INTACT INSURANCE GROUP USA

WELFARE PLAN

SUMMARY PLAN DESCRIPTION

Effective as of January 1, 2021

Intact Insurance Group USA Welfare Plan

2021 Summary Plan Description

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SECTION I

INTRODUCTION

1.1 Introduction

Intact Services USA LLC ("Intact") sponsors a comprehensive health and welfare benefit program for its employees and the employees of Participating Employers defined in Section 1.4. This summary, together with the documents, policies, contracts, booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, "Incorporated Documents"), constitute the Summary Plan Description ("SPD") for the Intact Welfare Plan (the "Plan"), as required by the Employee Retirement Income Security Act of 1974 ("ERISA").

Please note, however, that this document also describes certain other welfare benefits, such as the Dependent Care Flexible Spending Account ("Dependent Care FSA"), Transportation, and Health Savings Account ("HSA") benefits, which are not subject to ERISA and are therefore not considered part of the Plan.

In this summary, the term "Intact Companies" refers to Intact and each of the Participating Employers listed in Appendix B.

1.2 Highlights of the Plan

The Plan gives you the flexibility to make benefit decisions that are right for you and your individual needs. The Plan offers a broad range of benefit choices, with options on how much coverage you need and which dependents you want to cover. To help you understand your options, Intact encourages you to review the following highlights:

- *Eligibility requirements differ by benefit*. Review the appropriate sections of this SPD and each Incorporated Document which describes the specific eligibility requirements for each benefit.

- *Annual elections.* Elections are made each year for health and other insurance benefits for the coming plan year during annual enrollment. Your new benefits elections will be in effect from January 1 through December 31. In certain limited instances, you may be able to change your elections during the Plan Year.

- *Customizing Your Benefits.* Intact automatically provides certain benefits at a specific level. You may, in some cases, be able to elect additional coverage for yourself and your dependents. You may also choose from a variety of benefits that Intact does not provide automatically. For these benefits, you can elect coverage for yourself and your dependents, or you can waive coverage entirely.

- *Paying for Benefits.*

  Your Basic Benefits

  The Plan provides certain basic benefits to you automatically — you do not need to enroll in them. Intact pays the full cost of the basic benefits, which are:

  - Basic Life Insurance
  - Short-Term Disability coverage (for employees working 20 or more hours per week)
  - Business Travel Accident
  - Employee Assistance Program ("EAP")
  - Severance

  In addition, if you are an employee working 20 or more hours per week, you are automatically enrolled in Basic Long-Term Disability coverage. You and Intact share the cost of the Basic Long-Term Disability coverage.

  Your Optional Benefits

  All other benefits described in this summary are optional. To receive optional benefits for you and your family, you must enroll in them.

  Generally, you and Intact share the cost of these optional benefits:

  - Medical (which may be offered with an HSA or an employer-funded Health Reimbursement Arrangement ("HRA"))
  - Dental

  You pay the entire cost of these optional benefits:

  - Supplemental Life Insurance
  - Dependent Life Insurance
  - Supplemental Long-Term Disability
  - Accidental Death & Dismemberment
  - Health Care Flexible Spending Account ("Health Care FSA")
  - Dependent Care FSA
  - Health Savings Account ("HSA")
  - Vision
  - Group Legal
  - Transportation

You pay with pre-tax dollars for Medical, HSA, Dental, Vision, Accidental Death & Dismemberment, Health Care FSA, Dependent Care FSA and Transportation benefits, and

with after-tax dollars for Long-Term Disability, Group Legal, Supplemental Employee Life Insurance, and Dependent Life Insurance benefits.

Please note, however, that if you are not an active employee and are receiving benefits due to your status as a COBRA qualified beneficiary, or an individual on Long-Term Disability, you pay with after-tax dollars for any benefits you may be eligible for.

All benefits (except for Medical, HRA, HSA, Short-Term Disability, Transportation, Severance, and FSAs) are provided under insurance contracts or other pre-paid service contracts. The Medical, HRA, HSA, Short-Term Disability, Transportation, and FSA benefits are self-funded and administered under contracts with service providers. All benefits are summarized in this document and in the Incorporated Documents (as defined below).

1.3 Incorporated Documents

This SPD must be read in conjunction with the Incorporated Documents listed in Appendix A. The Incorporated Documents are provided by the insurance companies and service providers.

If there is ever a conflict or a difference between what is written in this SPD and the Incorporated Documents with respect to a specific benefit, the Incorporated Documents shall govern on all issues if the specific benefit is fully insured, unless otherwise required by federal or state law. If there is a conflict between the Incorporated Documents and this SPD with respect to the legal compliance requirements of ERISA, the Internal Revenue Code and any other federal or state law, the Plan documents will be interpreted to comply with applicable federal and state laws. If the specific benefit is not fully insured, then this document shall govern on all issues of eligibility, cost, coverage and beginning and ending dates, and the Incorporated Documents shall govern on all other issues, unless otherwise required by federal or state law.

The applicable Incorporated Documents describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverage will be provided for out-of-network services. A directory of participating network providers is available on the insurance companies' websites or you can call the insurance companies at the phone numbers indicated in the Incorporated Documents. You will also be informed about any conditions or limits on the selection of medical providers that may apply for one of the benefits described in this summary.

For additional information regarding the benefits described in this summary, please contact the Intact benefits team, as identified in Section 14.1.

1.4 Participating Employers

If you are employed by a Participating Employer (listed in Appendix B), you are eligible to participate in the Plan benefits your employer has adopted if you otherwise meet the Plan's eligibility requirements.

1.5 Amendment or Termination

Intact expects to continue the benefits described in this SPD indefinitely, but reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan or any benefits available under the Plan at any time. For example, Intact reserves the right to amend or terminate benefits, covered expenses, benefit copays, and reserves the right to amend the Plan to require or increase employee contributions. Intact also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable. You will be informed in writing if there is any significant amendment of the Plan or if the Plan and/or any of the benefits are terminated.

In the event of an amendment or termination of the Plan or any of the benefits available under the Plan, employees and their eligible dependents will have no further rights to benefits, except as otherwise specifically provided in the Plan documents, including the Incorporated Documents. However, no modification, alteration, amendment, suspension, or termination will be made that would diminish any benefits arising from incurred but unpaid claims of the employees or their covered dependents that existed prior to the effective date of the modification, alteration, amendment, suspension or termination.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Intact to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

Any amendment, termination or other action by Intact will be at the direction of an authorized officer or his authorized designee. Amendments may be retroactive to the extent necessary to comply with applicable law.

In the event of the dissolution, merger, consolidation or reorganization of Intact, the Plan shall terminate unless the Plan is continued by a successor to Intact.

1.6 Plan Is Not an Employment Contract

The Plan is not an employment contract. Nothing contained in this document or the Incorporated Documents gives you the right to be retained in the service of the Intact Companies or interferes with the right of the Intact Companies to discharge you or to terminate your service at any time.

SECTION II

ELIGIBILITY

2.1 Eligible Employees

Current Employees

In general, you are considered an "eligible employee" and are eligible to participate in the Plan on your date of hire if you are:

- An employee of the Intact Companies regularly scheduled and working 20 or more hours per week, or
- A seasonal or temporary employee of the Intact Companies working an average of 30 or more hours per week over a lookback period chosen by Intact.

Please see the applicable Incorporated Documents for the eligibility requirements for each specific benefit. For example, all employees of the Intact Companies are eligible for the Business Travel Accident benefit, EAP, and Transportation benefits, regardless of scheduled hours. On the other hand, only employees working 20 or more hours a week are eligible to participate in the Short-Term Disability plan or the Long-Term Disability plan.

2.2 Individual Not Eligible

In general, you are not eligible to participate in the Plan if you are:

- Regularly scheduled to work less than 20 hours per week,
- A seasonal or temporary employee (other than those who average 30 or more hours per week over a look-back period chosen by Intact),
- A leased employee,
- An independent contractor,
- A member of a collective bargaining unit, unless the applicable collective bargaining agreement provides for your participation in the Plan.

If Intact determines an individual is not an employee, such individual will not be eligible to participate in the Plan even if a court or tax or regulatory authority determines that the individual is an employee for other purposes.

Please see the applicable Incorporated Documents for the eligibility requirements for each specific benefit. For example, employees scheduled to work less than 20 hours per week are still eligible for the Business Travel Accident benefit, EAP, and Transportation benefits.

2.3 Eligible Dependents

Your eligible dependents (as described below) can be enrolled in Medical, Dental, Vision and Supplemental Life Insurance coverage under the Plan only if you (the employee) are enrolled.

If you are married to another eligible employee of the Intact Companies, you may be covered as an employee or a dependent, but not as both. In addition, only one of you may cover your eligible children as dependents.

Medical, Dental, Vision, Life Insurance, and Accidental Death & Dismemberment

The following dependents are eligible for Medical, Dental, Vision, Supplemental Life Insurance, and Accidental Death & Dismemberment coverage available under the Plan:

Covered Dependent Category	**Definition**
Spouse	A person to whom you are legally married (including a common-law spouse in those states that recognize common-law marriage) and from whom you are not legally separated. Former spouses are not eligible under this Plan, except through COBRA continuation rules described in Section VII (Continuing Health Care Coverage through COBRA) or as provided under an Incorporated Document with respect to the applicable type of health coverage.
Children under age 26	Your children or your spouse's children through the end of the month in which they obtain age 26, regardless of their marital status, and whether or not they live with you or you provide any of their support. Your eligible dependent children may be: • Your natural children; • Stepchildren; • Legally adopted children; • Children who are placed in your home for adoption; • Foster children; • Children for whom you are appointed as legal guardian who are chiefly dependent on you for support and maintenance; and • Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order.
Disabled children over age 26	Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation).

Health Care FSA

For purposes of the Health Care FSA, your dependents include:

- Your spouse,
- Your children under age 26, regardless of whether they are married or live with you and regardless of whether you provide any support,
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support,
- Any other person who meets the Internal Revenue Service ("IRS") definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support.

Children of divorced or separated parents can be covered as a dependent of both parents for purposes of tax-free health coverage if the child: (1) receives over half his or her annual support from his or her parents, (2) is in the custody of one or both the parents for more than half the year, and (3) otherwise qualifies under one of the last four descriptions, above, with respect to one of the parents.

Dependent Care FSA

Under IRS rules, "eligible dependents" for the Dependent Care FSA include:

- A child under age 13 who lives with you for more than half the year,
- A disabled spouse who lives with you for more than one half the year, and
- Any other relative or household member who receives more than one-half of his or her support from you, resides in your home and is physically or mentally unable to care for him or herself.

2.4 Qualified Medical Child Support Orders

Intact has adopted procedures to comply with and enforce the Qualified Medical Child Support Order ("QMCSO") rules and regulations. A QMCSO is an order by a court for the Plan to provide an employee's child (or children) with health insurance under the Plan. Intact shall comply with the terms of any QMCSO it receives, and shall:

- Establish reasonable procedures to determine whether a medical child support order is a QMCSO as defined under Section 609 of ERISA;
- Promptly notify the employee and any alternate recipient of the receipt of any medical child support order, and the Plan's procedures for determining whether a medical child support order is a QMCSO; and

- Within a reasonable period of time after receipt of such order, the Intact Benefits Team shall determine whether such order is a QMCSO and shall notify the employee and each alternate recipient of such determination.

2.5 Misrepresentation of Dependent Status

You are required to provide proof of your dependents' eligibility upon request. False or misrepresented eligibility information will cause your dependents' coverage, and, at the option of the Employer your coverage, to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline up to and including termination of employment. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. If any coverage is retroactively terminated, premiums you have paid for coverage will not be refunded.

Please see the applicable Incorporated Documents for additional eligibility requirements.

2.6 Additional Eligibility Information

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this SPD and any conditions and limitations to eligibility are contained in the Incorporated Documents provided by the applicable insurance companies and/or service providers.

SECTION III

PARTICIPATION

3.1 New Employees

If you are eligible, you will automatically be enrolled in the following benefits on your date of hire:

- Basic Life Insurance
- Business Travel Accident
- Short-Term Disability
- Long-Term Disability
- EAP
- Severance

If you are eligible, you and your eligible dependents must affirmatively enroll within 30 days of your date of hire for these optional benefits:

- Medical
- Dental
- Vision
- Employee, Spousal, and Dependent Supplemental Life Insurance
- Health Care FSA
- Dependent Care FSA
- Group Legal

- Accidental Death & Dismemberment
- Supplemental Long-Term Disability

If you and your eligible dependents do not enroll in the optional benefit coverage listed above within 30 days of your date of hire, you will have to wait until the next Open Enrollment period to enroll, unless you experience a change in status event as described in Section V.

Please refer to the applicable Incorporated Documents for additional details on eligibility.

If you do not enroll in Supplemental Life Insurance coverage when you are first eligible, you may apply in subsequent years during Open Enrollment but you will have to provide evidence of insurability. Please see the Incorporated Documents for more information.

If you become eligible for coverage after your initial hire date, your coverage will begin as of the date you become eligible. For example, if you are hired as an employee who works less than 20 hours per week and subsequently you become an employee eligible for benefits, your coverage will begin on the day you become a benefits-eligible employee. Your eligible dependents' coverage under the Plan will begin on the same date if you make the necessary elections within the time period required.

