Fringe Benefit Group

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR:

BAYADA Home Health Care MEC Plan

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INTRODUCTION

This document is a description of **BAYADA Home Health Care MEC Plan** (the Plan) offered by **BAYADA Home Health Care** (the Employer). No oral interpretations can change this Plan.

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

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

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

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

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

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

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

Minimum Essential Coverage Information

This plan is designed to provide Plan Participants with Minimum Essential Coverage under the federal income tax rules. This Plan is designed so that Plan Participants may enroll in this Plan and not have to pay a federal individual income tax penalty. However, while you are enrolled in this Plan, you will not be eligible for a federal tax credit through a federal or state exchange (sometimes referred to as the insurance marketplace). If you do not enroll in this Plan, you may be eligible for a federal tax credit that lowers your monthly premium or a reduction in certain cost-sharing if you enroll in a health insurance plan through the federal or state exchange.

This Plan does NOT provide Minimum Creditable Coverage (MCC) for residents of the Commonwealth of Massachusetts who are subject to individual health coverage requirements. Enrolled individuals may be subject to Commonwealth of Massachusetts tax penalties.

NETWORK BENEFITS ONLY

IMPORTANT: This Plan only pays benefits if you receive care through a Network provider. No benefits are paid or provided if you receive care from an out-of-network provider.

SCHEDULE OF BENEFITS

Verification of Eligibility: Call (855) 495-1190 to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

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

The Plan is a plan which contains a Preferred Provider Organization (PPO) network.

PPO Network name: First Health Network

Claims Address: Employer Plan Services, Inc.
Austin Claims Operation
PO Box 21854
Eagan, MN 55121

Website: www.FirstHealthLBP.com

This Plan has entered into an agreement with certain Physicians and other health care providers, which are called Network Providers. You must visit a network provider in order to have services covered by the Plan.

Deductibles and Copayments

There are no Copayments or Deductibles or other amounts that a Covered Person must pay before the Plan pays a benefit for the Covered Charges. See the Schedule of Benefits for details.

Minimum Essential Coverage Information

This Plan is designed to provide Participants with Minimum Essential Coverage (MEC) under federal income tax rules. Participants may enroll in this Plan and not have to pay a federal individual income tax penalty. However, **while you are enrolled in this Plan, you will not be eligible for a federal tax credit through a federal or state exchange.** If you do not enroll in this Plan, you may be eligible for a federal tax credit that lowers your monthly premium if you enroll in a health insurance plan through the federal or state exchange.

This **Plan pays for Routine Preventive Care only as described in the Schedule of Benefits. There are no Copayments or Deductibles or other amounts that a Covered Person must pay** before the Plan pays a benefit for the Covered Charges and there is no plan maximum for covered services.

Care must be provided by a First Health Network Provider. No benefits are paid if received from an out-of-network provider.

This Plan does not cover services related to accident, injury or illness.

Preventive Health Services for Adult Males

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease for men (must be physician approved)
- Blood pressure screening
- Cholesterol screening for adults or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening
- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- Immunization vaccines (see details under separate section)
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Falls prevention screening for exercise or physical therapy or vitamin D supplementation in adults age 65 and older who are at increased risk for falls

Preventive Health Services for Adult Females

- Pregnancy Preventative Care (see details under separate section)
- Well-woman visits to get recommended services for women under 65, including preconception care and certain prenatal care
- Immunization vaccines (see details under separate section)
- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease for women (must be physician approved)
- Blood pressure screening
- Cholesterol screening for adults or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening
- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for ages 15 to 65, and other ages at increased risk
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Anemia screening on a routine basis for pregnant women
- Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a healthcare provider for women with reproductive capacity (not including abortifacient drugs)
- Domestic and interpersonal violence screening and counseling for all women
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- HIV screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test every 3 years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Falls prevention screening for exercise or physical therapy or vitamin D supplementation in adults age 65 and older who are at increased risk for falls

