin Administration's right to reimbursement under this Plan. Planstin Administration reserves the right to intervene in any proceeding in which a Covered Person is a party to the extent that such intervention is reasonably necessary to protect the Plan's right to reimbursement.

Upon recovery of any portion of the Plan's right to reimbursement interest by way of settlement or judgment, Planstin Administration will not be required, under any circumstances, to pay a fee to the Covered Person's attorney or share in any costs incurred by the Covered Person and/or the Covered Person's attorney in bringing about the settlement or judgment. If Planstin Administration engages an attorney or other agent(s) for the purpose of enforcing their right to reimbursement, Planstin Administration will be entitled to an award of their costs, including without limitation reasonable attorneys' fees associated with all trial and appellate proceedings.

A Covered Person is not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this Plan.

WORKERS' COMPENSATION NOT AFFECTED

Coverage under this Plan does not replace or affect any requirements for coverage by Workers' Compensation Insurance. If state law allows, the Plan may participate in a workers' compensation dispute arising from a claim for which the Plan paid benefits.

OTHER PROVISIONS

CONFORMITY WITH FEDERAL STATUTES

If this Plan, on its effective date, conflicts with any applicable federal laws, it is changed to meet the minimum requirements of those laws. If new or applicable federal laws are enacted that conflict with current provisions of this Plan Document, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the Plan Document to the contrary.

ENFORCEMENT OF PLAN PROVISIONS

Failure by Us to enforce or require compliance with any provision within this Plan Document will not waive, modify, or render any provision unenforceable at any other time, whether the circumstances are the same or not.

REQUIRED DATA

You must furnish the Plan with all information that the Plan may reasonably require. You may receive correspondence from Planstin Administration asking You to confirm or provide Your Social Security number information. The Employer must also obtain Social Security numbers for all beneficiaries.

RESCISSION

The Employer reserves the right to rescind coverage for a Covered Person if that person performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact with respect to the requirements for Plan coverage. Rescission is a retroactive cancellation of coverage. The Employer can also retroactively terminate coverage in other circumstances, including but not limited to non-payment of premiums.

ASSIGNEMENT

Except for voluntary assignments to healthcare providers, as may be required by law or as may be provided in applicable policies, Your right to receive benefits under the Plan may not be assigned, voluntarily or involuntarily, to any other person.

SEVERABILITY

If any clause or portion of this Plan Document is held invalid by a court of law or is otherwise unenforceable, the remaining provisions of this document shall not be invalid.

LEGAL ACTION

No cause of action, claim, or suit in law or in equity may be brought to recover benefits under the Plan until the exhaustion of administrative remedies. You agree that You will not file a suit or legal action against Us for any breach of this agreement, or denial of benefits, without first submitting the dispute through the claims review process. No cause of action, claim, or suit in law or in equity can be brought later than 18 months from the date of the alleged breach of this agreement or denial of benefits, regardless of any statute of limitations to the contrary. You waive the right to a jury trial and agree to mediation followed by subsequent binding arbitration, if needed, for any instance of a dispute with the Plan or its affiliates.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts; collective bargaining agreements; and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as detailed reports and Plan Document descriptions. Obtain copies of all Plan documents, other Plan information, and an updated Summary Plan Description (SPD) upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage. Continue healthcare coverage for You if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan Administrator and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $120 fine a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful the

court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

NOTICE OF PRIVACY PRACTICES

This notice describes how protected health information that is created or received by the health Plan may be used and disclosed and how a Covered Person can get access to this information. Please review it carefully.

A federal law called HIPAA requires that health plans and other covered entities (such as healthcare providers) protect the privacy of certain information. This Notice of Privacy Practices ("Notice") is intended to inform Covered Persons, in summary fashion, of their rights under HIPAA's privacy provisions and the HIPAA obligations imposed on the group health plan sponsored by their Employer ("Plan"). This Notice describes how protected health information ("PHI") may be used or disclosed by this Plan to carry out treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. This Notice also sets out this Plan's legal obligations concerning a Covered Person's protected health information, and describes a Covered Person's rights to access, amend and manage that protected health information.

Any reference to "We" or "Us" means the Plan.

Only Protected Health Information ("PHI") is covered by this Notice. Protected Health Information is individually identifiable health information, including demographic information, that is collected from a Covered Person, or created or received by a healthcare provider, a health plan, an employer (when functioning on behalf of the group health plan), or a healthcare clearinghouse and that relates to:

1. A Covered Person's past, present, or future physical or mental health or condition;
2. The provision of healthcare to a Covered Person; or
3. The past, present, or future payment for the provision of healthcare to a Covered Person.

The Plan restricts access to PHI to those who "need to know that information" to provide services to Covered Persons, or on behalf of Covered Persons. Health Information that a Covered Person's employer receives about the Covered Person as an employer (or in a capacity other than as administrator of the Plan) is not PHI. Thus, a Covered Person's sick leave records, FMLA leave information, drug testing results, Workers' Compensation files, disability, life insurance, and OSHA records are not PHI and are not covered by this Notice. This Notice has been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If You have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the "Privacy Contact." The Privacy Contact will be designated by Your Employer in another document.

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on January 1, 2022.