If you enroll yourself or a dependent in the Medical, Dental, Vision, Health Care FSA, and/or Dependent Care FSA benefits mid-year due to a change in status, coverage will be effective as of the date of the event. For additional information about change in status events, see Section V.

If you are eligible, you and your eligible dependents may affirmatively enroll ***at any time*** for these additional optional benefits:

- Transportation
- HSA Contributions (if enrolled in the HSA medical plan)

3.2 Current Employees

Open Enrollment is held annually. This is your opportunity to enroll, change, or drop coverage. Changes are effective on January 1 following Open Enrollment. You will receive information, including instructions on how to enroll, before Open Enrollment each year.

Generally, if you do not change your election during the Open Enrollment period, your current election will remain in force. However, to continue participation in the FSA plans, you must file a new election with the Intact Benefits Service Center (Benefits Service Center) during the Open Enrollment period. If you do not file an election to participate in the FSAs during Open Enrollment before the beginning of the Plan year, you may not participate in the FSAs during the Plan Year unless you experience a change in status as described in Section V.

3.3 Individuals Receiving Long-Term Disability Benefits

If you go on long-term disability, your employment will be terminated, but you will be offered COBRA for any Medical, Dental, Vision, or Health Care FSA benefits you were enrolled in prior to the termination of your employment due to going on long-term disability leave. You

will no longer be eligible for any other benefits under the Plan other than group-term life insurance (please contact the Benefits Service Center for more information on this coverage). In addition, if you go on long-term disability, you may be eligible to receive a premium waiver for your group-term life insurance coverage.

Intact currently allows former employees on long-term disability to continue group health coverage they have properly elected under COBRA at active employee rates; however, please note that this is not required by law and Intact reserves the right to discontinue this policy at any time. Furthermore, please keep in mind that any period of continuation coverage at active employee rates will count toward your maximum continuation period under COBRA. See Section VII - Continuing Health Care Coverage through COBRA for more information about COBRA.

3.4 Rehired Employees

If you terminate employment with the Intact Companies and are rehired as an eligible employee within 30 days of your termination date, your elections in effect on your date of termination will be reinstated. If you are rehired by the Intact Companies more than 30 days following your termination, or if your break in employment crossed a plan year, you may file new elections with the Benefits Service Center as if you are a newly eligible employee.

3.5 HIPAA Special Enrollment Events

If you decline enrollment for Medical, Dental, Vision or Health Care FSA benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Medical, Dental, Vision or Health FSA benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your new eligible dependent children. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you request a change due to a special enrollment event within the 30-day timeframe, your newborn or adopted child's coverage will be retroactive to the date the child was born or placed with you for adoption, and coverage for any other person will be effective as of the date of the special enrollment event.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Plan allows a HIPAA special enrollment for employees and dependents (who are eligible but not enrolled if they lose Medicaid or Children's Health Insurance Program ("CHIP") coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment

under the Plan. If you request this change, coverage will be effective as of the date of the special enrollment event. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact the Benefits Service Center.

3.6 When Your Coverage Ends

Your coverage will terminate on the earliest of the following dates:

- at midnight on the date you terminate employment with the Intact Companies,
- at midnight on the date you cease to meet the eligibility requirements,
- the first day of the month for which you fail to make any premium contribution as required,
- the effective date of a Plan amendment that terminates coverage for your job category, or
- the date the Plan terminates.

In some cases, you may be eligible for continued health coverage as described in Sections VI (Coverage During a Leave of Absence) and VII (Continuing Health Care Coverage through COBRA). You may also be eligible for continued life insurance. For additional information, refer to the applicable Incorporated Documents.

3.7 When Your Spouse's or Dependents' Coverage Ends

Coverage for your spouse and other dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Incorporated Documents. In addition, their coverage will terminate:

- For dependent children's coverage, the end of the month in which he or she attains age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support);
- The date on which your legally married spouse or child is no longer considered an eligible dependent (for example, date of divorce) as defined in Section 2.3;
- The end of the month in which you stop making contributions required for dependent coverage.

For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

3.8 Continuation of Coverage

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA Section 7), during Military Leave (see Section 6.3), or under a conversion right under a particular benefit plan.

Employees enrolled in Life Insurance benefits are eligible for MN Continuation coverage and/or conversion coverage upon termination of employment. Employees transitioning to Long-Term Disability may be eligible to receive a premium waiver for their group-term life insurance coverage.

Refer to your Incorporated Documents for more information on conversion.

SECTION IV

CONTRIBUTIONS

4.1 Employee Contributions

You pay your share of the cost of Medical, Dental, and Vision coverage on a pre-tax basis (see below for more information). The level of contribution is determined by Intact.

Contributions to the Health Care and Dependent Care FSAs are made on a pre-tax basis. If you wish to enroll, you will be required to agree to have your salary reduced by your elected contribution amount. These elections must be made annually.

Contributions for Transportation benefits and to an HSA are also made on a pre-tax basis (up to specified limits that are announced each year). These elections can be changed from month to month.

Contributions to Long-Term Disability coverage, Supplemental Life Insurance, Accidental Death & Dismemberment, and Group Legal benefits, are paid for on an after-tax basis.

Contributions are deducted from employees paychecks based on your elected level of coverage.

You do not pay Social Security taxes on the pretax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan will normally be greater than any eventual reduction in Social Security benefits.

Employees who are on leave and not receiving regular paychecks will be required to make any required contribution directly to HealthEquity. Such contributions are paid on an after-tax basis.

Note: If you have elected the HRA Medical Plan, you do not contribute to your HRA because only Intact contributions are allowed into the HRA.

4.2 Section 125 Plan – Pre-Tax Payment

The pre-tax payment of certain benefits described in this summary is permitted pursuant to Code Section 125.

SECTION V

CHANGING YOUR BENEFIT ELECTIONS DURING THE PLAN YEAR

5.1 Changing Benefit Elections During the Plan Year

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the Plan year in which you are enrolled. Elections you make during Open Enrollment generally remain in effect for the following plan year (January 1 through December 31).

If you do not enroll in Supplemental Life Insurance coverage when you are first eligible, you may apply in subsequent years during Open Enrollment but you will have to provide evidence of insurability.

Note: Your after-tax elections for any benefit (with the exclusion of ARAG, the group legal benefit) and your pre-tax elections for Transportation and HSA benefits may be changed prospectively at any time during the Plan Year and therefore the provisions of this Section V do not apply to those benefits.

5.2 Changes in Status Events

During the Plan Year, you can change your benefit coverage if a qualified change in status affects your or your dependents' eligibility under the Intact plans or another employer's plans. Please note that in order to change your benefit elections due to a change in status, you may be required to verify that these events have occurred (*e.g.*, copy of marriage or birth certificate, or divorce decree, etc.).

The following is a list of changes in status events that may allow you to make a change to your pre-tax or after-tax elections (as long as you meet the consistency requirements, as described below).

- Birth, Adoption or establish legal guardianship
- Marriage
- Divorce or legal separation, Death of a spouse or dependent child
- Dependent (spouse, child) loses other coverage
- Dependent (spouse, child) gains other coverage
- Dependent (spouse, child) loses eligibility for other coverage
- Dependent (spouse, child) gains eligibility for other coverage
- Change in Dependent Care Cost
- Employee Status Change and loss of other coverage
- Gain of CHIP coverage
- Loss of CHIP coverage

5.3 Consistency Requirements for Changes in Status

Except for election changes due to a HIPAA special enrollment (described in Section 3.6), the changes you make to your coverage must be "on account of and correspond with" the event. To satisfy the "consistency rule," both the event and the corresponding change in coverage must meet all the following requirements:

- Effect on Eligibility: The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.

- Corresponding Election Change: The election change must correspond with the event. For example, if your dependent child(ren) gains coverage under a new health plan, under the terms of the health plan, you may cancel health coverage only for that dependent child(ren). Similarly, if you lose your spouse due to divorce or death, you may cancel coverage only for your spouse. In both examples, you cannot cancel coverage for yourself or other covered dependents.

5.4 Notification Following Change in Status Event

If you experience one of the events described in 5.2 and want to make a change to your coverage due to such event, you must notify the Benefits Service Center within 30 days of the event, or 60 days from the date you or your dependents lose Medicaid or CHIP as described in Section 3.6. If you do not notify the Benefits Service Center within the 30-day (or 60-day) period, you will not be able to make any changes to your coverage until the next Open Enrollment period.

The notice must be made in accordance with the procedures put in place by Intact and contain the change in status event, the date of the event, and your requested change and must be submitted to the Benefits Service Center.

5.5 Other Events that Allow You to Change Elections

Entitlement to Government Benefits

If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs, you may make a corresponding change to your Medical, Dental, and Vision coverage or Health Care FSA election. If you want to make a change, you must notify the Benefits Service Center within 30 days of the event, or 60 days from the date you or your dependents lose coverage under Medicaid or CHIP as described in Section 3.6.

QMCSOs

If a QMCSO requires the Plan to provide coverage to your child, then Intact automatically may change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire.

If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Intact benefits team that such other person actually provides the coverage for the child.

Cost or Coverage Change Events

In some instances, you can make elections if the type of coverage or cost of coverage changes. **These rules do not apply for purposes of a Health Care FSA.** Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

Cost Changes

If the Plan Administrator determines there is a significant increase or decrease in the cost of Medical, Dental and Vision coverage, you may be permitted to revoke your election and make a corresponding new election. If you previously declined coverage, you may also make a corresponding new election.

Any change in the cost of your plan option that Intact determines is not significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Coverage Changes

The following are additional situations in which you may change your current coverage.

- Restriction or Loss of Coverage — If your coverage is significantly restricted or ceases entirely, you may revoke your elections and elect coverage under another option that provides similar coverage. Coverage is considered "significantly restricted" if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election.
- Changes in Coverage under Another Employer's Plan — If your spouse or dependent child(ren) is employed and his or her employer's plan allows for a change in your family member's coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family coverage during his or her employer's open enrollment period, you may request to end your coverage under this Plan.
- Loss of Other Group Health Plan Coverage – If you or your spouse or dependent child(ren) lose coverage under another group health plan sponsored by a governmental or educational institution, including a state CHIP, medical care program of an Indian

Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll for coverage under this Plan.

5.6 Dependent Care FSA: Cost or Coverage Changes

In addition to the changes described above, you may make mid-year election changes to your Dependent Care FSA if you have one of the following events:

- An increase or decrease in dependent care provider fees (except for increases by a provider who is related to you),
- You choose a different dependent care provider who charges a different amount, or
- You make a change to you or your spouse's regular work schedule that increases or decreases your need for dependent care.

Additionally, during calendar year 2020 and 2021 only, you were permitted to revoke or decrease your Dependent Care FSA election mid-year if you had a reduced need for dependent care as a result of the COVID-19 National Emergency. The 2021 changes need to be made by April 30, 2021 as a result of the extended grace period for the 2020 Dependent Care FSA of December 31, 2021.

SECTION VI

COVERAGE DURING LEAVE OF ABSENCE

6.1 Introduction

This section describes benefit continuation for Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, contact the Intact Benefits Team.

6.2 FMLA Leave

The federal Family and Medical Leave Act ("FMLA") allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty. Contact the Intact Benefits Team for more information about what leave is available under FMLA.

If you take an FMLA leave, you may continue group health coverage (Medical, Dental, Vision, and Health Care FSA coverage) for yourself and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute the active employee share of the cost of group health

coverage during the leave by paying for coverage during your leave on an after-tax basis, and/or, with the consent of Intact, catching up with pre-tax contributions upon your return from leave. You also have the option to suspend your health coverage during the unpaid leave. For additional information on FMLA leaves, please contact the Intact Benefits Team

If your Health Care FSA coverage terminates during your leave, you will be reinstated if you return to work in the same year that your leave began. When you return from leave, your contributions will be increased to "make-up" for contributions missed during your leave period. You may, however, elect to resume contributions to the spending accounts at the same level in effect before your leave. If you simply resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred while your account participation is suspended will not be reimbursed.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health Care FSA coverage amount.)

Your Basic Life Insurance, Business Travel Accident, Short-Term Disability and Basic Long-Term Disability coverage will continue during an FMLA leave. Your Supplemental Life Insurance, Supplemental Long-Term Disability and Group Legal coverage will continue during FMLA leave if you continue to pay the required after-tax contributions during your leave.

Any coverage that is terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you suspend any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage (see Section VII - Continuing Health Care Coverage through COBRA).

6.3 Military Leave

Your right to continued participation in a group health plan during leaves for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue your Medical, Dental, Vision or Health Care FSA coverage.

If you are absent for less than 31 days, you pay the regular employee share of the cost of the health coverage. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.

Continuation coverage will terminate on the earlier of:

- The last day of the 24 month period beginning on the first day of military leave, or
- The date you fail to apply for reemployment, as required under USERRA, after returning from military leave.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

If you are a member of a military service unit ordered or called to active duty for a period of at least 180 days or for an indefinite period, you will be able to take your unused Health Care FSA balance as a taxable cash distribution by the last day of the FSA plan year during which the order or call occurred.

If you take a military leave, but your coverage under the Plan is terminated – for instance, because you do not elect the extended coverage – when you return to work at the Intact Companies you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverage. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

Benefits during a period of military leave must be as generous as benefits available to similarly situated employees on other employer-approved leaves of absence (*e.g.*, family and medical leave).