Preventive Health Services for Pregnant Women

- Well-woman visits to get recommended services for women under 65, including preconception care and certain prenatal care
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Urinary Tract or other infection screening for pregnant women
- Syphilis screening for all pregnant women or other women at increased risk
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Gestational diabetes screening for women 24 to 48 weeks pregnant and those at high risk of developing gestational diabetes
- Folic Acid supplements for women who may become pregnant
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women

Immunization Vaccines (doses, recommended ages and recommended populations vary)

- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella
- Haemophilus influenza type b
- Inactivated Poliovirus **(children only)**
- Rotavirus **(children only)**

Preventive Health Services for Children

- Autism screening for children at 18 and 24 months
- Immunization vaccines (see details under separate section)
- Behavioral assessments for children up to the age of 16
- Alcohol and drug use assessments for adolescents
- Blood pressure screening for children up to the age of 17
- Cervical Dysplasia screening for sexually active females
- Depression screening for adolescents
- Developmental screening for children under age 3
- Dyslipidemia screening for children ages 1 to 17 years at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea prevention medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children up to the age of 17
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development up the age of 17 year
- Obesity screening and counseling
- Oral Health risk assessment for children up to the age of 10
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis up to the age of 17
- Vision screening for all children

Services Not Covered

Below is a partial list of items NOT covered by this plan.
Only items specifically designed as covered and provided by a First Health Network provider will be paid for by this plan.
This plan does NOT cover services related to accident, injury or sickness.

- Acupuncture
- Allergy testing, serum and injections
- Ambulance service
- Jaw Joint / TMJ
- Bariatric surgery
- Chiropractic care
- Chiropractic Services Orthotics
- Cosmetic surgery
- Dental care (adult)
- Diagnostic testing (e.g. x-ray imaging, labs)
- Durable Medical Equipment
- Emergency services / Emergency Room visit
- Organ transplants
- Outpatient care
- Hearing aids
- Heart Disease treatment
- Home health care
- Hospice care
- Hospital room and board
- Skilled Nursing Facility or Hospice
- Inpatient or outpatient care
- Intensive Care Unit
- Long-term care
- Natural / Cesarean child birth
- Care when traveling outside of the U.S.
- Physical or Speech therapy
- Cancer treatment
- Prescription drugs (except birth control)
- Private duty nursing
- Routine eye care (adult)
- Routine foot care
- Surgery

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees: All Active Employees of the Employer

Eligibility Requirements for Employee Coverage: A person is eligible for Employee coverage from the first day that he/she is in a class of employees eligible for coverage.

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

1. A covered Employee's Spouse. The term "Spouse" shall mean an opposite or same sex individual who is treated as a legal spouse under the Code. The Plan Administrator may require documentation proving a legal marital relationship.

2. A covered Employee's Child(ren): An Employee's "Child" includes his/her natural child, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until the end of the month in which he or she reaches the age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

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

   Any Child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

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

   The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

3. A covered Dependent Child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

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

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

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

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

FUNDING

Cost of the Plan: BAYADA Home Health Care may share the cost of the Employee and Dependent coverage under this Plan with the covered Employees. At the time of enrollment in the Plan an authorization for payroll deduction will be made available. This authorization must be completed and submitted with the enrollment application.

The level of any Employee contributions is set by **BAYADA Home Health Care**, who reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements: An Employee must enroll in the Plan during open Enrollment or following a qualified enrollment event by completing an enrollment form and an applicable payroll deduction authorization, which includes electronic enrollment requests, via the telephone or through an Internet enrollment site.

Enrollment Requirements for Newborn Children: A covered Employee has 31 days after the date of birth to enroll a newborn child, effective as of the date of birth. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan.

Timely Enrollment: The enrollment will be "timely" if submitted to the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (spouses) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee.

SPECIAL ENROLLMENT RIGHTS

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

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

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator or Employer Plan Services, Inc., 11910 Anderson Mill Road, Suite 401, Austin, Texas, 78726, (855) 495-1190.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

1. **Individuals losing other coverage creating a Special Enrollment right:** An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if he or she loses eligibility for such other coverage.