THE PLAN'S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of a Covered Person's PHI. The Plan is obligated to provide the Covered Person with a copy of this Notice of the Plan's:

1. Legal duties;
2. Rights and obligations under HIPAA regarding a Covered Person's PHI;
3. Privacy practices with respect to such PHI;
4. Obligation to abide by the terms of the Notice that is currently in effect; and
5. Obligation to notify the Covered Person in the event of a breach of the Covered Person's unsecured PHI.

The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that it maintains. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

When using or disclosing PHI, or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to, or requests by, a healthcare provider for treatment;
- Uses or disclosures made by the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- Uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and, with respect to which, there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

INFORMATION COLLECTED

The Plan may collect information directly from a Covered Person orally, or on an application or other form. The Plan also collects information from third parties, such as current or former healthcare providers, and consumer reporting agencies.

It is impossible to describe every type of information that may be collected, but here are some examples:

- A Covered Person's name, age, address, Social Security number, telephone number, occupation, and other demographic information;
- A Covered Person's history of other insurance coverage and applications
- A Covered Person's past, present, or future physical, mental, or behavioral health or condition;
- A Covered Person's healthcare history;
- A Covered Person's prescription information; and

- Information about the Covered Person from consumer reporting agencies and data collection agencies.

PERMISSABLE USES AND DISCLOSURES OF PHI

This section describes how the Plan is most likely to use and/or disclose a Covered Person's PHI. Please note that this Notice does not list every use or disclosure, instead it gives examples of the most common uses and disclosures.

TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

The Plan has the right to use and disclose a Covered Person's PHI for all activities that are included within the definitions of "treatment," "payment," and "healthcare operations" as described in the applicable HIPAA Privacy Rule. Generally, this means that the Plan may use Your PHI for the following purposes:

The Plan may use or disclose PHI so that a Covered Person may seek medical treatment. Treatment is the provision, coordination, or management of healthcare and related services. It also includes but is not limited to consultations and referrals between two or more of a Covered Person's providers. For example, the Plan may disclose to a treating specialist the name of a Covered Person's licensed primary care physician so that the specialist may request medical records from that licensed primary care physician. The Plan also may send healthcare information to doctors for patient safety or other treatment-related reasons.

The Plan may use and disclose PHI to pay claims for services provided to a Covered Person, and to obtain stop-loss reimbursements (if applicable), or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Covered Person's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary.

The Plan may also share PHI with a utilization review or pre-certification service provider. Likewise, the Plan may share medical information with another entity to coordinate payment of benefits (e.g., under the plan of the Covered Person's spouse). The Plan will also share PHI to assist with subrogation of a Covered Person's claims.

The Plan may use or disclose PHI to support its business functions. These functions include but are not limited to quality assessment and improvement; reviewing provider performance; licensing; stop-loss underwriting; cost management; business planning; and business development. For example, the Plan may use or disclose PHI:

1. To provide a Covered Person with information about a disease management program;
2. To respond to a customer service inquiry from a Covered Person;
3. In connection with fraud and abuse detection and compliance programs;
4. In connection with underwriting and soliciting bids from potential insurance carriers;
5. In connection with merger and acquisition activities;
6. In connection with setting monthly contributions, deciding employee monthly contributions, or submitting claims to the stop-loss (or excess loss) carrier;
7. To conduct or arrange for medical review; or,
8. In connection with legal services or audit services.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures that the Plan is required by law to make.

Disclosures To the Secretary of The U.S. Department of Health And Human Services. The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Disclosures To Covered Persons. The Plan is required to disclose to a Covered Person most of the PHI in a "designated record set" when that Covered Person requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's healthcare benefits. The Plan also is required to provide, upon the Covered Person's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and healthcare operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan discloses PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Covered Person designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Person's personal representative if a reasonable belief exists that:

1. The Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person;
2. Treating such person as his personal representative could endanger the Covered Person; or,
3. The Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Person's personal representative.

The Plan may use or disclosure PHI to other family members who are covered under the Plan regarding a Covered Person's care or payment related to the care. If a Covered Person objects to the use or disclosure of PHI in communications with other family members covered under the Plan, please contact the Privacy Contact identified on the first page of this Notice.

Business Associates. The Plan contracts with individuals and entities ("Business Associates") to perform various functions on its behalf, or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management. Examples of the Plan's Business Associates would be its third-party administrator, broker, preferred provider organization, and utilization review vendor.

Other Covered Entities. The Plan may use or disclose PHI to assist healthcare providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain healthcare operations. For example, the Plan may disclose PHI to a healthcare provider when needed by the provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct healthcare operations in the areas of fraud and abuse detection; compliance, quality assurance and improvement activities; or accreditation, certification, licensing, or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits if a Covered Person has coverage through another carrier.

Plan Sponsor. The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

Plan Sponsor Personnel. The Plan may disclose PHI to certain employees of the Plan Sponsor ("Plan Sponsor Personnel"), who have been authorized by the Plan to receive PHI from or on behalf of the Plan, as necessary to perform certain Plan administration functions on behalf of the Plan. Plan Sponsor Personnel are subject to the same restrictions as the Plan, and in no event may Plan Sponsor Personnel use PHI for employment related purposes.