For additional information about military leave, please refer to the Military Leave Policy. To obtain a copy of the Military Leave Policy, please contact the Intact benefits team.

SECTION VII

CONTINUING HEALTH COVERAGE THROUGH COBRA

7.1 Introduction

Under a Federal law called COBRA ("Consolidated Omnibus Budget Reconciliation Act"), the Plan is required to offer covered employees, their covered spouses and dependents the opportunity to make separate elections to extend group health coverage temporarily at group rates after group health coverage under the Plan would otherwise cease. This extension is called COBRA continuation coverage. Evidence of your good health is not required for this extension.

Note: These rules apply to the Medical, Dental, Vision and Health Care FSA benefits. Special rules regarding the length of coverage apply to the Health Care FSA benefits and are described in Section 7.11.

7.2 When You May Elect Continuation Health Coverage

As an employee covered under the Plan, you have the right to elect COBRA continuation coverage if you lose health coverage (or premium payments or contributions for health coverage increase) because:

- Your hours of employment are reduced;
- Your employment is terminated for reasons other than gross misconduct; or
- Intact starts bankruptcy proceedings under Title XI, if you are a retired employee.

7.3 When Your Spouse May Elect Continuation Health Coverage

Your spouse may elect continuation health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You divorce or are legally separated;
- You become enrolled in Medicare (Part A or B); or
- Intact starts bankruptcy proceedings under Title XI, and you are retired.

7.4 When Your Dependent Child May Elect Continuation Health Coverage

Your dependent child may continue health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- He or she loses dependent status under the Plan;
- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You and your spouse divorce or are legally separated;
- You become enrolled in Medicare (Part A or B); or
- Intact starts bankruptcy proceedings under Title XI, and you are retired.

7.5 When You Must Notify the Benefits Service Center of a Qualifying Event

You (or your spouse or dependent child, if applicable) must notify the Benefits Service Center within 60 days after:

- You and your spouse are divorced or legally separated; or
- One of your dependents loses dependent status under the Plan (*i.e.*, stepchild with divorce, child turns age 26, etc.).

You (or your spouse or dependent child, if applicable) will then be notified of the right to elect continuation health coverage and the cost to do so.

7.6 Deadline for Electing Continuation of Health Coverage

The deadline for electing continuation health coverage is 60 days after the date the Plan ceases to cover you or your spouse or dependent child or the date you, your spouse, or dependent child are notified, whichever is later.

If you (or your spouse or dependent children, if applicable) do not elect continuation of coverage, your health coverage will stop.

7.7 Continuation Health Coverage

If you (or your spouse or dependent child, if applicable) choose continuation of health coverage, Intact will provide health coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during annual enrollment.

7.8 Paying for Continuation Coverage

You (or your spouse or dependent child, if applicable) must pay for COBRA continuation coverage. The COBRA premium will not exceed 102% of the total cost paid by you and Intact for that level of coverage. There is a grace period of 30 days for payment of the regularly scheduled premium. Coverage will terminate if you do not pay the premium in a timely manner.

If you are a participant in the Medical, Dental, Vision, or Health Care FSA plans, reside in the United States and are on an approved medical leave of absence for six months or longer or you are receiving Long-Term Disability benefits under the Plan, you will be eligible for continuation coverage in accordance with this Section VII. However, you will only be required to pay the same premium as similarly situated active employees.

7.9 Maximum Length of Continuation of Coverage Period

If the original qualifying event causing the loss of health coverage is the death of the employee, divorce, legal separation, Medicare entitlement, or loss of "dependent status" of a dependent child under the Plan, then each qualified beneficiary will have the opportunity to elect 36 months of continuation of coverage from the date of the qualifying event.

If you (or your spouse or dependent child, if applicable) lose health coverage under the Plan because your employment terminated for reasons other than gross misconduct or your hours of employment were reduced, then the maximum continuation period will be 18 months from the date of the qualifying event.

If coverage is lost at a date later than the date of the qualifying event and the Plan measures the maximum coverage period and notice period from the date of health coverage loss, then the maximum continuation period will be 18 months from the date of health coverage loss.

The maximum coverage period under the Health Care FSA plans ends on the last day of the Plan Year in which you experience a loss of coverage. For example, if you terminate in July you

may continue participation through December if you continue your contributions to the Plan on an after-tax basis.

7.10 Second Qualifying Event May Extend Maximum Length of COBRA Continuation Coverage

If the qualifying event is a reduction in hours or termination of employment and during the 18-month continuation period another qualifying event takes place that entitles your spouse (or dependent child, if applicable) to continuation of health coverage, their continuation coverage may be extended by another 18 months. You must make sure that the Benefits Service Center is notified of the second qualifying event within 60 days of the second qualifying event. In no event will your spouse's (or dependent child's) continuation health coverage extend for more than a total of 36 months from the date of the initial event.

If your spouse and/or dependent child (if applicable) lose health coverage under the Plan due to your termination of employment or a reduction in hours and such loss occurs within 18 months after you had enrolled in Medicare as an active employee, then the maximum continuation period for your spouse and/or dependent will be the greater of 18 months or 36 months from the date you enrolled in Medicare.

7.11 Special Rule for Health Care FSA

COBRA coverage for the Health Care FSA, if elected, will consist of the Health Care FSA coverage in force at the time of the qualifying event (*i.e.*, the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The **"use it or lose it"** rule will continue to apply. All qualified beneficiaries who were covered under the Health Care FSA will be covered together for Health Care FSA COBRA coverage.

7.12 Special Rules if Disabled

If the Social Security Administration determines that you (or your spouse or dependent child, if applicable) are disabled at any time during the first 60 days of the continuation health coverage period, or in the case of a child born to, adopted by or placed for adoption with a covered employee during a COBRA coverage period, during the first 60 days after a child's birth, adoption or placement for adoption, then your continuation coverage period as well as your spouse's and any dependent's continuation periods may be extended from 18 months to 29 months. Intact may charge up to 150% of the total premium paid by you and the Intact Companies during this extended period. To qualify, you (or your spouse or dependent child, if applicable) must notify the Benefits Service Center in writing within 60 days of the date of the Social Security determination and during the initial 18-month continuation coverage period. Your written notice must include your name and Social Security number, and indicate you have continuation coverage under the Plan. If there is a final determination that the qualified beneficiary is no longer disabled, the Benefits Service Center must be notified within 30 days of the determination by the qualified beneficiary, and any health coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

7.13 Special Rules if Employer Is Bankrupt

In certain circumstances, the Intact Companies' bankruptcy under Title XI will entitle you to continuation health coverage. If the qualifying event causing the loss of health coverage is the Intact Companies' bankruptcy under Title XI, then each covered retired employee will have the opportunity to receive continuation health coverage until his death. Furthermore, your covered spouse, surviving spouse and dependents will have the opportunity to elect continuation health coverage for a period that will terminate upon their death or, if earlier, 36 months following your death.

7.14 Special Second Election Period

You may be eligible to elect continuation group health plan coverage for yourself and your covered family members during a special second election period if all of the following apply:

- You are receiving trade adjustment assistance benefits (or would be eligible to receive trade adjustment assistance benefits but have not exhausted your unemployment benefits).
- You lost health coverage under the Plan due to termination of employment that resulted in eligibility for trade adjustment assistance benefits.
- You did not elect COBRA continuation coverage during the initial election period described above.
- You filed with the Department of Labor for trade adjustment assistance benefits on or after November 4, 2002.

The second election period is a 60-day period beginning on the first day of the month in which you become eligible for a second election period. You must make your election within six months after you initially lose coverage. COBRA coverage begins on the first day of your second election period, and is not retroactive to the date you initially lost coverage.

7.15 Summary of Continuation Coverage Rules

The length of time and eligibility rules for COBRA continuation coverage differ according to who is continuing coverage. The chart below summarizes how COBRA works under varying circumstances.

Continuation Coverage May Be Elected for:	If the Loss of Group Health Coverage Is Due to:	And Group Health Coverage May Continue for a Maximum of:
You, your spouse and your dependent children*	A reduction in your hours of employment or your loss of employment for reasons other than gross misconduct	18 months**
Your spouse and dependent children	Your death	36 months
	Your divorce or legal	36 months

Continuation Coverage May Be Elected for:	If the Loss of Group Health Coverage Is Due to:	And Group Health Coverage May Continue for a Maximum of:
	separation	
	Your enrollment in Medicare	36 months from the date you become enrolled in Medicare
Your dependent children	Loss of eligibility for group health coverage under the Plan	36 months

* You may be able to add a spouse, a newborn or an adopted child during the COBRA continuation period. You must do so within 30 days of your marriage or the child's birth or adoption. Your newborn or adopted child's coverage is retroactive to the date the child was born or placed with you for adoption, if you make your election within the 30-day period.

** Coverage may be extended to 29 months if you or a covered family member is disabled (as defined by the Social Security Act) within the first 60 days of COBRA continuation coverage.

7.16 When COBRA Continuation Coverage Ends

Your right to continuation health coverage (or your spouse's or dependent child's right, if applicable) under COBRA ends if:

- Intact ceases to provide group health coverage to any of its employees;
- You (or your spouse or dependent child, if applicable) fail to pay the premium within 30 days after its monthly due date;
- You (or your spouse or dependent child, if applicable) become covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary (other than an exclusion or limitation that may be disregarded under the law);
- You (or your spouse or dependent child, if applicable) have extended continuation coverage due to a disability, and after 18 months of continuation coverage, you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For cause, such as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

7.17 COBRA and FMLA

If you take a leave of absence that qualified under FMLA and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- you were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and

- you lose group health coverage under the Plan because the employee does not return to work at the end of the leave.

COBRA coverage will begin following termination of employment.

7.18 COBRA and QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a QMCSO received by Intact during the covered employee's period of employment with Intact is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

7.19 Protecting Your Family's Rights

In order to protect your family's rights, you should keep the Benefits Service Center informed of any changes in the addresses of your family members. You should also keep a copy of any notices you send to the Plan or the COBRA Administrator.

SECTION VIII

SPECIAL PROVISIONS FOR GROUP HEALTH PLANS

8.1 Group Health Plans

Group health plans are employer-sponsored health plans that provide coverage to more than one employee and eligible family members. Intact maintains group health plans that provide Medical, Dental, and Vision coverage. The Health Care FSA is also a group health plan for purposes of this section.

8.2 HIPAA Privacy

A federal law, HIPAA, requires that group health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice or, if appropriate, in the privacy notice provided by the insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Intact benefits team.

Neither this Plan nor Intact will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Intact.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also

have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

8.3 Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

8.4 Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the plan or coverage. For answers to specific questions regarding your particular health plan's policy, contact the health plan provider.

8.5 Genetic Information Nondiscrimination Act of 2008 ("GINA").

Unless otherwise permitted, GINA prohibits the Plan from requesting or requiring your, your spouse's, your dependents' or a family member's genetic information.

The Plan will not request any genetic information when requesting medical information. However, with respect to any wellness program available under the Plan, Intact may request, but may not require, you to provide genetic information in accordance with Equal Employment Opportunity Commission Regulation 3046-AA84 (29 C.F.R § 1635).

Intact will not request, require or purchase genetic information in violation of GINA. If Intact intentionally or unintentionally obtains genetic information for you or one of your family members, Intact will not use such genetic information in violation of GINA. Any genetic information received by Intact that pertains to you or one of your family members, will be maintained on forms and in medical files that are separate from personnel files, and shall be treated as confidential medical records.

Genetic Information

"Genetic information" as defined by GINA, includes family medical history, the results of your, your spouse's, your dependents' or family member's genetic tests, the fact that you, your spouse, your dependent or a family member sought or received genetic services, and genetic

information of a fetus carried by you, your spouse, your dependent or a family member or an embryo lawfully held by you, your spouse, your dependent or family member receiving assistive reproductive services.

SECTION IX

HEALTH CARE FSA BENEFITS

9.1 Introduction

The Health Care FSA may be of interest to you if you are paying for health care expenses that are not fully reimbursed or not covered by any health coverage you may otherwise have. This section explains how the Health Care FSA allows you to pay for certain health care expenses with pre-tax dollars. By participating, you will receive reimbursements for health care expenses on a pre-tax basis instead of an amount that would otherwise be taxable as regular pay. This reduces the amount of taxable income you receive and, therefore, reduces your taxes.

9.2 Eligible Expenses

The Health Care FSA is an account that allows you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. You may submit bills for most expenses for health care, as defined in Internal Revenue Code Section 213 (except long-term care premiums and expenses associated with long-term care and other health care premiums), which you are obligated to pay and which are not covered by any plan.

This may include amounts that are not paid by your employer-sponsored health care plan, such as deductibles, co-payments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for medical, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return (Form 1040).

Effective January 1, 2020, expenses for over-the-counter medications may be reimbursed even without a prescription. You may also submit claims for equipment, supplies and diagnostic devices, such as bandages, crutches, blood sugar test kits, or menstrual care products obtained over-the-counter if they are used for the diagnosis, treatment or prevention of disease.