2. **Dependent beneficiaries:**

   A. If the Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

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

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

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

   A. in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

   B. in the case of a Dependent's birth, as of the date of birth; or

   C. in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

3. **Medicaid and State Child Health Insurance Programs:** An Employee or Dependent who is eligible, but not enrolled **in** this Plan, may enroll if:

   A. The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

   B. The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage: An Employee will be covered under this Plan as of the first day of the first payroll cycle following the date that the Employee satisfies all of the following:

1. The Eligibility Requirement
2. The Active Employee Requirement
3. The Enrollment Requirements of the Plan

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

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

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

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

1. The date the Plan is terminated.
2. The last day of the coverage week in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability or other leave of absence, unless the Plan specifically provides for continuation during these periods.
3. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
4. If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action.

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

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

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

Rehiring a Terminated Employee: A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. If an Employee returns to active employment as a rehire within 13 weeks of termination, such Employee may have coverage reinstated (for himself/herself and any Dependents who were covered at the point contributions ceased) without satisfying an additional waiting period. Prior accumulation towards the Deductible and Out-of-Pocket will be credited to each Covered Person upon reinstatement if reinstated within the same Calendar Year. However, Claims incurred between time coverage ended and reinstatement are not eligible for coverage.

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

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

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

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

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

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator or Employer Plan Services, Inc., 11910 Anderson Mill Road, Suite 401, Austin, Texas, 78726, (855) 495-1190. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

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

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

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

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

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

OPEN ENROLLMENT

OPEN ENROLLMENT

During the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective on the plan renewal date and remain in effect until the next annual open enrollment unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage election.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for Preventative Care and while the person is covered for these benefits under the Plan.

COVERED CHARGES

Covered Charges are the negotiated Maximum Allowable Charge that a member incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

Routine Preventive Care: Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Additional preventive care shall be provided as required by applicable law if provided by a Network Participating Provider. A current listing of required preventive care can be accessed at https://www.healthcare.gov/center/regulations/prevention.html.

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

Charges for Routine Women's Care: Preventive health services for women that is not for an Injury or Sickness.

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

DEFINED TERMS

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

Active Employee: An Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his/her job with the Employer on a full-time basis.

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

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

Covered Charge(s): Those Medically Necessary services or supplies that are covered under this Plan. Covered Person is an Employee or Dependent who is covered under this Plan.

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

Employer: BAYADA Home Health Care

Enrollment Date: The first day of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

Genetic Information: Information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

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

The definition of "Hospital" shall be expanded to include the following:

1. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

2. A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

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

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

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

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

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

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

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

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

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

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

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

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

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

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

Plan: BAYADA Home Health Care MEC Plan, which is a benefits plan for certain Employees of **BAYADA Home Health Care** and is described in this document.

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

Plan Year: The 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

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

PLAN EXCLUSIONS

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

Abortion: Services, supplies, care or treatment in connection with an abortion.

Acupuncture

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

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

Educational or vocational testing: Services for educational or vocational testing or training.

Emergency Services: Medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Excess charges: Part of an expense for care and treatment of care that is in excess of the Maximum Allowable Fee that has been negotiated with the provider.

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

Experimental or not Medically Necessary: Care and treatment that is either Experimental/Investigational or not Medically Necessary.

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

Foot care: Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease.)

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

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

Hair loss: Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.

Hearing aids and exams: Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.

Hospital employees: Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Illegal acts: Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required.. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Impotence: Care, treatment, services, supplies or medication in connection with treatment for impotence.

Infertility: Care, supplies, services and treatment for infertility, artificial insemination or in vitro fertilization.

Marital or pre-marital counseling: Care and treatment for marital or pre-marital counseling.

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

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

Non-emergency Hospital admissions: Care and treatment billed by a Hospital for non-Medical Emergency admissions.

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

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

Not specified as covered: Medical services, treatments and supplies which are not specified as covered under this Plan.

Occupational Care: Treatment of an Injury or Sickness that is occupational, that is, arises from work for wage or profit including self-employment.