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

As Required by Law. The Plan may use or disclose PHI to the extent the federal, state, or local law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

Public Health Activities. The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight Activities. The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee:

1. The healthcare system;
2. Government benefit programs;
3. Other government regulatory programs; and
4. Compliance with civil rights laws.

Abuse or Neglect. The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, the Plan may disclose PHI to a governmental entity authorized to receive such information if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

Legal Proceedings. The Plan may disclose PHI:

1. In the course of any judicial or administrative proceeding;
2. In response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and
3. In response to a subpoena, a discovery request, or other lawful process once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

Law Enforcement. Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to:

1. It is required by law or some other legal process;
2. It is necessary to locate or identify a suspect, fugitive, material witness, or missing person; or
3. It is necessary to provide evidence of a crime.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation Organizations. The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

Research. The Plan may disclose PHI to a third party for purposes of research when:

1. Individual identifiers have been removed; or
2. An institutional review board or privacy board has:
    a. Reviewed the research proposal and established protocols to ensure the privacy of the information; and
    b. Approved the research.

To Prevent a Serious Threat to Health Or Safety. Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a

serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security, Protective Services. Under certain conditions, the Plan may disclose PHI if Covered Persons are, or were, Armed Forces personnel, for activities deemed necessary by appropriate military command authorities. If Covered Persons are members of foreign military service, the Plan may disclose PHI about foreign military personnel to the appropriate foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence or counterintelligence, and for the protection of the President and other authorized persons or heads of state.

Inmates. If a Covered Person is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for:

1. The institution to provide healthcare to the Covered Person;
2. The Covered Person's health and safety and the health and safety of others; or
3. The safety and security of the correctional institution.

Workers' Compensation. The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Emergency Situations. The Plan may disclose PHI of a Covered Person in an emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person.

If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person. The Plan may also disclose PHI of a Covered Person to an entity assisting in a disaster relief effort so that the Covered Person's family can be notified about the Covered Person's condition, status, and location.

Group Health Plan Disclosures. The Plan may disclose the PHI of a Covered Person to a sponsor of the group health plan – such as an employer or other entity – that is providing a healthcare program to the Covered Person. The Plan can disclose the PHI of the Covered Person to that entity if that entity has contracted with the Plan to administer the Covered Person's healthcare program on its behalf.

Underwriting Purposes. The Plan may use or disclose the PHI of a Covered Person for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does use or disclose the PHI of the Covered Person for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI of the Covered Person that is genetic information.

Others Involved in Your Healthcare. Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Person

identifies. Such use will be based on how involved the person is in the Covered Person's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law. If a Covered Person is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Person's best interest.

USES AND DISCLOSURES OF PHI THAT REQUIRE A COVERED PERSON'S AUTHORIZATION

Other uses and disclosures of PHI that are not described above will be made only with the Covered Person's written authorization. If the Covered Person provides the Plan with such an authorization, the Covered Person may revoke the authorization in writing, and the revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that the Plan already has used or disclosed in reliance on the authorization.

Sale Of PHI. The Plan will request the written authorization of a Covered Person before the Plan makes any disclosure that is deemed a sale of the Covered Person's PHI, meaning that the Plan is receiving compensation for disclosing the PHI in this manner.

Marketing. The Plan will request the written authorization of a Covered Person to use or disclose the Covered Person's PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Covered Person, or when the Plan provides promotional gifts of nominal value.

Psychotherapy Notes. The Plan will request the written authorization of a Covered Person to use or disclose any of the Covered Person's psychotherapy notes that the Plan may have on file, with limited exception, such as for certain treatment, payment, or healthcare operation functions.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent a law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate.

The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply, the Plan will comply with the stricter law. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

A COVERED PERSON'S RIGHTS

The following is a description of a Covered Person's rights with respect to PHI:

Right To Request a Restriction. A Covered Person has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment, or healthcare operations. To request restrictions, a Covered Person must make a written request to the Privacy Contact identified on the first page of this Notice. In the request, the Covered Person must include:

1. What information he/she wants to limit;
2. Whether he/she wants to limit the use, disclosure, or both; and
3. To whom the Covered Person wants the limits to apply—for example, disclosures to the Covered Person's spouse.

The Plan is not required to agree to any restriction that a Covered Person may request. If the Plan agrees to the restriction, it will comply with the restriction until it is revoked, or unless the information is needed to provide emergency treatment to the Covered Person.

Right To Request Confidential Communications. If a Covered Person believes that a disclosure of all or part of his/her PHI may endanger him/her, that Covered Person may request that the Plan communicates with him/her regarding PHI in an alternative manner, or at an alternative location. For example, the Covered Person may ask that the Plan only contact the Covered Person at a work address or via the Covered Person's work e-mail.

To request a restriction, the Covered Person must make a written request to the Privacy Contact identified on the first page of this Notice. This written request should inform the Plan: 1) that he/she wants the Plan to communicate his PHI in an alternative manner, or at an alternative location; and 2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Person in danger.