Below is a partial list of expenses eligible for reimbursement under the Health Care FSA:

- Medical Expenses
    - Deductibles
    - Copayments
    - Coinsurance
    - Charges for routine check-ups, physical examinations, and tests connected with routine exams

- Charges over the "reasonable and customary" limits
- Expenses not covered by a medical plan due to a pre-existing condition, or exclusion by the insurance company
- Medications requiring a doctor's written prescription that are not covered by insurance
- Over-the-counter items (including menstrual care products) as permitted under applicable law or regulation
- Over-the-counter drugs
- Insulin
- Smoking cessation programs and related medicines
- Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
- Other selected expenses not covered by a medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches).

- Dental Expenses
  - Deductibles
  - Copayments
  - Coinsurance
  - Expenses that exceed the maximum annual amount allowed by a dental plan
  - Charges over the "reasonable and customary" limits
  - Orthodontia treatments that are not strictly cosmetic

- Vision and Hearing Expenses
  - Vision examinations and treatment not covered by a vision plan
  - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
  - Cost of hearing exams, aids and batteries

More information is available in IRS Publication #502. A copy of that publication can be obtained at www.irs.gov.

9.3 Ineligible Expenses

Below is a partial list of expenses ***not*** eligible for reimbursement under the Health Care FSA:

- Premiums
  - Premiums paid by you, your spouse or other dependents for coverage under any health plan
  - Premiums paid for Medicare
  - Premiums paid for long-term care insurance

- Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.

- Cosmetic Procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery are not expenses for medical care.

- Expenses Related to General Health - An expense which is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense.

- Long-Term Care Expenses

The IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care FSA.

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator listed in Appendix A.

9.4 Military Leave

If you are called to active military duty for at least 180 days (or for an indefinite period), you may receive a distribution of all or part of the balance remaining in your account. Distributions must be made during the period beginning with the active-duty call and ending on the last day of the Plan Year that includes the date of the active-duty call.

SECTION X

DEPENDENT CARE FSA BENEFITS

10.1 Introduction

The Dependent Care FSA may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your spouse to work. The Dependent Care FSA allows you to pay for certain dependent care expenses with pre-tax dollars. By participating, you will receive in dependent care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes. This section describes the eligible expenses for reimbursement under the Dependent Care FSA, as well as special rules that apply to Dependent Care Spending Accounts.

10.2 Eligible Expenses

Eligible expenses for reimbursement under the Dependent Care FSA include expenses incurred for the care of your qualified dependents:

- In your home,
- In another person's home,
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center. A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there, or
- At a specialty day camp (*e.g.,* soccer camp, computer camp).

Expenses must be incurred in order to allow you – or if you're married, you and your spouse – to work or if your spouse is disabled and unable to care for him/herself or is a full-time student for at least 5 months of the year. To be eligible, expenses must have been incurred during the Plan Year (or grace period, as described below) and while you were covered under the Dependent Care FSA. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill.

Effective January 1, 2020, eligible expenses for reimbursement under the Dependent Care FSA include expenses incurred during the Plan's grace period. To receive reimbursement, eligible expenses must be incurred by March 15 of the following Plan Year in order to be applied towards your Dependent Care FSA balance for the current Plan Year. Note that you are not required to submit such expenses for reimbursement until March 31 of the following Plan Year, but you must incur those expenses by March 15 of the following Plan Year in order to be applied towards your Dependent Care FSA balance for the current Plan Year. Please also note that the grace period only applies to the Dependent Care FSA, not the Health Care FSA. Furthermore, the grace period for the 2020 Dependent Care FSA was extended to December 31, 2021.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

10.3 Ineligible Expenses

You cannot use the money in your Dependent Care FSA to pay for:

- General "baby-sitting" other than during work hours
- Care or services provided by:
- Your children under age 19 (whether or not they are your tax dependents)
- Anyone you (or your spouse if you are married) can claim as a dependent for federal income tax purposes
- Nursing home care
- Overnight camp
- Private school tuition
- Expenses for education (kindergarten and above)
- Expenses that would not otherwise be eligible to be credited on your federal income tax return
- The cost of transportation between the place where day care services are provided and your home unless such transportation is furnished by the dependent care provider

- Expenses incurred while you are off from work for any reason. However, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation may be eligible.
- Expenses for which you claim IRS child care credit when you file your tax return

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the FSA.

See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.

10.4 Special Rules Affecting Dependent Care Accounts

Several special rules apply to Dependent Care Spending Accounts. You should consider the following paragraphs, as they may affect the amount you choose to contribute to this account:

The IRS requires that the maximum amount you can take as a child care tax credit for dependent care expenses be deducted – dollar for dollar – by any reimbursements you receive from your Dependent Care FSA. ***Some employees will receive more tax advantages by taking the dependent care tax credit, while others will do better by contributing to the Dependent Care FSA. Please consult your tax advisor or carefully review your situation before making a choice.***

The money in your Dependent Care Spending Account must be used to pay for dependent care expenses that allow you and your spouse to work. However, this rule does not apply if your spouse is disabled and incapable of self-care or a full-time student at an accredited institution for at least five months each year.

If you and your spouse are divorced and you have custody of your child(ren), you may be able to be reimbursed from the Dependent Care Spending Account even if you do not claim the dependent on your federal income tax return. See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.

SECTION XI

EMPLOYEE ASSISTANCE PROGRAM

11.1 Introduction

The Employee Assistance Program ("EAP") is a resource provided by the Employer at no cost to you. The Employer has contracted with Blue Cross Blue Shield of Minnesota to provide information, resources and referral services, as well as EAP professional counseling services.

11.2 Eligibility

You will automatically be enrolled in the EAP on your date of hire. Your spouse and other dependents are also eligible for EAP benefits.

SECTION XII

CLAIMS AND APPEAL PROCESS

12.1 Claims Procedures For The Plan

Except as provided below, claims for benefits that are available under the Plan that are either insured or self-insured will be reviewed in accordance with procedures contained in the Incorporated Documents which are listed in Appendix A. A claimant can obtain the necessary forms from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan. To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the Incorporated Documents.

If a claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If the Claims Administrator fails to respond within 90 days, your claim is treated as denied. (This period may be extended to 180 days under certain circumstances.) Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Claims Administrator are final, conclusive and binding.

Note: Because the cafeteria plan only provides for the contribution of amounts to an HSA and not for the payment of qualified expenses by an HSA, this summary does not address the claims procedures for the payment of qualified expenses by an HSA. Claims will generally be submitted to, and be reimbursed by, the trustee or custodian of the HSA. Please see the separate documents governing your HSA for details.

12.2 Claims Procedures For Benefits Based on Determination of Disability

The following claims procedure shall apply specifically to claims made under the Plan for benefits based on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the applicable Incorporated Documents, the claims procedure in the Incorporated Documents shall supersede this procedure as long as such other claims procedure complies with DOL Regulation 2560.503-1. If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification within a reasonable period of time, but no later than 45 days after

the Claims Administrator's receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period. You have 180 days to appeal an adverse benefit determination. You will be notified of the Claims Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Administrator receives your appeal request. The 45-day period may be extended for an additional 45-day period if the Claims Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

12.3 Claims Procedures For Group Health Plans

The following claims procedure shall apply specifically to claims made under any group health plan (*i.e.*, Medical, Dental, Vision, and Health Care FSA plans) under this Plan. To the extent that this procedure is inconsistent with the claims procedure contained in the Incorporated Documents for the group health plan, the claims procedure in such Incorporated Documents shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulation sections 2560.503-1 and 2590.715-2719. These regulations and claims procedures are subject to change, so please contact the party that processes your health care claims (the "Claims Administrator"), the Benefit Services Center, or the Intact Benefits Team for a current written explanation of the claims procedures for group health plans.

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a onetime extension not longer than 15 days and suspend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the

Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the group health plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days. After reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days, and may request a one-time extension not longer than 15 days and suspend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

12.4 Appealing a Claim Decision Regarding Group Health Plan Benefits

If you disagree with a claim determination after following the applicable steps in Section 12.3, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name;
- The date(s) of health care service(s);
- The provider's name;
- The reason(s) you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Care Claims, see "Urgent Care Claim Appeals" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.

- The Claims Administrator will provide you with a written or electronic determination as soon as possible but in any event within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

External Review

If you exhaust all internal appeals procedures, have been denied continued coverage for an ongoing course of treatment or have an urgent care claim you may be entitled to an external review of your claim. Please consult the Benefit Services Center, the Intact Benefits Team, or Claims Administrator for further details.

Expedited Reviews

The Plan will allow a claimant to make a request for an expedited external review when he/she receives:

- An adverse benefit determination and the determination involves a medical condition for which even an expedited internal appeal would seriously jeopardize the health of the claimant or would jeopardize the claimant's ability to regain maximum function; or
- A final internal adverse benefit determination, if the timeframe to complete the standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function. Also, an expedited external review may be requested if the final internal adverse benefit determination concerns admission, availability of care, continued stay, or healthcare item/service for which the claimant received emergency services, and the claimant has not been discharged from a health facility.

For additional information regarding expedited reviews, contact the applicable Claims Administrator listed in Appendix A.

SECTION XIII

SUBROGATION/REIMBURSEMENT/BENEFIT OFFSET

13.1 Introduction

If you file a claim for benefits for medical expenses you have incurred which may be the responsibility of a third party, you must reimburse the Plan from any recovery you receive or the Plan may offset future benefits. For example, if you are injured in an automobile accident which is not your fault, you must repay the Plan for the health benefits you collect from the third party responsible for the accident, his insurance company or anyone else from which you receive payment for the accident. You cannot avoid reimbursing the Plan by treating the recovery as damages for pain and suffering or otherwise not treating the recovery as a payment for medical expenses. You must notify the Plan of any claim you may have against any third party as soon as you become aware of the claim, you must sign any subrogation/reimbursement/benefit offset agreement requested by the Plan, and you must cooperate with the Plan in all attempts to collect from the third party. This means that the Plan has the right to act on your behalf in pursuing payment from the third party.

13.2 Subrogation

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;

- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Benefits Administrator, the Claims Administrator or their representatives, or the Intact Benefits Team or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

13.3 Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

13.4 Non-assignment of Benefits

Plan participants cannot assign, pledge, borrow against, or otherwise promise any right or benefit under the Plan or ERISA (including the right to sue) at any time before or after covered services are rendered. Coverage under the plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage, or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer will be null and void, before receipt of that benefit. However, benefits will be provided to a participant's child if required

by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and Intact to the extent of such payment.

SECTION XIV

ADMINISTRATIVE INFORMATION

14.1 Plan Information

Below is key information you need to know about the Plan:

Plan Name	Intact Welfare Plan
Plan Number	506
Plan Sponsor	Intact Services~~,~~ USA LLC 605 Waterford Park 605 Highway 169 North, Suite 800 Plymouth, MN 55441
Employer Identification Number	26-3300555
Plan Administrator	Intact Insurance Group USA 605 Waterford Park 605 Highway 169 North, Suite 800 Plymouth, MN 55441
Agent for Service of Legal Process	Plan Administrator
Benefits Service Center	Benefitfocus Intact Benefits Service Center 855-889-6524 www.intactusa.hrintouch.com
Intact Benefits Team	www.benefits.intactspecialty.com/ benefits@intactinsurance.com
Plan Year	January 1 through December 31
Plan Type	Welfare benefit plan providing the following types of benefits: ▪ Medical (which may be offered with an HRA or compatible with an HSA) ▪ Dental ▪ Vision ▪ Short-Term Disability ▪ Long-Term Disability ▪ Basic Life Insurance

	▪ Supplemental Life Insurance ▪ Accidental Death & Dismemberment ▪ Health Care FSA ▪ HSA Contributions ▪ Business Travel Accident ▪ Group Legal ▪ EAP ▪ Severance Although the Dependent Care FSA, Transportation, HSA, and New York and New Jersey Statutory Disability benefits may be described in this summary, they are not benefits subject to ERISA and are **not** part of the Intact Welfare Plan.
Participant Contributions	Intact will notify employees annually as to what the employee contribution rates will be. Intact, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse the Intact Companies for their contributions, unless otherwise provided in that group insurance contract or required by applicable law.

14.2 Plan Administration

Intact is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in an Incorporated Document. Intact has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and Intact will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Intact will not be liable in any manner for any determination made in good faith.

Intact may designate other organizations or persons to carry out specific fiduciary responsibilities for Intact in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or

to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

Intact will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

14.3 Power and Authority of the Insurance Company

The Dental, Vision, Basic Life Insurance, Supplemental Life Insurance, Accidental Death & Dismemberment, Business Travel Accident, New York and New Jersey Statutory Disability, Long-Term Disability, and Group Legal benefits under this Plan are fully insured. Benefits may be provided under a group insurance contract entered into between Intact and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the insurance company. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not Intact.

The insurance company is responsible for:
- Determining coverage amount of any benefits payable under the Plan.
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan.

The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Intact does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program, because these goods and services are provided by personnel and agencies outside Intact's control.

14.4 Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

14.5 Questions

If you have general questions regarding the Plan, please contact the Intact benefits team. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your Incorporated Documents or contact the Benefits Service Center, the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.

SECTION XV

YOUR ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA") for the benefits provided under the Plan. ERISA provides that you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

- Review at Intact's office, all documents governing the Plan, insurance contracts, Incorporated Documents, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Incorporated Documents and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report

(if any) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A

Incorporated Documents

This summary should be read in combination with the insurance contracts, member handbooks, certificates of coverage or evidence of coverage documents (together and individually referred to as "Incorporated Documents") provided by the insurance companies and service providers.