Personal comfort items: Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies and nonhospital adjustable beds.

Pregnancy: Childbirth and conditions associated with Pregnancy, including complications.

Private duty nursing: Charges in connection with care, treatment or services of a private duty nurse.

Prosthetics: Charges in connection with prosthetics.

Relative giving services: Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Replacement braces: For the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

Routine care: Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

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

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

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

Sleep disorders: Care and treatment for sleep disorders unless deemed Medically Necessary.

Surgical sterilization reversal: Care and treatment for reversal of surgical sterilization.

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

Substance Abuse: Regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks. (However, see the Schedule of Benefits where certain counseling is provided with respect to substance abuse.)

Prescription Drug: Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury. (However, see the Schedule of Benefits where FDA approved birth control, including prescription birth control, is provided.)

Sickness: Covered Person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility: Facility that fully meets all of these tests:

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

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

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

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

5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

7. It is approved and licensed by Medicare.

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

Travel or accommodations: Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

Temporomandibular Joint (TMJ): The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Medical Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

1. serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child),

2. serious impairment to body functions, or

3. serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care: Care which can safely and adequately be provided other than in a Hospital.

War: Any loss that is due to a declared or undeclared act of war.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

1. Obtain a Claim form from the Plan Administrator or its representative;

2. Complete the Employee portion of the form (ALL QUESTIONS MUST BE ANSWERED);

3. Have the Physician complete the provider's portion of the form;

4. For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
   - Name of the Plan
   - Employee's name
   - Name of patient
   - Name, address, telephone number of the provider of care
   - Diagnosis
   - Type of services rendered, with diagnosis and/or procedure codes
   - Date of services
   - Charges

5. Send the above to the Claims Administrator at this address:
   Employer Plan Services, Inc.
   Austin Claims Operation
   PO Box 21854
   Eagan, MN 55121

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

1. it's not reasonably possible to submit the claim in that time; and

2. the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

PROCESSING CLAIMS AND APPEALS

The Plan's administrative procedures for processing claims and appeals are described in the attached Claims and Appeal Procedures.

COORDINATION OF BENEFITS

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

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

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

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
6. No Fault Auto Insurance, by whatever names it is called, when not prohibited by law.

Allowable Charge: For a charge to be allowable at least part of it must be covered under this Plan and the charge must be equal to or less than the Maximum Allowable Charge that the Participating Provider has agreed to accept as payment for that service.

Automobile limitations: When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

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

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:
    A. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
    B. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
    C. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
    D. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
        i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
        ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
    E. When a child's parents are divorced or legally separated, these rules will apply:
        i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
        ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

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

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

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

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

3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

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

5. The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period: Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

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

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

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

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

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

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

Covered Person: Anyone covered under the Plan, including minor dependents

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

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

Subrogation: The Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

Third Party: Any Third Party including another person or a business entity.

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

Rights of Plan Administrator: The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The Plan Administrator has designated Employer Plan Services, Inc. to service the COBRA program Employer Plan Services, Inc. 11910 Anderson Mill Road, Suite 401, Austin, Texas, 78726, (855) 495-1190. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

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

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

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

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his/her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

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

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

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

1. The death of a covered Employee;

2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment;

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

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

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

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

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

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

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

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

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,

2. death of the employee,

3. commencement of a proceeding in bankruptcy with respect to the employer, or

4. enrollment of the employee in any part of Medicare.

IMPORTANT

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

NOTICE PROCEDURES

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

Employer Plan Services, Inc.
11910 Anderson Mill Road, Suite 401
Austin, Texas 78726

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

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

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

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

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

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he/she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

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

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

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

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

4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary;