The Plan will accommodate a request for confidential communications that is reasonable, and that states that the disclosure of all or part of a Covered Person's PHI could endanger that Covered Person. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Covered Person's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Person submits a claim for payment, state, or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Covered Person may receive benefits (e.g., an Explanation of Benefits "EOB"). Unless the Covered Person has made other payment arrangements, the EOB (in which a Covered Person's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible. Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Person contact the Privacy Contact as soon as the Covered Person determines the need to restrict disclosures of his/her PHI.

If the Covered Person terminates his request for confidential communications, the restriction will be removed for all of the Covered Person's PHI that the Plan holds, including PHI that was previously

protected. Therefore, a Covered Person should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

Right To Inspect and Copy. A Covered Person has the right to inspect and copy PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's healthcare benefits. However, the Covered Person may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy PHI that is contained in a designated record set, the Covered Person must submit a written request to the Privacy Contact identified on the first page of this Notice. If the Covered Person requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Covered Person's request to inspect and copy PHI in certain limited circumstances. HIPAA provides several important exceptions to a Covered Person's right to access PHI. For example, a Covered Person will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. The Plan will not allow a Covered Person to access PHI if these or any of the exceptions permitted under HIPAA apply. If a Covered Person is denied access to PHI, he/she may request that the denial be reviewed. To request a review, the Covered Person must contact the Privacy Contact identified on the first page of this Notice.

A licensed healthcare professional chosen by the Plan will review the Covered Person's request and the denial. The person performing this review will not be the same one who denied the Covered Person's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Covered Person through the denial that the decision is not reviewable.

Right To Amend. If a Covered Person believes that his/her PHI is incorrect or incomplete, the Covered Person may ask the Plan to amend that information. The Covered Person may request that the Plan amend such information by submitting a written request to the Privacy Contact identified on the first page of this Notice. The request must list the specific PHI that needs amending and explain why it is incorrect or incomplete.

In certain cases, the Plan may deny the Covered Person's request for an amendment. For example, the Plan may deny the request if the information the Covered Person wants to amend is not maintained by the Plan, but by another entity. In addition, the Plan may deny a request if the Covered Person asks the Plan to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan or its third-party administrators;
- is not part of the information which the Covered Person would be permitted to inspect and copy; or
- is accurate and complete.

If the Plan denies the request, they will provide a written explanation for the denial. The Covered Person has the right to file a written statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information, and all future disclosures of the disputed information will include this statement.

Right of an Accounting. The Covered Person has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment, or healthcare operations. An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Covered Person or his personal representative. The Covered Person should know that most disclosures of PHI will be for purposes of payment or healthcare operations, and, therefore, will not be subject to this right. There also are other exceptions to this right. For example, the accounting will not include:

1. Disclosures made to friends or family in the presence of a Covered Person, or because of an emergency;
2. Disclosures for national security purposes; or
3. Disclosures incidental to otherwise permissible disclosures.

To request an accounting of disclosures, a Covered Person must submit a written request to the Privacy Contact identified on the first page of this Notice. A Covered Person's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first accounting requested within a 12-month period will be free. For additional lists of accounting, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Person of the cost involved, and he/she may choose to withdraw or modify the request before any costs are incurred.

Right To Be Notified of a Breach. The Plan is required by law to maintain the privacy and security of PHI. A Covered Person will be promptly notified if a breach occurs that may have compromised the privacy or security of PHI.

Right To a Copy Of This Notice. A Covered Person has the right to request a copy of this Notice by submitting a request to the Privacy Contact identified on the first page of this Notice. If a Covered Person has agreed to accept this Notice electronically, on the Plan's website or by electronic mail, he/she is also entitled to request a paper copy of this Notice at any time.

COMPLAINTS

A Covered Person may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Person may file a complaint with the Plan by contacting the Privacy Contact identified on the first page of this Notice.

A copy of a complaint form is available from this contact office. A Covered person may also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by:

1. sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. calling (877) 696-6775; or,
3. visiting the website at http://www.hhs.gov/ocr/privacy/index.html.

Complaints filed directly with the Secretary must:

1. Be in writing;
2. Contain the name of the entity against which the complaint is lodged;
3. Describe the relevant problems; and
4. Be filed within 180 days of the time the Covered Person became, or should have become, aware of the problem.

The Plan will not penalize or in any other way retaliate against a Covered Person for filing a complaint with the Secretary or with the Plan.

DISCLOSURE OF PHI TO OBTAIN STOP LOSS OR EXCESS LOSS COVERAGE

The Plan Sponsor may hereby authorize and direct the Plan, through Planstin Administration to disclose PHI to stop loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

RESOLUTION OF NON-COMPLIANCE

Any and all authorized individuals 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 Officer.

ASSIGNMENTS

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Covered Person, at the discretion of Planstin Administration, assigns its right to seek and receive payment of eligible Plan benefits, less deductible, copayments and coinsurance amounts, to a medical provider. If a provider accepts said arrangement, the provider's rights to receive Plan benefits are equal to those of the Covered Person and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an AOB and deductibles, copayments, and coinsurance amounts, as consideration in full for treatment rendered.

Planstin Administration may revoke an AOB at its discretion and treat the Covered Person of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the Covered Person, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person, has been received before the proof of loss is submitted, or Planstin Administration – at its discretion – revokes the assignment.