The Incorporated Documents are intended to describe the benefits available to you as an employee of the Intact Companies, and, when read with this summary, are intended to meet ERISA's SPD requirements.

Please see the Incorporated Documents for details of Plan benefits.

For additional information, please contact the Intact Benefits Team.

Coverage	Incorporated Documents
Medical	Blue Cross Blue Shield of Minnesota HRA SPD Blue Cross Blue Shield of Minnesota HSA SPD HRA Further Summary
Dental	Delta Dental Basic Plan Summary Delta Dental Enhanced Plan Summary
Vision	EyeMed Vision Services Plan Summary of Benefits
Basic Life Insurance	Reliastar Life Insurance Company (VOYA) Certificate of Coverage
Supplemental Life Insurance (employee, spouse, child)	Reliastar Life Insurance Company (VOYA) Certificate of Coverage
Short-Term Disability	Lincoln Life Assurance (Lincoln Financial) Short-Term Disability Plan Summary of Benefits
Long-Term Disability	Lincoln Life Assurance (Lincoln Financial) Certificate of Coverage
Accidental Death & Dismemberment	Intact Accident & Health Voluntary Accident Group Policy

Coverage	Incorporated Documents
Business Travel Accident	Intact Accident & Health Business Travel Accident Group Policy
Group Legal	ARAG Insurance Company Summary of Benefits
Employee Assistance Program	BCBS Summary of Benefits Brochure
Severance Plan	Intact Severance Plan and Summary Plan Description

Claims Administrators

Claims Administrators – Insured or Pre-Paid Benefits

Intact provides the following benefits through contracts with the companies listed below. The Dental, Vision, Basic Life Insurance, Supplemental Life Insurance, Accidental Death & Dismemberment, New York and New Jersey Statutory Disability, Long-Term Disability, Business Travel Accident, Group Legal, and EAP benefits are guaranteed under insurance contracts or other pre-paid service contracts with the companies listed below. The companies administer claims for those benefits and are solely responsible for providing benefits.

Dental	Delta Dental of MN 800.448.3815
Vision	EyeMed Vision Services Plan www.eyemedvisioncare.com 866.723.0513
Basic Life Insurance, Supplemental Life Insurance (including employee, spousal, and dependent supplemental life insurance)	Reliastar Life Insurance Company (VOYA) www.voya.com 800.955.7736
Accidental Death & Dismemberment	Intact Accident & Health 800.527.1255 ext. 6611
New York Statutory Disability Plan	Lincoln Life Assurance (Lincoln Financial) 800.853.7105
New Jersey Statutory Disability Plan	Lincoln Life Assurance (Lincoln Financial) 800.853.7105
Long-Term Disability	Lincoln Life Assurance (Lincoln Financial) 800.853.7105
Business Travel Accident	Intact Accident & Health 800.527.1255 ext. 6611

Claims Administrators – Insured or Pre-Paid Benefits

Group Legal	ARAG Group Legal https://www.araglegalcenter.com Access Code: 15621one 800.247.4184
EAP	Blue Cross Blue Shield 800.432.5155 http://www.bluecrossmn.com/eap

Claims Administrators – Self-Insured Benefits

The Health Care FSA, Dependent Care FSA, Transportation, Short-Term Disability, HRA, and Severance benefits are self-insured. Benefits are paid out of the general assets of Intact and are not guaranteed under a contract or policy of insurance.

Medical **(including prescription drug)**	Blue Cross Blue Shield 866.873.5943 www.bluecrossmn.com Prime Therapeutics (prescription drug) 800.531.6676 www.myprime.com/
Transportation Benefits	WageWorks 877-924-3967 www.wageworks.com/
Short-Term Disability	Lincoln Financial Group www.mylibertyclaim.com ID# - 10253226 PIN# - SSN w/ no spaces or dashes 800.853.7105
FSA, HRA, and HSA Benefits	Further (formerly SelectAccount) 800.859.2144 www.hellofurther.com
Severance Plan	Intact Benefits Department benefits@intactinsurance.com

This section provides general information about who to contact for more information about the claims and appeals procedures applicable to the benefits described in this summary. Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. See the Incorporated Documents for more information.

APPENDIX B

Participating Employers

As of January 1, 2021, the following Participating Employers have adopted all of the benefits described in this summary:

- Intact Services USA LLC
- A.W.G. Dewar, Inc.
- Atlantic Specialty Insurance Company

For employees of:

Intact Services USA LLC

HRA Plan

THIS HEALTH CARE PLAN IS INTENDED FOR USE WITH A FINANCIAL ACCOUNT

PLEASE READ YOUR BENEFIT BOOKLET CAREFULLY

LANGUAGE ACCESS SERVICES

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နှဉ်လီၤ. ကိး: 1-866-251-6744 လၢ TTYအဂီ, ကိး: 711 တကှ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih áǫįęęǫįǫąǫąęįą. TTY biniiyégo éí íáájį' béésh bee hodíílnih.

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

The claims administrator complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The claims administrator provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with the claims administrator.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact the claims administrator at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312
- Grievance forms are available by contacting the claims administrator at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting the claims administrator at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

CUSTOMER SERVICE

Whether it is for help with a claim or a question about your benefits, you can call your customer service telephone number or log onto the claims administrator's member website both located on the back of your ID card.

A customer service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

The customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters.

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WELCOME

This benefit booklet provides you with the information you need to understand your health care plan. You are encouraged to take the time to review this information so you understand how your health care plan works.

This benefit booklet replaces all other certificates/benefit booklets you have received from the plan administrator before the effective date. For purposes of this benefit booklet, "you" or "your" refers to the employee named on the identification (ID) card and other covered dependents. Employee is the person for whom the employer has provided coverage. Dependent is a covered dependent of the employee.

The plan administrator has contracted with the claims administrator to provide coverage for its employees and their dependents. Terms are defined in "Terms You Should Know."

This benefit booklet explains the health care plan, eligibility, notification procedures, covered services, and expenses that are not covered. It is important that you read this entire benefit booklet carefully. If you have questions about your coverage, please contact customer service at the telephone number listed on the back of your member ID card or log onto your claims administrator's member website at www.bluecrossmnonline.com.

This plan, financed and administered by Intact Services USA LLC, is a self-insured medical plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) is the claims administrator and provides administrative services only. The claims administrator does not assume any financial risk or obligation with respect to claims. Coverage is subject to all terms and conditions of this benefit booklet, including medical necessity and appropriateness.

If you have any questions on your health care plan, please contact customer service at the telephone number listed on the back of your member ID card.

MEMBER RIGHTS AND RESPONSIBILITES

You have the right as a health care plan member to:

- be treated with respect, dignity and privacy;
- have available and accessible medically necessary and appropriate covered services, including emergency services, 24 hours a day, seven (7) days a week;
- be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for treatment;
- participate with your health care provider in decisions about your treatment;
- give your health care provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity);
- refuse treatment;
- privacy of medical and financial records maintained by the health care plan, the claims administrator and its health care providers in accordance with existing law;
- receive information about the health care plan, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at the health care plan, the claims administrator or at the clinic that you can contact with any concerns about services;
- file an appeal with the claims administrator and receive a prompt and fair review; and
- initiate a legal proceeding when experiencing a problem with the health care plan or its providers.

You have the responsibility as a health care plan member to:

- know your health care plan benefits and requirements;
- provide, to the extent possible, information that the health care plan, the claims administrator and its providers need in order to care for you;
- understand your health problems and work with your doctor to set mutually agreed upon treatment goals;
- follow the treatment plan prescribed by your health care provider or to discuss with your provider why you are unable to follow the treatment plan;
- provide proof of coverage when you receive services and to update the clinic with any personal changes;
- pay copays at the time of service and to promptly pay deductibles, coinsurance and, if applicable, charges for services that are not covered; and
- keep appointments for care or to give early notice if you need to cancel a scheduled appointment.

BENEFIT OVERVIEW

Your Benefits

This benefit booklet outlines the general coverage under this plan. Please be certain to check the "Benefit Chart" section to identify specifically covered benefits. All services must be medically necessary and appropriate to be covered.

Please also review the "Not Covered" sections of the Benefit Chart and "General Exclusions" to determine services that are not covered. Some services and supplies are not covered, even if a provider considers them to be medically necessary and appropriate.

The "Terms You Should Know" section defines terms used in this benefit booklet. If you have questions, contact customer service using the telephone number listed on the back of your member ID card.

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during your covered calendar year will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

Benefit Period

Your health care plan's benefit period is based on a calendar year. The calendar year is January 1 to December 31.

During this time, charges for covered services must be incurred in order to be eligible for payment by Blue Cross. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Networks	
Your provider directory lists network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is network for your particular plan. Not every provider is network for every plan. For a list of providers in the directory, visit www.bluecrossmnonline.com ("Member Log in" then "Find a Doctor") or contact customer service at the telephone number listed on the back of your member ID card.	
• In-Network Providers ▪ In Minnesota ▪ Outside Minnesota	 Aware network providers BlueCard PPO network providers
• In-Network Participating Pharmacy Providers	Select pharmacy network

Benefits	In-Network Providers	Out-of-Network Providers
General Provisions		
Deductible including Pharmacy • Individual • Family	 You pay $900 You pay $1,800	 You pay $1,800 You pay $3,600
The amounts accumulated toward the deductible are applied to covered services provided by both network providers and out-of-network providers. Amounts accumulated toward the network deductible also accumulate toward the out-of-network deductible. When the network deductible is satisfied, covered services from network providers will be paid at the covered percentage. Amounts accumulated toward the out-of-network deductible also accumulate toward the network deductible. When the out-of-network deductible is satisfied, the claims administrator considers both the network and out-of-network deductibles satisfied and covered services from all providers will be paid at the covered percentage.		

Benefits	In-Network Providers	Out-of-Network Providers
Coinsurance	Generally, you pay 20% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year	Generally, you pay 50% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year
Out-of-Pocket Limits - eligible medical services including pharmacy		
• Individual	You pay $4,000	You pay $8,000
• Family	You pay $8,000	You pay $16,000
The amounts accumulated toward the out-of-pocket limit are applied to covered services provided by both network providers and out-of-network providers. Amounts accumulated toward the network out-of-pocket limit also accumulate toward the out-of-network out-of-pocket limit. When the network out-of-pocket limit is satisfied, covered services from network providers will be paid at 100% of the allowed amount. Amounts accumulated toward the out-of-network out-of-pocket limit also accumulate toward the network out-of-pocket limit. When the out-of-network out-of-pocket limit is satisfied, the claims administrator considers both the network and out-of-network out-of-pocket limits satisfied and covered services from all providers will be paid at 100% of the allowed amount.		
Lifetime Maximum (per person)		
• Assisted fertilization ▪ all services combined (medical and prescription drugs)	$20,000	
• Bariatric surgery	$20,000	
• Travel expenses for transplants to a Blue Distinction Center only	$10,000	
• Total benefits paid to all other providers combined	Not applicable	

Prescription Drug Benefits	In-Network Provider	Out-of-Network Provider
Prescription Drugs: • **Affordable Care Act (ACA) preventive covered prescription drugs**	**Retail Pharmacy:** You pay nothing **90dayRx Participating Retail Pharmacy:** You pay nothing **Mail Service Pharmacy:** You pay nothing	You pay nothing
• **Designated preventive prescription drugs other than Affordable Care Act (ACA) preventive prescription drugs**	**Retail Pharmacy:** You pay 30% coinsurance **90dayRx Participating Retail Pharmacy:** You pay 30% coinsurance **Mail Service Pharmacy:** You pay 30% coinsurance	You pay 30% coinsurance

Prescription Drug Benefits	In-Network Provider	Out-of-Network Provider
• **FlexRx Preferred generic prescription drugs**	**Retail Pharmacy:** You pay $50.00 copay or 30% coinsurance after deductible, whichever is less per prescription **90dayRx Participating Retail Pharmacy:** You pay $125.00 copay or 30% coinsurance after deductible whichever is less per prescription **Mail Service Pharmacy:** You pay $125.00 copay or 30% coinsurance after deductible whichever is less per prescription	You pay $50.00 copay or 30% coinsurance after deductible whichever is less per prescription
• **FlexRx Preferred brand prescription drugs**	**Retail Pharmacy:** You pay $150.00 copay or 30% coinsurance after deductible, whichever is less per prescription **90dayRx Participating Retail Pharmacy:** You pay $375.00 copay or 30% coinsurance after deductible whichever is less per prescription **Mail Service Pharmacy:** You pay $375.00 copay or 30% coinsurance after deductible whichever is less per prescription	You pay $150.00 copay or 30% coinsurance after deductible whichever is less per prescription
• **Non-preferred generic prescription drugs**	**Retail Pharmacy:** You pay $50.00 copay or 30% coinsurance after deductible, whichever is less per prescription **90dayRx Participating Retail Pharmacy:** You pay $125.00 copay or 30% coinsurance after deductible whichever is less per prescription **Mail Service Pharmacy:** You pay $125.00 copay or 30% coinsurance after deductible whichever is less per prescription	You pay $50.00 copay or 30% coinsurance after deductible whichever is less per prescription
• **Non-preferred brand prescription drugs**	**Retail Pharmacy:** You pay $250.00 copay or 30% coinsurance after deductible, whichever is less per prescription **90dayRx Participating Retail Pharmacy:** You pay $625.00 copay or 30% coinsurance after deductible whichever is less per prescription **Mail Service Pharmacy:** You pay $625.00 copay or 30% coinsurance after deductible whichever is less per prescription	You pay $250.00 copay or 30% coinsurance after deductible whichever is less per prescription

Prescription Drug Benefits	In-Network Provider	Out-of-Network Provider
• **Designated Preferred brand specialty prescription drugs purchased through a specialty pharmacy network supplier**	**Specialty pharmacy network supplier:** You pay 30% coinsurance after deductible up to a maximum of $375.00 per prescription for Preferred specialty drugs **90dayRx Participating Retail Pharmacy:** NO COVERAGE **Mail Service Participating Pharmacy:** NO COVERAGE	NO COVERAGE
• **Designated Nonpreferred brand specialty prescription drugs purchased through a specialty pharmacy network supplier**	**Specialty pharmacy network supplier:** You pay 30% coinsurance after deductible up to a maximum of $625.00 per prescription for Nonpreferred specialty drugs **90dayRx Participating Retail Pharmacy:** NO COVERAGE **Mail Service Participating Pharmacy:** NO COVERAGE	NO COVERAGE
• **Retail Pharmacy Vaccine program** ▪ certain eligible vaccines administered at a participating retail pharmacy	You pay nothing	NO COVERAGE

BENEFIT CHART

The health care plan provides coverage of benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copays amounts are described in "Benefit Overview." In-network care is generally covered at a higher level of benefits than out-of-network care.