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

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

    a. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If You Have Questions: If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Duties of the Employer as Plan Administrator: The named Plan Administrator, a Fiduciary under the plan, shall be the Employer, or other group or committee formed by the Employer, for purposes of administration of the Plan (the "Plan Administrator"). The Plan Administrator shall have the authority to do all such acts and exercise all such rights and privileges as the Plan Administrator may deem necessary or advisable to carry out the purposes of the Plan. The Plan Administrator shall exercise its discretionary authority to construe and interpret the Plan, decide all questions of eligibility and the amount, manner and time of payment of any benefits, interpret the provisions of the Plan, prepare and publish rules and procedures for the Plan which are not inconsistent with its terms and provisions. All discretionary acts, interpretations and constructions shall be done in a nondiscriminatory manner based upon uniform principles consistently applied. No action shall be taken which would be inconsistent with the intent that the Plan satisfies the requirements of ERISA and the Code. The decisions of the Plan Administrator will be final and binding on all interested parties.

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

DUTIES OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following:

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

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

Fiduciary: Exercises discretionary authority or control over management of the Plan, the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan. A fiduciary must carry out his/her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3. in accordance with the Plan Documents to the extent that they agree with ERISA.

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

COMPLIANCE WITH HIPAA PRIVACY STANDARDS

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

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

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

2. **Permitted Uses and Disclosures:** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

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

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

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

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

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

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

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

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

4. **Certification of Employe**r

   The Employer must provide certification to the Plan that it agrees to:

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

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

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

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

   E. Make available Protected Health Information to individual Plan members in accordance with Section 164 .524 of the Privacy Standards;

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

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

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

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

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

The following members of **BAYADA Home Health Care** workforce are designated as authorized to receive Protected Health Information from the Plan and service providers in order to perform their duties with respect to the Plan: Human Resources, benefits, financial, audit and information systems personnel.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARD: Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq, the "Security Standards"), the Employer agrees to the following:

1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

AMENDING AND TERMINATING THE PLAN

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

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

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

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

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

3. Continue health care coverage for a Plan Participant, Spouse or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

4. Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

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

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

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

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

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or may file suit **in** a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses; the court may order him/her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous. If the Plan Participant has any questions about the Plan, he/she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his/her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/ (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME BAYADA Home Health Care MEC Plan

PLAN NUMBER: _____

TAX ID NUMBER: 23-1943113

PLAN EFFECTIVE DATE: June 29, 2015

PLAN YEAR ENDS: June 26, 2015

EMPLOYER INFORMATION

PLAN ADMINISTRATOR:
Employer Name: BAYADA Home Health Care
Employer Address: 1315 Walnut St
Employer City State Zip: Philadelphia, PA 19107
Employer Phone Number: (877) 291-3000

NAMED FIDUCIARY: BAYADA Home Health Care

AGENT FOR SERVICE OF LEGAL PROCESS:
Employer Name: BAYADA Home Health Care
Employer Address: 1315 Walnut St
Employer City State Zip: Philadelphia, PA 19107
Employer Phone Number: (877) 291-3000

CLAIMS ADMINISTRATOR (not for submitting claims):
Name: Employer Plan Services, Inc.
Address: 11910 Anderson Mill Road, Suite 401
City State Zip: Austin, TX 78726
Phone Number: (855) 495-1190

BY THIS AGREEMENT, **BAYADA Home Health Care MEC Plan** is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Employer Plan Services, Inc. on or as of the day and year first below written.

BAYADA Home Health Care
Employer Name

By:

_____ _____
Authorized Signature **Date**

_____
Print Name

_____
Print Title

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied.

The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan. If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal". If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination". If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

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

A claimant must follow all Claims and Appeal procedures both internal and external before he/she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable.. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

Pre-Service Claim: Any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to precertification.