No Covered Person shall at any time, either during the time in which he or she is covered under the Plan or following his or her termination as a Covered Person, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

NON-U.S. PROVIDERS

A provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non-U.S. Provider." Claims for medical care, supplies, or services provided by a Non-U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by Planstin Administration, subject to all Plan exclusions, limitations, maximums, and other provisions. Assignment of Benefits to a Non-U.S. Provider is prohibited absent an explicit written waiver executed by Planstin Administration. If Assignment of Benefits is not authorized, the Claimant is responsible for making all payments to Non-U.S. Providers and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by Planstin Administration to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non-U.S. Provider shall be subject to, and shall act in compliance with, all U.S. and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

CLERICAL ERROR/DELAY

Any clerical error by Planstin Administration in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Covered Person's due to such clerical error will be returned to the Covered Person; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to remedy amounts owed may result in termination of coverage. Effective dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered. If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, the amount of overpayment may be deducted from future benefits payable.

CONFORMITY WITH APPLICABLE LAWS

Any provision of this Plan that is contrary to any applicable law, equitable principle, regulation, or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including,

but not limited to, stated maximums, exclusions, or statutes of limitations. It is intended that the Plan will conform to the requirements of 45 CFR § 148.220, as it applies to health and welfare plans, as well as any other applicable law.

FRAUD UNDER THIS PLAN

Coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud and fails to bring that fraud to Planstin Administration's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

NO WAIVER OR ESTOPPEL

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by Planstin Administration. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein and shall be interpreted in the narrowest fashion possible.

PLAN CONTRIBUTIONS

Planstin Administration shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant. The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Federal Regulations, 45 CFR § 148.220, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the participating employer's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to

the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Plan's obligation with respect to such payments.

If the Plan Sponsor terminates the Plan, then as of the effective date of termination, the Plan Sponsor and eligible Covered Persons shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

RIGHT TO RECEIVE AND RELEASE INFORMATION

Planstin Administration may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which Planstin Administration, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan.

In so acting, Planstin Administration shall be free from any liability that may arise about such action. Any Participant claiming benefits under this Plan shall furnish to Planstin Administration such information as requested and as may be necessary to implement this provision.

WRITTEN NOTICE

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

PROTECTION AGAINST CREDITORS

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void.

If Planstin Administration shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, Planstin Administration in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case Planstin Administration shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his or her spouse / domestic partner, parent, adult child, guardian of a minor child, brother, or sister, or other relative of a Dependent of such Participant or former Participant, as Planstin Administration may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of Planstin Administration, benefit payments may be assigned to health care providers.

BINDING ARBITRATION

NOTE: The Covered Person is enrolled in a plan provided by the Employer that is subject to 45 CFR § 148.220. Any dispute involving an Adverse Benefit Determination must be resolved under 45 CFR § 148.220's claims procedure rules and is not subject to mandatory binding arbitration. The individual may pursue voluntary binding arbitration after he or she has completed an appeal under 45 CFR § 148.220.

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable or is held not to require arbitration of a claim, State law governing agreements to arbitrate shall apply. The Participant and Planstin Administration agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and Planstin Administration agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against Planstin Administration and Planstin Administration waives any right to pursue on a class basis any such controversy or claim against the Participant. The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on Planstin Administration. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and Planstin Administration, or by order of the court, if the Participant and Planstin Administration cannot agree. The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties.

TIMELY REDEMPTION OF PAYMENT

If any claims payment check remains uncashed after 12 months from the date the check was issued, or if a payment issued by other means is unredeemed after 12 months from the date the payment was issued, the claim shall be deemed denied upon the expiration of the 12-month period.

STOP LOSS INSURANCE

Stop Loss Insurance for the plan is provided by Greystone Risk.

CONTINUE PLAN COVERAGE

Coverage for the Covered Person, if there is a loss of coverage under the Plan as a result of a Qualifying Event, may be continued. The Covered Person may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing the Participant's COBRA Continuation Coverage rights.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Becoming familiar with the terms defined in the Definitions section will help You to better understand the provisions of this Plan.

For the purpose of computing the benefits to which a Covered Person is entitled under this policy, all Injuries sustained by a Covered Person in any one Accident shall be considered a single Injury.

Accident means a sudden, abrupt, and unexpected event that takes place at a discrete, identifiable time and place during the Policy Period, and which results in injury.

Accidental Death means death caused by sudden, unforeseen, and involuntary event caused by external, visible, and violent means as revealed by an autopsy provided such death was caused directly by such Accident, and independently of any physical or mental illness within 90 days of the date of accident.

Adverse Benefit Determination means the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

After the Termination Date refers to services that are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Aggregate Benefit means the combined total benefits available to a Covered Person and his or her beneficiaries.

Alcohol refers to the involvement of a Participant who has taken part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury:

1. Resulted from being the victim of an act of domestic violence, or
2. Resulted from a documented medical condition (including both physical and mental health conditions).

Ambulatory Medical Center means a licensed public establishment with an organized staff of Licensed Physicians and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing surgical procedures. Such establishment must provide continuous

Licensed Physician and registered nursing (RN) services whenever a patient is in the facility. An Ambulatory Medical Center does not include a Hospital, a Licensed Physician's office, or a clinic.