Prior authorization, admission notification, or emergency admission notification are required for specific services. Please refer to "Health Care Management."

Please refer to "Not Covered" sections of the Benefit Chart and “General Exclusions” for additional information.

Benefit Descriptions

Please refer to the following pages for a more detailed description of benefits.

AMBULANCE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Emergency medically necessary and appropriate service from the place of departure to the nearest medical facility equipped to treat the condition	You pay 20% coinsurance after deductible	Same as in-network services
• Non-emergency medically necessary and appropriate service from the place of departure to nearest medical facility equipped to treat the condition	You pay 20% coinsurance after deductible	Same as in-network services

NOTES:

- Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility provider;
  - between hospitals; or
  - between a hospital and a skilled nursing facility provider;

  when such facility provider is the closest institution that can provide covered services appropriate for your condition. If there is no facility provider in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility provider outside the local area that can provide the necessary service.
- Transportation and related emergency service provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room for an injury or condition that is not considered emergency care will not be covered as emergency ambulance service. Please refer to "Terms You Should Know" for a definition of medical emergency.
- Benefits include non-emergency medically necessary and appropriate prearranged or scheduled ambulance service requested by an attending physician or nurse from the place of departure to the closest facility provider that can provide the necessary service.
- Eligible services you receive from out-of-network providers apply to the in-network deductible.
- Eligible services you receive from out-of-network providers apply to the in-network out-of-pocket limit.

NOT COVERED:

- ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility equipped to treat the condition (example: facility A is the closest medical facility equipped to treat the condition but you choose to be transported to facility B. The plan will cover eligible medically necessary and appropriate ambulance transportation costs that would otherwise apply to transportation to facility A. If you choose to be transported by ambulance to facility B, the cost of transportation service in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to facility A are not covered under the plan, and you will be responsible for those costs)
- travel, transportation, or living expenses, whether or not recommended by a physician, except as provided herein
- ambulance transportation services that are not medically necessary and appropriate for basic or advanced life support
- transportation services, including ambulance services that are mainly for your convenience

BEHAVIORAL HEALTH MENTAL HEALTH CARE

Your mental health is just as important as your physical health. That is why your health care plan provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance use disorder professional providers, so you can get the appropriate level of responsive, confidential care.

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit ▪ telemedicine services ▪ individual/family therapy (office/in-home mental health services)	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services in an office or clinic ▪ assessment and diagnostic services ▪ neuropsychological examination	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services ▪ neuropsychological examination	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Outpatient hospital/outpatient behavioral health treatment facility services including ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional health care services including: ▪ clinical based partial programs ▪ clinical based day treatment ▪ clinical based Intensive Outpatient Programs (IOP)	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Facility health services including: ▪ hospital based partial programs ▪ hospital based day treatment ▪ hospital based intensive outpatient programs (IOP)	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient health care professional services including: ▪ individual psychotherapy ▪ group psychotherapy ▪ psychological testing ▪ counseling with family members to assist in your diagnosis and treatment	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Inpatient hospital/residential behavioral health treatment facility services including: ▪ all eligible inpatient services ▪ emergency holds	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- For home health related services, please refer to "Home Health Care."
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, is deemed medically necessary and appropriate.
- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity and appropriateness. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and appropriate and otherwise covered under this health care plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
- Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
- Coverage is provided for inpatient care and outpatient care for the treatment of serious mental illness. A serious mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient care cost-sharing amounts. Serious mental illnesses include schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa and delusional disorder.
- Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as previously described, are also available when you are an outpatient.
- Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:
  - mental health and substance use disorder services are to be covered on the same basis as similar medical services;
  - cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
  - treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
- Coverage is provided on the same basis as other benefits for treatment of emotionally disabled dependent children in a licensed residential behavioral health treatment facility. "Emotionally disabled child" shall have the meaning set forth by the Minnesota Commissioner of Human services in the rules relating to residential treatment facilities.
- Coverage is provided for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments must be recommended by your physician and include, but are not limited to: antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

NOTES:

- Benefits are provided for autism treatment, including intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (EIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy. The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities. Treatment must be in accordance with an individualized treatment plan prescribed by the member's treating physician or mental health professional.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- services for mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- evaluations that are not performed for the purpose of diagnosing or treating mental health or substance use disorder conditions such as: custody evaluations; parenting assessments; education classes for DUI or DWI offences; competency evaluations; adoption home status; parental competency; and domestic violence programs
- services for or related to room and board for foster care, group homes, shelter care and lodging programs, halfway house services, and skills training
- services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or, marriage/couples retreats, encounters, or seminars
- services primarily educational in nature, except nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders not otherwise specified (NOS) and except as provided herein
- services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment for support for the foster child's improved functioning)
- services for the treatment of learning disabilities
- services for therapeutic day care and therapeutic camp services
- court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law
- services for or related to marriage/couples counseling

BEHAVIORAL HEALTH SUBSTANCE USE CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit ▪ telemedicine services ▪ individual and family therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services in an office or clinic ▪ assessment and diagnostic services ▪ opioid treatment	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services ▪ opioid treatment	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient health care professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient hospital/residential behavioral health treatment facility services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- Outpatient family therapy is covered if rendered by a health care professional, and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance use disorder including the following:
  - inpatient hospital or substance use disorder treatment facility provider services for detoxification
  - substance use disorder treatment facility provider services for non-hospital inpatient residential treatment and rehabilitation services
  - outpatient hospital/facility or substance use disorder treatment facility provider or outpatient substance use disorder treatment facility provider services for rehabilitation therapy
  - court-ordered treatment provided by the Department of Corrections is covered when included in a sentencing order and is based on a chemical assessment conducted by the Department of Corrections
  - admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold
  - coverage includes medication assisted treatment (MAT) for opioid use disorder
- For purposes of this benefit, a substance use disorder service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- For home health related services, please refer to "Home Health Care."
- For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:
  - mental health and substance use disorder services are to be covered on the same basis as similar medical services;

NOTES:

- cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
- treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.

- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- services for substance use disorder or addiction not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary and appropriate
- evaluations that are not performed for the purpose of diagnosing or treating substance use disorder or addictions including, but not limited to: custody evaluations; parenting assessments; education classes for driving under the influence (DUI)/driving while intoxicated (DWI) offenses; competency evaluations; adoption home status; and parental competency and domestic violence programs
- services for or related to room and board for foster care, group homes, shelter care, and lodging programs, halfway house services, and skills training
- substance use disorder interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person, with the intent of convincing the affected person to enter treatment for the condition
- services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit
- services for therapeutic day care and therapeutic camp services
- services for hippotherapy (equine movement therapy)
- court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law

CHIROPRACTIC CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Spinal manipulations - includes office visit	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Other chiropractic services including therapies	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Benefits include coverage for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visits and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem and chiropractor time.
- Eligible acupuncture services are limited to 20 visits per person per calendar year.
- Spinal manipulations and other chiropractic services including therapies are limited to 20 visits per person per calendar year.

NOT COVERED:

- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider
- services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; etc.; and all related material and products for these programs
- services for or related to therapeutic massage
- maintenance services
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and appropriate and part of specialized maintenance therapy to treat the member's condition
- custodial care

DENTAL CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
This is not a dental plan. The following limited dental-related coverage is provided: • Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy natural teeth (see NOTES) • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder including: ▪ orthognathic surgery ▪ related orthodontia	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- For medical services, please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc.
- Mandibular staple implant is covered, provided the procedure is not done to prepare the mouth for dentures.
- Bone grafts for the purpose of reconstruction of the jaw is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.
- A sound and healthy natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one (1) year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one (1) year. A dental implant is not a sound and healthy natural tooth.
- Accident-related dental services, treatment and/or restoration of a sound and healthy natural tooth must begin within 12 months of the date of injury or within 12 months of your effective date of coverage under this plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date of treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy natural teeth, crowns, fillings and bridges.
- The health care plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. For hospital/facility charges please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." Dental services are not covered unless otherwise noted.
- Services for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder, including orthognathic surgery and related orthodontia, must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.

NOT COVERED:

- services for or related to orthodontia, except as provided herein
- oral surgery procedures, except as provided herein
- dental services to treat an injury from biting or chewing
- dentures, regardless of the cause or the condition, and any associated services including bone grafts
- dental implants, and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19
- removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as provided herein
- services for or related to replacement of a damaged dental bridge from an accident-related injury
- osteotomies and other procedures associated with the fitting of dentures or dental implants, except as provided herein
- services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia, or facility charges, except as provided herein
- services, including dental splints, to treat bruxism
- charges for routine dental care, except as provided herein

EMERGENCY CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services to treat an emergency medical condition as defined in Minnesota law	You pay 20% coinsurance after deductible	Same as in-network services
• Outpatient hospital/facility services to treat an emergency medical condition as defined in Minnesota law	You pay 20% coinsurance after deductible	Same as in-network services

NOTES:

- In emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number. When determining if a situation is a medical emergency the claims administrator will take into consideration presenting symptoms including, but not limited to, severe pain and a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day. Once the crisis has passed, call your physician to receive appropriate follow-up care.
- Please refer to "Terms You Should Know" for a definition of medical emergency.
- For inpatient services, please refer to "Hospital Inpatient Care" and "Office Visit and Professional Services."
- For urgent care visits, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services."
- Eligible services you receive from out-of-network providers apply to the in-network deductible.
- Eligible services you receive from out-of-network providers apply to the in-network out-of-pocket limit.

GENDER CONFIRMATION CARE

The services outlined on this page are for the treatment of gender dysphoria. Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. The therapeutic approach to gender dysphoria, as outlined by the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, from the World Professional Association for Transgender Health (WPATH), may consist of several interventions with the type and sequence of interventions differing from person to person.

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional services for gender affirming procedures for the treatment of gender dysphoria	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Services include related preparation and follow-up treatment care.
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- For outpatient counseling services, please refer to "Behavioral Health Mental Health Care."
- For prescription drugs for the management of gender dysphoria, please refer to "Prescription Drugs."
- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- For therapeutic injections, please refer to "Hospital Outpatient Care" or "Office Visit and Professional Services."
- For more information contact customer service at the telephone number on the back of your member ID card or visit www.bluecrossmnonline.com.
- Coverage includes cosmetic surgery related to sex transformation surgery only.

NOT COVERED:

- treatment, services or supplies that are not medically necessary and appropriate

HOME HEALTH CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Home health care agency or hospital program for home health care including, but not limited to: ▪ intermittent skilled nursing care in your home by a: • licensed registered nurse • licensed practical nurse ▪ physical therapy and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services provided by a medical technologist ▪ services provided by a licensed registered dietician ▪ services provided by a respiratory therapist ▪ services of a home health aide or master's level social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees ▪ use of appliances that are owned or rented by the home health agency ▪ home health care following early maternity discharge ▪ palliative care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services.
- Benefits for home/suite infusion therapy and related home health care are listed under "Infusion Therapy."
- For supplies and durable medical equipment billed by a home health agency, please refer to "Medical Equipment and Supplies."
- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and her newborn child.

NOT COVERED:

- homemaker services
- maintenance services
- services for dialysis treatment you receive from a home health care agency
- services for custodial care you receive from a home health care agency

NOT COVERED:

- services for food or home-delivered meals you receive from a home health care agency
- services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury (please refer to "Custodial Care" and "Skilled Care" in the "Terms You Should Know")
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care

HOSPICE CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Hospice care for terminal condition	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- Benefits are limited to members with a terminal condition (i.e., life expectancy of six (6) months or less). The member’s primary physician must certify, in writing, a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program.
- Inpatient respite care is for the relief of the member’s primary caregiver and is limited to a maximum of five (5) consecutive days at a time.
- Home respite care is for the relief of the member's primary caregiver and is limited to a maximum of five (5) consecutive days per admission to the hospice program.
- Hospice program general inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Benefits include family counseling related to the member's terminal condition.
- Medical care services unrelated to the terminal condition under the hospice program are covered, but are separate from the hospice benefit.