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

- Notification to claimant of Adverse Benefit Determination: 15 Days
- Extension due to matters beyond the control of the Plan: 15 Days
- Insufficient information on the Claim (notification): 15 Days
- Response by claimant: 45 Days
- Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim: 5 Days
- Reduction or termination before the end of the treatment: 15 Days
- Request to extend course of treatment: 15 Days

Post-Service Claim: A Claim that is a request for payment under the Plan for medical services already received by the claimant

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

- Notification to claimant of Adverse Benefit Determination: 30 Days
- Extension due to matters beyond the control of the Plan: 15 Days
- Extension due to insufficient information on the Claim: 15 Days
- Response by claimant following notice of insufficient information: 45 Days
- Notification of Adverse Benefit Determination on Appeal (per benefit appeal): 30 Days

Notice to Claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. The Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

1. Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

2. The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, which was used in denying the Claim.

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

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

5. A description of the Plan's internal and external Appeal procedures incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

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

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

8. Information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records and other information relating to the Claim.

If the claimant so requests, he/she will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

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

1. was relied upon in making the benefit determination;

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

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

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

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing. The timeframe for notifying you of an Appeal determination is set forth above in the Pre-Service and Post-Service claim charts.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

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

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

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a manner calculated to be understood by the claimant:

1. Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning).

2. The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any that was used in denying the Claim.

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

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

5. A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim. "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

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

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

9. Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Voluntary Appeals

In addition to the Claims and Appeals Procedures described above, the Plan permits voluntary dispute resolution procedures. If a claimant agrees in writing to use these procedures, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan will not assert that a claimant has failed to exhaust administrative remedies merely because he/she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after receipt of a Final Adverse Benefit Determination.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he/she may request that the Claim be reviewed under the Plan's External Review process. This request must be filed in writing within four months after receipt of the Final Adverse Benefit Determination.

Limited Types of External Appeals

External appeals only apply to certain types of claims and appeals, listed as follows:

1. Medical Judgment Claims and Appeals: External appeal procedures apply to adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a benefit or experimental or investigational determinations).

2. Rescissions of Coverage: External appeal procedures apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of a rescission (Subject to certain exceptions, a rescission is a retroactive termination of coverage).

External appeal procedures do not apply to any other adverse determination (other than medical judgment and rescissions as set forth above), including eligibility appeals.

Filing an External Appeal Request

If your internal claim for medical benefits is denied and you have properly filed all internal appeals for that benefit claim which are also denied, an additional external appeal procedure may apply. To file a request for an additional external appeal, you must file the request with the Claims Administrator.

Your external appeal request must be filed within four months after the date you received your denied internal appeal. If there is no corresponding date four months after the date you received your denied internal appeal, then the request must be filed by the first day of the fifth month following the receipt of the denied internal appeal. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

Procedures After an External Appeal Request is Filed

Within five business days following the date your request for an external appeal is received, the carrier or other applicable party will complete a preliminary review of the request to determine whether you qualify for an external appeal.

Within one business day after completing the above preliminary review, the claims administrator or other applicable party will issue a notification in writing. If the request is complete but not eligible for external appeal, such notification must include the reasons for its ineligibility. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and you will have the later of the remaining time within the four-month filing period or 48 hours following the receipt of the notification to perfect your appeal request.

Procedures After Your Request for External Appeal is Approved

If your appeal request is approved, the claims administrator or other applicable party will assign it to an independent review organization (IRO) to conduct the external appeal.

Procedures of the IRO

The assigned IRO will timely notify you in writing of your eligibility and acceptance for external appeal. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date you receive the notice additional information that the IRO must consider when conducting the external appeal. The IRO is not required to, but may accept and consider additional information submitted after ten business days. Any additional information the IRO receives from you will be shared with the claims administrator and the applicable plan. Upon receiving this information, the medical carrier or other applicable party may reconsider its prior appeal decision and reverse the prior denial of the internal appeal. If the claims administrator reverses its decision and fully approves the internal appeal, then your claim will be paid accordingly and the external appeal will be terminated.

If the external appeal is not terminated as noted above, the IRO will review all information and documents related to your denied internal appeal. The IRO is not bound by any decisions or conclusions reached by your claims administrator or other applicable party during the internal claim and appeal process. The IRO must complete its review within 45 days after the IRO receives the request from you for an external appeal. The IRO will deliver a notice of the final external review decision to you and your medical carrier or other applicable party. If the medical carrier and applicable plan receive notice of a final external appeal decision reversing the internal appeal decision, they will provide the applicable coverage or payment for the claim.