Assignment of Benefits is a legal agreement that allows your insurance company to directly pay a third-party for services performed on your behalf.

Average Weekly Earnings means the Covered Person's average weekly gross income from Occupational services as reported to the Internal Revenue Service as Adjusted Gross Income on the Covered Person's federal tax return for the tax year immediately preceding the year in which the Temporary Total Disability began.

Benefit Week means a 7-day period of time that begins on the first day of Temporary Total Disability after the Waiting Period shown in the Schedule of Benefits for Temporary Total Disability and on the same day of each Week thereafter.

Broken Appointments refers to charges received solely due to the Participant's having failed to honor an appointment.

Complications of Non-Covered Services refers to services that are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Continuous Care means medical monitoring and/or evaluation of the disabling condition by a Licensed Physician on a monthly or more frequent basis. The Plan must receive proof of continuing Temporary Total Disability on at least a monthly basis.

Continuous Total Disability and Continuously Totally Disabled refer to disability that:

1. Prevents a Covered Person from performing the duties of all occupations for which he or she is otherwise qualified by reason of education, training, or experience; and
2. Requires and results in the Covered Person's receiving Continuous Care.

Contractor refers to an Independent contractor, 1099, or other self-employed worker that completes particular jobs or assignments for the Employer.

Cosmetic Surgery refers to charges that are Incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for repair or alleviation of damage resulting from an Accident.

Covered Accident Medical Service(s) means any of the following services:

1. Hospital semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including, but not limited to, use of the operating room or emergency room); or use of an Ambulatory Medical Center;
2. Services of a Licensed Physician, a Registered Nurse, LPNs, BSNs, nurse practitioners, PAs, or other kinds of licensed nursing personnel;
3. Ambulance service to or from a Hospital;
4. Laboratory tests;
5. Radiological procedures;
6. Anesthetics and the administration of anesthetics;
7. Blood, blood products and artificial blood products, and the transfusion, thereof;
8. Physical therapy, Occupational therapy, and chiropractic care, up to the Physical Therapy, Occupational Therapy and Chiropractic Care Maximum, if any, shown in the Schedule of Benefits;
9. Rental of Durable Medical Equipment, up to the actual purchase price of such equipment;
10. Artificial limbs, artificial eyes, or other prosthetic appliances; or
11. Medicines or drugs administered by a Licensed Physician or that can be obtained only with a Licensed Physician's written prescription; or
12. The following specific Dental Services, required to treat a dental Injury as a result of an Occupational Accident which happens while covered:
    a. Appliances and splints placed on or attached to sound natural teeth;
    b. Full or partial dentures;
    c. Fixed bridgework, if needed because of accidental injury to sound natural teeth; and
    d. Prompt repair to sound natural teeth if needed because of accidental injury to those teeth.

Covered Loss means an accidental death, dismemberment or other injury covered under the Plan and as shown in the Schedule of Benefits.

Covered Person refers to a person who is eligible to receive benefits under this Plan and for whom coverage is in effect based on enrollment approved by the Plan.

Custodial Care refers to services that do not restore health, unless specifically mentioned otherwise.

Custodial Services means any of the following kinds of services which are provided to care for a Covered Person's physical well-being but are not intended primarily as medical treatment for a specific Injury. Custodial Services include, but shall not be limited to, services:

1. Related to watching or protecting the Covered Person;
2. That are not required to be performed by trained or skilled medial or paramedical personnel; and
3. Related to performing or assisting the Covered Person in performing any activities of daily living, such as:
    a. Walking;
    b. Grooming;
    c. Bathing;
    d. Dressing;
    e. Getting in or out of bed;

f. Toileting;
g. Eating;
h. Preparing foods; or

Deductible (Applies to Accident Medical Expense Benefits Only)
The Deductible Amounts, if applicable, shown in the Schedule apply per Covered Loss and to each Covered Person sustaining a particular type of Covered Loss. For Accidents causing more than one Covered Loss, each deductible amount is applied to the total benefits payable.

Dependent Child(ren) means a child under 26 years of age who is at least one of the following:

1. The Employee's naturally born child;
2. The Employee's legally adopted child;
3. A child that is placed for adoption with Covered Person;
4. A stepchild of the Covered Person; or
5. A child for which the Covered Person is the court appointed legal guardian.

Designated Beneficiary is the individual named on a policy as the recipient of those assets in the event of the Covered Persons death.

Durable Medical Equipment refers to equipment of a type that is designed primarily for use, and used primarily, by people who are injured (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not injured, even if the items can also be used in the treatment of injury or for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Effective Date refers to the date coverage under the Plan begins for a Covered Person. The Covered Person's coverage begins on this date at 12:01 a.m. local time at the Covered Employee's state of residence. The Employer will provide confirmation of the Covered Person's Effective Date.

Eligibility Date refers to the date You are first eligible to apply for coverage under the Plan.

Emergency Room refers to a place affiliated with and physically connected to a Hospital and used primarily for short-term Emergency Treatment.

Excess refers to charges that exceeds Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in Planstin Administration's discretion and as determined by Planstin Administration, in accordance with the Plan terms as set forth by and within this document.