NOT COVERED:

- services for respite care, except as provided herein
- room and board expenses in a residential hospice facility
- services for dialysis treatment you receive from hospice or a hospital program for hospice care
- services for custodial care you receive from hospice or a hospital program for hospice care
- services for food or home-delivered meals you receive from hospice or a hospital program for hospice care

HOSPITAL INPATIENT CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Hospital room and board, and general nursing services • Special care unit which is a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients • Use of operating, delivery, and treatment rooms and equipment • Anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery • Medical and surgical dressings, supplies, casts, and splints • Prescription drugs and medicines provided to you while you are inpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • Diagnostic services • Communication services of a private-duty nurse or a personal care assistant up to 120 hours per hospital admission for ventilator dependent persons • Therapy and rehabilitation services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- The health care plan covers inpatient services from a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the member's condition.
- The plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major organ transplant or other kinds of transplants, please refer to "Transplant."
- The plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the plan:
  - potential donor testing;
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement.
- Diagnostic services include the following when ordered by a health care provider:
  - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
  - diagnostic pathology consisting of laboratory and pathology tests;
  - diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the claims administrator; and
  - allergy testing consisting of percutaneous, intracutaneous, and patch tests.

NOTES:

- The health care plan covers anesthesia and inpatient hospital services when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or, has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- charges for inpatient admissions which are primarily for diagnostic studies
- personal comfort items such as telephone, television
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this plan
- communication services provided on an outpatient basis or in the home
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care

HOSPITAL OUTPATIENT CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient hospital/facility services, except as noted below • Surgeon or assistant at surgery • Use of operating, delivery, and treatment rooms and equipment • Medical and surgical dressings, supplies, casts and splints • Radiation and chemotherapy • Dialysis treatment • Respiratory therapy • Cardiac rehabilitation • Physical, occupational, and speech therapy • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • Prescription drugs and medicines provided to you while you are outpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Laboratory services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Facility billed freestanding ambulatory surgical center services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Urgent care center visits		
▪ facility billed services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ facility laboratory services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ facility diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Pre-admission testing is covered for tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.
- Coverage is provided for hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.
- Coverage is provided for anesthesia, anesthesia supplies and devices rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery.

NOTES:

- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The health care plan covers anesthesia and outpatient hospital services when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- Assisted fertilization services are subject to a lifetime maximum limit of $20,000 per person for medical services and prescription drugs combined.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

INFUSION THERAPY

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Home infusion and suite infusion therapy services • Intravenous solutions and pharmaceutical additives, pharmacy compounding and dispensing services • Medical/surgical supplies • Nursing services associated with infusion therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or home setting.
- Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy.

NOT COVERED:

- infusion services or supplies not specifically listed as covered services
- nursing services to administer infusion therapy when the patient or caregiver can be successfully trained to administer therapy

MATERNITY CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Prenatal hospital/facility provider services	You pay nothing	You pay 50% coinsurance after deductible
• Prenatal professional services	You pay nothing	You pay 50% coinsurance after deductible
• Health care professional services for: ▪ delivery in a hospital/facility ▪ examination of the newborn infant while the mother is an inpatient	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ postpartum care • office visit	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• all other eligible services - office/clinic	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• all other eligible services – outpatient hospital/facility	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient hospital/facility services for: ▪ delivery in a hospital/facility ▪ postpartum care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and her newborn child.
- If you think you are pregnant, you may contact your physician or go to an in-network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital.
- Normal pregnancy – normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.
- Hospital, medical and surgical services rendered by a facility provider or professional provider for:
  - Complications of pregnancy - physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.
  - Prenatal care - the comprehensive package of medical and psychosocial support provided throughout the pregnancy, includes risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.
- Under federal law, group health plans such as this plan are required to provide benefits for any hospital length of stay in connection with childbirth as follows:
  - inpatient hospital coverage for the mother (to the extent the mother is covered under this health care plan) is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this health care plan. Please refer to "Home Health Care."

NOTES:

- inpatient hospital coverage for the newborn (to the extent the newborn is covered under this health care plan) is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this plan. Please refer to "Home Health Care."

- Under federal law, the health care plan may require that a provider obtain authorization from the health care plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.
- Eligible acupuncture services are limited to 20 visits per person per calendar year.

NOT COVERED:

- health care professional services for childbirth deliveries in the home
- services for or related adoption fees
- services for or related to surrogate pregnancy including: diagnostic screening, physician services, assisted fertilization, and prenatal/delivery/postnatal services when the surrogate is not a covered member under this plan
- services for childbirth classes
- services for or related to preservation, storage, and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue
- services for donor ova or sperm
- services for or related to elective cesarean (C)-section for the purpose of convenience
- services and prescription drugs for or related to the selection of gender in embryos

MEDICAL EQUIPMENT AND SUPPLIES

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Durable medical equipment (DME), except as noted below • Amino acid-based elemental formula • Corrective lenses, frames and contact lenses after cataract surgery (purchased within 24 months of cataract surgery) • Scalp hair prostheses (wigs) for hair loss due to alopecia areata or cancer only • Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Insulin infusion devices	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Blood glucose monitors	You pay nothing	You pay 50% coinsurance after deductible
• Orthotics	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Cochlear implants	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Non-investigative bone conductive hearing devices	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Coverage includes the purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.
- Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a health care provider legally authorized to prescribe such items under the law:
  - equipment and supplies: all physician prescribed medically necessary and appropriate equipment and supplies, including but not limited to, blood glucose monitors, monitor supplies, and insulin infusion devices.
- The rental or, upon approval by the claims administrator, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a health care provider within the scope of his/her license. Rental costs cannot exceed the total cost of purchase.
- Amino acid-based elemental formula is a type of exempt formula which is regulated by the U.S. Food and Drug Administration (FDA) and is prescribed for infants or children with specific medical or dietary problems. An amino acid-based formula contains proteins which are broken down into their simplest and purest form making it easier for the body to process and digest. An infant or child may be placed on an amino acid-based formula if he/she is unable to digest or tolerate whole proteins found in other formulas, due to certain allergies or gastrointestinal conditions. Examples of amino acid-based elemental formulas are Neocate®, EleCare®, PurAmino™ (formerly Nutramigen® AA™ LIPIL), Vivonex®, Tolerex®, Alfamino, and E028 Neocate Splash.

NOTES:

- Coverage for eligible orthotic devices includes purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.
- Scalp hair prostheses (wigs) for hair loss due to alopecia areata or cancer only. Maximum of $350 per person per calendar year.
- Corrective lenses, frames and contact lenses must be purchased within 24 months of cataract surgery.
- Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years.
- You are required to obtain prior authorization for durable medical equipment when you use nonparticipating providers in Minnesota or any provider outside of Minnesota. Please refer to www.bluecrossmnonline.com (click on "For Providers" at the bottom of the page, then "Medical Policy" under "Tools and Resources") or contact customer service at the telephone number on the back of your member ID card.

NOT COVERED:

- foot orthoses, except as provided herein
- services for or related to hearing aids or devices, except as provided herein
- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the "Benefit Chart"
- personal and convenience items or items provided at levels which exceed our determination of medically necessary and appropriate for durable medical equipment, supplies, and prosthetics
- services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; and incontinence pads or pants
- modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- replacement of properly functioning durable medical equipment
- duplicate equipment, prosthetics, or supplies
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- charges for devices for maintenance services
- scalp hair prostheses (wigs), except as provided herein
- charges for the rental of a manual breast pump
- charges for an electric breast pump
- services for eyeglasses or contact lenses for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury)

OFFICE VISIT AND PROFESSIONAL SERVICES

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• General physician office visits	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Specialty physician office visits	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• E-visits • Telephone consultations	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Urgent care center visits for illness/injury ▪ office visit for urgent care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ professional laboratory services for urgent care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ professional diagnostic imaging services for urgent care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services for urgent care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Retail health clinic ▪ retail health clinic office visit	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ laboratory services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional office and outpatient laboratory services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional office and outpatient diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional billed services received at a freestanding ambulatory surgical center	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Omada program for members age 18 or older for: ▪ pre-diabetes/pre-cardiac	You pay nothing	NO COVERAGE
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Assisted fertilization	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• All other professional services – office/clinic	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• All other professional services – outpatient hospital/facility	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- For members diagnosed with End Stage Renal Disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the claims administrator. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.
- Medical care rendered concurrently with surgery during one inpatient stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Medical care by two or more professional providers rendered concurrently during one inpatient stay when the nature or severity of your condition requires the skills of separate physicians.
- Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a health care provider legally authorized to prescribe such items under the law:
  - Diabetes Education Program*: When your health care provider certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
    - visits medically necessary and appropriate upon the diagnosis of diabetes
    - subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

  *Diabetes Education Program – an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care provider working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association with expertise in diabetes.
- If more than one (1) surgical procedure is performed during the same operative session, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- Physician services include services of an optometrist and an advanced practice nurse when performed within the scope of their licensure.
- The plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; and psychotherapy.
- A retail health clinic, located in a retail establishment or worksite, provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital/facility provider. Retail health clinics are staffed by eligible nurse practitioners or other eligible health care providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
- The plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major organ transplant, please refer to "Transplant."
- The plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the plan:
  - potential donor testing;
  - donor evaluation and workup; and
  - hospital and professional services related to organ procurement.
- The plan covers certain routine patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.

NOTES:

- Diagnostic services include the following when ordered by a health care provider:
  - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine
  - diagnostic pathology consisting of laboratory and pathology tests
  - diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the claims administrator; and
  - allergy testing consisting of percutaneous, intracutaneous, and patch tests
- Eligible therapeutic injections, including specialty drugs, administered by a health care provider required in the diagnosis, prevention and treatment of an injury or illness, provided that the drugs are not "usually self-administered" by a member and when the administration of the drug and the medication are billed by the health care provider and eligible under the "Office Visit and Professional Services" benefit. For injectable medications billed by a pharmacy or specialty drugs billed by the participating specialty pharmacy network provider, please refer to "Prescription Drugs." For specialty drugs that are administered in a clinic or an outpatient hospital, your health care provider may be required to obtain the specialty drugs from a designated vendor.
- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The plan covers services for or related to growth hormone replacement therapy if it is determined to be medically necessary and appropriate and otherwise covered under this health care plan.
- Please refer to “Preventive Care” for female sterilization.
- Omada delivers the largest CDC recognized prevention program for high-risk (pre-diabetes/pre-cardiac) conditions. Eligible members age 18 and older may participate in the digital care program, personalized to meet each eligible participant’s unique needs, as they evolve. The Omada for prevention program helps participants lose weight (and keep it off), build strategies for healthy eating, activity, sleep, and stress management, and reduce the risk of developing diabetes and cardiovascular disease-one step at a time. Each participant is given a professional health coach, connected devices, including a digital scale, online peer community, weekly interactive lessons and insight driven health goals.
- You are entitled to receive care at the in-network level from out-of-network providers if these services are covered under your plan:
  - the voluntary planning of the conception and bearing of children;
  - the diagnosis of infertility;
  - the testing and treatment of a sexually transmitted disease; or
  - the testing of AIDS or other HIV-related conditions.
- E-visit is a patient-initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services. These services provide real-time interaction between a distant site physician/medical practitioner and the member who is present and participating in the televideo visit at a remote facility.
- Therapeutic injections include coverage for off-label prescription drugs used for cancer treatment as specified by law. An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard compendia or in one article in the medical literature as specified by law.
- For self-administered prescription medications/drugs, please refer to “Prescription Drugs.”

NOTES:

- If you are prescribed a medication subject to step therapy, another eligible medication that is safe, more clinically effective, and in some cases more cost effective must have been prescribed and tried before the medication subject to step therapy will be paid under the medical benefit. Medical policy guidelines are available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. At your written request, we will provide you the criteria that we use to determine the medical necessity and appropriateness of a prescription drug that is subject to step therapy. If you or your prescribing health care provider believe that you need coverage for a prescription drug that is subject to the step therapy provision, an override from step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. If the step therapy override request meets one of the legally required conditions, we will grant the request, override the step therapy requirement, and cover the drug if it is a covered prescription drug under your plan.
- Assisted fertilization services are subject to a lifetime maximum limit of $20,000 per person for medical services and prescription drugs combined.
- The plan covers hearing aid examinations/fitting/adjustments for children age 18 and younger.
- Eligible acupuncture services are limited to 20 visits per person per calendar year.