Experimental refers to services that are Experimental or Investigational.

Family Member refers to services that are performed by a person who is related to the Participant as a spouse / domestic partner, parent, child, brother, or sister, whether the relationship exists by virtue of "blood" or "in law".

Foreign Travel refers to services that are received outside of the United States if travel is for the purpose of obtaining medical services, unless otherwise approved by Planstin Administration.

Government refers to services that the Participant obtains, but which is paid, may be paid, is provided, or could be provided for at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities refers to facilities that meet the following requirements:

1. That are furnished to the Participant in any veteran's Hospital, military Hospital, Institution, or facility operated by the United States government or by any State government or any agency or instrumentality of such governments; and
2. That can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

Hemiplegia means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body.

Hemorrhoids means a mass of dilated veins in swollen tissue at the margin of the anus or nearby within the rectum.

Hernia means a condition in which part of an organ is displaced and protrudes through connective tissue or through the wall of the cavity in which it is normally enclosed. Hernia does not include diaphragmatic (hiatal) hernia.

Hospital means a facility that:

1. Is operated according to law for the care and treatment of injured people;
2. Has organized facilities for diagnosis and surgery on its premises, or in facilities available to it on a prearranged basis;
3. Has 24-hour nursing service by registered nurses (RNs), on duty or on call; and
4. Is supervised by one or more Licensed Physicians.

A Hospital does not include:

1. A nursing, convalescent or geriatric unit of a hospital in which a patient is confined mainly to receive nursing care;
2. A facility that is, other than incidentally, a rest home, nursing home, convalescent home, or home for the aged; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes; or

3. Any military or veterans' hospital or soldiers' or sailors' home or any hospital contracted for or operated by any government or government agency for the treatment of members or ex-members of the armed forces.

Illegal Acts refers to any Injury or Accident which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This Exclusion does not apply if the Injury:

1. Resulted from being the victim of an act of domestic violence, or
2. Resulted from a documented medical condition (including both physical and mental health conditions).

Incur or Incurred refers to the date services are provided, or supplies are received.

Incurral Period means, with respect to Accident Medical Expense, the maximum period for which benefits shall be payable for Covered Accident Medical Services for or in connection with a single Accident Medical Expense Covered Loss. The length of the Incurral Period for Accident Medical Expense is shown in the Schedule of Benefits.

Incurred by Other Persons refers to expenses that are Incurred by other persons.

Injury means bodily injury sustained by an Insured Person caused by an Occupational Accident that results directly and independently of all other causes in a Covered Loss. All Injuries sustained by an Insured Person in any one Accident, including all related conditions and recurrent symptoms of the Injuries, are considered a single Injury.

Inpatient refers to being admitted to a Hospital or other licensed facility for a stay of at least 24 hours for which a charge is Incurred for room and board or observation.

Licensed Physician

Limb means entire arm or entire leg.

Long Term Care refers to services that are related to long term care.

Maximum Benefit Period means, with respect to Continuous Total Disability, the maximum period for which benefits shall be payable for a Continuous Total Disability Covered Loss(es). If applicable, the length of the Maximum Benefit Period for Continuous Total Disability is shown in the Schedule of Benefits.

Maximum Benefit Period means, with respect to Temporary Total Disability, the maximum period for which benefits shall be payable for a Temporary Total Disability Covered Loss during a Single Period of Total Disability. The length of the Maximum Benefit Period for Temporary Total Disability is shown in the Schedule of Benefits.

Medically Necessary means that a Covered Accident Medical Service that:

1. Is essential for diagnosis, treatment, or care of the Occupational Injury for which it is prescribed or performed,
2. Meets generally accepted standards of medical practice, and
3. Is ordered by a Licensed Physician and performed either by a Licensed Physician or under his or her care, supervision, or order.

Military Service refers to related conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Negligence refers to Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any caregiver, Institution, or Provider, as determined by Planstin Administration, in its discretion, considering applicable laws and evidence available to Planstin Administration.

No Coverage refers to services that are Incurred at a time when no coverage is in force for the applicable Participant.

Non-Prescription Drugs refers to drugs for use outside of a Hospital or other Inpatient facility that can be purchased over the counter and without a Licensed Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the nonprescription drug must be covered under Preventive Care, subject to the Affordable Care Act.

Not Acceptable refers to services that are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Specified as Covered refers to services that are not specified as covered under any provision of this Plan.

Occupational Accident means an accident-causing injury to any part or function of the body or causing death to employees, which happens during the working process and is closely related to the performance of the assigned work or task.

Occupational Injury means an injury which happens in the course of any work performed by the Covered Person for wage or profit.

Other than Attending Licensed Physician refers to providers that are other than those certified by a Licensed Physician who is attending the Participant as being required for the treatment of Injury or Disease and performed by an appropriate Provider.

Outpatient refers to treatment, services, or supplies received at a licensed medical facility, Healthcare Practitioner's office, or dispensary other than an Inpatient basis for a stay of less than 24 hours.

Paraplegia means the complete and irreversible paralysis of both lower limbs.

Personal Comfort or Convenience Item(s) means those items that are not Medically Necessary for the care and treatment of the Covered Person's Occupational Injury. The term Personal Comfort or Convenience Item(s) includes but is not limited to:

1. A private Hospital room, unless Medically Necessary;
2. Television rental; and
3. Hospital telephone charges.

Personal Injury Insurance refers to a connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether the Participant had such mandatory coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family-owned vehicle or a pedestrian.

Plan Effective Date refers to the date coverage under this Plan becomes available. The Plan Effective Date may or may not coincide with the Effective Date for a Covered Person. Coverage for a Covered Person is effective only when the Covered Person becomes eligible and enrolled under this Plan as of the Effective Date for that Covered Person.

Plan Year refers to the 12-month period shown in the Plan Information section during which the Plan is in force.

Policy means this Occupational Accident Insurance Policy.

Policy Period means the period of time commencing with the Policy Effective Date and ending on the Policy Termination Date. The Policy Period is shown in the Schedule of Benefits.

Postage, Shipping, Handling Charges, Etc. refers to charges for any postage, shipping or handling charges which may occur in the transmittal of information to the Third-Party Administrator; including interest or financing charges.

Principal Sum
As applicable to each Covered Person, Principal Sum means the amount of insurance in force under this Policy on the date of the Accident, as described in the Schedule of Benefits.

Prior to Coverage refers to services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Professional (and Semi-Professional) Athletics (Injury/Illness) refers to a connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law refers to the extent that payment under this Plan is prohibited by law.

Provider Error refers to services that are required as a result of unreasonable Provider error.

Quadriplegia means the complete and irreversible paralysis of both upper and both lower limbs.

Schedule of Benefits means the schedule identifying the benefits, benefit amounts and other terms and provisions of coverage selected by the Covered Person, which is attached to and made part of this Plan.

Self-Inflicted refers to services that are Incurred due to an intentionally self-inflicted Injury or Illness not definitively:

1. Resulting from being the victim of an act of domestic violence, or
2. Resulting from a documented medical condition (including both physical and mental health conditions).

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area due to an Injury that is a full-thickness or third-degree burn as determined by a Licensed Physician. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity, or radiation).

Single Period of Total Disability means all periods of Temporary Total Disability due to the same or related causes (whether or not this insurance has been interrupted) except any of the following which are considered separate periods of disability:

1. Successive periods of Temporary Total Disability, due to entirely different and unrelated causes, separated by at least one full day during which the Covered Person is not Temporarily Totally Disabled; and
2. Successive periods of Temporary Total Disability, due to the same or related causes, separated by at least 6 months during which the Covered Person is not Temporarily Totally Disabled.

Social Security Retirement Age means the full retirement age as defined by the United States Social Security Administration.

Sound Natural Teeth means natural teeth that either are unaltered or are fully restored to their normal function and are disease-free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Spouse means an adult person with whom the Covered Person enters into a marriage, civil union, or comparable relationship in a state or nation in which the marriage, civil union or comparable relationship is sanctioned by law and legally valid at the time it is entered into by the parties.

Subrogation, Reimbursement, and/or Third-Party Responsibility refers to an Injury or Accident not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

Temporary Total Disability and Temporarily Totally Disabled refer to disability that:

1. Prevents a Covered Person from performing the duties of his or her regular, primary occupation; and
2. Requires and results in the Covered Person's receiving Continuous Care.

UCR (Usual, Customary, and Reasonable) refers to rates paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The plan will pay UCR in the absence of a Medicare rate.

Uniplegia means the complete and irreversible paralysis of one limb.

Unreasonable refers to services that are not reasonable in nature or in charge (see definition of Maximum Allowable Charge) or are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection, or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of Planstin Administration in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider

Urgent Care refers to treatment or services provided for an Accident or Injury that develops suddenly and unexpectedly outside of a Healthcare Practitioner's normal business hours and requires immediate treatment but is not of sufficient severity to be considered Emergency Treatment.

Usual and Customary Charge(s) means a charge that:

1. Is made for a Covered Accident Medical Service;
2. Does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (or, for a Hospital room and board charge, other than for a Medically Necessary stay in an intensive care unit, one that does not exceed the Hospital's most common charge for semi- private room and board); and
3. Does not include charges that would not have been made if no insurance existed.

Vehicle Accident refers to any treatment of any Injury where it is determined that a Participant was involved in a motorcycle Accident while not wearing a helmet or in an automobile Accident while not wearing a seatbelt (or car seat), even if the cause of the Illness or Injury is not related to the failure of the Participant to wear a helmet or seatbelt (or car seat). This Exclusion does not apply:

1. To Participants who were passengers on public transportation, ride for hire or livery services or
2. When a seatbelt or helmet is not required by law.

Waiting Period means the consecutive number of days a Covered Person must be Temporarily Totally Disabled or Continuously Totally Disabled before benefits become payable under this Plan. Temporary Total Disability Benefits and Continuous Total Disability Benefits are not retroactive to the first day of disability. The applicable Waiting Period is shown in the Schedule of Benefits.

War/Riot refers to services that are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces and does not apply to victims of any act of war or aggression.

We, Our, Us refers to the Plan.

You, Your, Yours refers to the Covered Person.