NOT COVERED:

- out-of-network provider-initiated communications
- charges for giving injections that can be self-administered
- self-administered drugs that are available for coverage under the pharmacy/prescription drug benefit
- services for autopsies
- services for or related to cosmetic health services or surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as provided herein
- separate services for pre-operative and post-operative care for surgery billed by an out-of-network provider
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered under this plan
- services for or related to the LINX™ Reflux Management System (considered investigative) for the treatment of gastroesophageal reflux disease (GERD)
- services and supplies for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, except as provided herein
- services for routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein
- services for educational classes or programs, except as required by law
- services for or related to vision correction surgery such as the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, laser-assisted in situ keratomileusis (LASIK) and all related services
- services for or related to vocational rehabilitation (defined as service provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider

NOT COVERED:

- services provided during an e-visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit
- services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit
- services for or related to reversal of sterilization

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Habilitative and rehabilitative office visits from a physical therapist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative therapies from a physical therapist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative office visits from an occupational therapist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative therapies from an occupational therapist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative office visits from a speech or language pathologist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative therapies from a speech or language pathologist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Coverage includes benefits for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
- For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- Office visits may include an evaluation or re-evaluation of the following therapies:
  - physical
  - occupational
  - speech
  - swallowing
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a hospital/facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Habilitation and rehabilitation therapy benefits for physical, occupational, and speech therapy are limited to a combined maximum of 90 visits per person per calendar year.

NOT COVERED:

- services for or related to vocational rehabilitation (defined as service provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider
- services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate

PRESCRIPTION DRUGS

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips, needles and syringes, lancets • Prescription injectable drugs that are self-administered and do not require the services of a health care professional, except for designated specialty drugs (see NOTES) • Insulin • Affordable Care Act (ACA) preventive covered prescription drugs • FDA-approved tobacco cessation drugs and products, subject to limitations below • Designated specialty drugs purchased through a participating specialty pharmacy network supplier • Retail pharmacy vaccine program ▪ certain eligible vaccines administered at a participating retail pharmacy (see NOTES)	Please refer to "Prescription Drug Benefits" in "Benefit Overview."	Please refer to "Prescription Drug Benefits" in "Benefit Overview."

NOTES:

- Covered prescription drugs include drugs listed in your health care plan's covered drug list; including compounded medications, consisting of the mixture of at least two (2) or more FDA-approved prescription drugs/medications. (Please refer to “Terms You Should Know”).
- The claims administrator covered drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the Blue Cross Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. This list can change throughout the year.
- Eligible prescription drugs are covered when you purchase them through the pharmacy network applicable to your health care plan, except as provided herein. For convenience and choice, in-network pharmacies include both major chains and independent stores. Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day.
- The claims administrator chooses which drugs are on its drug lists, or excluded from its drug lists, based on numerous factors including their quality, safety and effectiveness, and overall cost. The overall cost of a drug can be impacted by volume discounts or reimbursements paid by drug manufacturers. At times, this may result in a brand name drug being included on a drug list while the generic of the same drug is excluded from a drug list.
- To receive a copy of your covered drug list visit www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card.
- The drug list is subject to periodic review and modification by the claims administrator or a designated committee of physicians and pharmacists.
- A retail pharmacy is a licensed pharmacy that you can physically enter to obtain a prescription drug. Eligible prescription drugs and diabetic supplies are generally covered up to a 31-day supply.
- 90dayRx includes the following: a retail pharmacy participating in the 90dayRx network and a participating mail service pharmacy that dispenses prescription drugs through the U.S. Mail. Eligible prescription drugs are dispensed up to a 90-day authorized supply of ongoing, long-term prescription drugs.

NOTES:

- The health care plan will cover off-label prescription drugs used for cancer treatment as specified by law. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard compendia or in one article in the medical literature as specified by law.
- Amino acid-based elemental formula is considered a supply item. Please refer to “Medical Equipment and Supplies.”
- Biosimilar drugs are not considered generic drugs. Please refer to your covered drug list.
- There may be circumstances where early or extended prescription drug refills are available. Please contact customer service at the telephone number listed on the back of your member ID card for further information. Restrictions apply.
- The claims administrator may receive pharmaceutical manufacturer volume discounts or reimbursements in connection with the purchase of certain prescription drugs covered under the health care plan. Such discounts are the sole property of the claims administrator and/or the health care plan and will not be considered in calculating any coinsurance, copay, deductible, or benefit maximums, except as required by law.
- Benefits are provided for a range of FDA-approved preventive contraceptive methods and for patient education/counseling, for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
- Benefits are provided for designated ACA preventive drugs with a prescription which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
- For more information regarding contraceptive or ACA preventive prescription drug coverage, please visit www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card.
- The claims administrator applies medical management in determining which contraceptives are included on your covered drug list, as well as a subset of contraceptive medications where a $0 member cost-sharing applies. To view a current list of contraceptive medications that are eligible for coverage without member cost-sharing under your plan visit www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. If your prescribing health care professional determines that none of the $0 member cost-sharing options available under your plan are clinically appropriate for you, he or she may request an exception through www.bluecrossmnonline.com (select "Forms” then “Coverage Exception Form”).
- Covered prescription drugs also include selected specialty prescription drugs within, but not limited to, the following prescription drugs classifications only when such prescription drugs are covered medications and are dispensed through exclusive specialty pharmacy network supplier. Specialty prescription drugs are designated complex injectable and oral drugs generally covered up to a 31-day supply that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Specialty prescription drugs are prescription drugs including, but not limited to prescription drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia. A current list of designated specialty prescription drugs and suppliers is available at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. Specialty prescription drugs are not available through 90dayRx.
- Specialty prescription drugs may be ordered by a health care provider on your behalf or you may submit the prescription order directly to the specialty pharmacy network supplier. In either situation, the specialty pharmacy network supplier will deliver the prescription to you.
- The retail pharmacy vaccine program allows you the opportunity to receive certain otherwise eligible vaccines at designated participating retail pharmacies subject to your prescription drug cost-sharing. This program is in addition to your current vaccine benefit administered through your clinic/physician's office. A list of eligible vaccines under this program and designated participating pharmacies is available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card.

NOTES:

- If you are prescribed a medication subject to step therapy, another eligible medication that is safe, more clinically effective, and in some cases more cost effective must have been prescribed and tried before the medication subject to step therapy will be paid under the prescription drug benefit. Step therapy prescription drug categories are available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. At your written request, we will provide you the criteria that we use to determine the medically necessity and appropriateness of a prescription drug that is subject to step therapy. If you or your prescribing health care provider believes that you need coverage for a prescription drug that is subject to the step therapy provision, an override from step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. If the step therapy override request meets one of the legally required conditions, we will grant the request, override the step therapy requirement, and cover the prescription drug if it is a covered prescription drug under your plan.
- If you are prescribed a brand drug when there is an equivalent generic drug, you will also pay the difference in cost between the brand drug and the generic drug, in addition to the applicable member cost-sharing. When you have reached your out-of-pocket limit, you still pay the difference in cost between the brand drug and the generic drug, even though you are no longer responsible for the applicable prescription drug member cost-sharing. You are also responsible for the payment differential when a generic drug is authorized by the physician and the member purchases a brand drug. Your payment is the price difference between the brand drug and generic drug in addition to the brand drug cost-sharing amounts that apply.
- Self-administered injectable and oral prescription drugs for assisted fertilization must be obtained through a specialty pharmacy network supplier and are subject to the lifetime maximum limit of $20,000 per member for all assisted fertilization for all charges and networks combined.

NOT COVERED:

- any charges by any pharmacy provider or pharmacist, except as provided herein
- any prescription for more than the retail days supply or 90dayRx days supply as outlined in “Benefit Overview,” except as provided herein
- charges for any drug purchased through mail order but not dispensed by a designated mail order pharmacy provider
- blenderized food, baby food, or regular shelf food when used with an enteral system, banked breast milk
- milk or soy-based infant formula with intact proteins
- any formula (standard and specialized), when used for the convenience of you or your family members
- solid or liquid food, standard or specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except if administered by tube feeding and as provided in the "Benefit Chart"
- investigative or non-FDA approved drugs, except as provided by law
- vitamin or dietary supplements, except as provided herein
- services for or related to tobacco cessation drugs and program fees and/or supplies, except as provided herein
- semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally
- normal food products used in the dietary management of rare hereditary genetic metabolic disorders
- medical devices approved by the FDA under the prescription drug benefit unless the devices are on your covered drug list. Covered medical devices are generally submitted and reimbursed under your medical benefits, please refer to “Medical Equipment and Supplies”
- specialty drugs not purchased through a specialty pharmacy network supplier
- drugs removed from the covered drug list due to safety reasons may not be covered
- over-the-counter drugs, except as provided herein

NOT COVERED:

- tobacco cessation drugs and products without a prescription
- prescription drugs for cosmetic alteration
- prescription drugs for weight loss

PREVENTIVE CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
Preventive care services from health care professionals, outpatient hospitals/facilities, and medical equipment suppliers in accordance with a predefined schedule based on age, sex and certain risk factors which are the recommendations of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, Health Resources and Services Administration (HRSA), and the Internal Revenue Service (IRS) for:		
• Adults and children age 6 and older ▪ routine physical examinations	You pay nothing	You pay 50% coinsurance after deductible
▪ vision examination (glaucoma, acuity, refraction)	You pay nothing	You pay 50% coinsurance after deductible
▪ hearing screening	You pay nothing	You pay 50% coinsurance after deductible
▪ adult immunizations that require administration by a health care provider, including the immunizing agent, when required for the prevention of disease	You pay nothing	You pay 50% coinsurance after deductible
▪ diagnostic services and procedures ▪ surveillance tests for ovarian cancer - (CA125 tumor marker, trans-vaginal ultrasound, pelvic examination)	You pay nothing	You pay 50% coinsurance after deductible
▪ routine gynecological examinations, including a Papanicolaou (PAP) test	You pay nothing	You pay 50% coinsurance after deductible
▪ mammograms, 2 dimensional (2D) or 3 dimensional (3D), annual routine and medically necessary and appropriate	You pay nothing	You pay 50% coinsurance after deductible
▪ colorectal cancer screening ▪ prostate specific antigen (PSA) tests and digital rectal examinations for men of all ages	You pay nothing	You pay 50% coinsurance after deductible
• Infants and children ▪ routine physical examinations from birth to age 6 ▪ developmental assessments from birth to age 6	You pay nothing	You pay 50% coinsurance after deductible
▪ pediatric immunizations from birth to age 18	You pay nothing	You pay 50% coinsurance after deductible

NOTES:

- Preventive care services are consistent with state and federal statutes, regulations, and related guidance.
- Benefits for services identified as preventive care are determined based on recommendations and criteria established by professional associations and experts in the field of preventive care (e.g., Institute for Clinical Systems Improvement (ICSI), United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), etc.). For all other eligible services, please refer to “Hospital Inpatient Care,” "Hospital Outpatient Care," "Office Visit and Professional Services," etc. for appropriate benefit levels.

NOTES:

- Routine physical examinations including a complete medical history for adults, and other items and services.
- For more information regarding preventive care services, please visit www.bluecrossmnonline.com (choose "Live Healthy" then "Preventive Care") or contact customer service at the telephone number listed on the back of your member ID card.
- Preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors which are the recommendations of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and Health Resources and Services Administration (HRSA). The claims administrator periodically reviews the schedule of covered services based on the requirements of the Patient Protection and Affordable Care Act of 2010, and recommendations from USPSTF, ACIP and HRSA. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto the member website at, www.bluecrossmnonline.com or call customer service at the telephone number listed on the back of your member ID card.
- Benefits are provided for surgical implants and tubal ligation for elective sterilization for females which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage please visit www.bluecrossmnonline.com ("Member Sign In" then "Plan Details"/"Preventive care benefit information"/"learn more") or contact customer service.
- Benefits are provided for a full range of FDA-approved preventive contraceptive methods and for patient education/counseling, for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. Please refer to "Prescription Drug Benefits" in the "Benefit Overview" section for outpatient drug coverage.
- Services for complications related to female contraceptive drugs, devices, and services for women of reproductive capacity may be covered under other plan benefits. Please refer to "Hospital Inpatient Care, "Hospital Outpatient Care, "Office Visit and Professional Services," etc. for appropriate benefit levels.
- Benefits are provided for “child health supervision services,” which means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age 6, and appropriate immunizations from ages six (6) to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. We will reimburse five (5) child health supervision visits from birth to 12 months, three (3) child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.
- Well-woman benefits are provided for female members for items and services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling and breastfeeding support and counseling.
- You are entitled to receive care at the in-network level for screening for sexually transmitted disease or HIV.
- Benefits are provided for the purchase of a manual breast pump.
- Adult preventive care services are limited to those on the health care plan’s preventive schedule and the women's health preventive schedule. Gender, age and frequency limits may apply.
- Pediatric preventive care services are limited to those on the health care plan’s preventive schedule. Gender, age and frequency limits may apply.
- Services to treat an illness/injury diagnosed as a result of preventive care services or preventive care services in excess of USPSTF, ACIP of the Centers for Disease Control, HRSA, or the IRS recommendations and criteria may be covered under other plan benefits. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. for appropriate benefit levels.
- All female members, regardless of age, are covered for routine gynecological examinations, including a pelvic and clinical breast examination.
- Benefits are provided to eligible dependent children for pediatric immunizations.

NOTES:

- Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:
  - diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
  - diagnostic imaging screening services such as barium enema
  - surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
  - such other diagnostic pathology and laboratory, diagnostic imaging, surgical screening tests and diagnostic screening services consistent with approved medical standards and practices for the detection of colon cancer
- If you are determined to be at high or increased risk, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician. Colorectal cancer screening services which are otherwise not described herein and are prescribed by a physician for a symptomatic member are not considered preventive care services. The payment for these services will be consistent with similar medically necessary and appropriate covered services.

NOT COVERED:

- services for routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein

RECONSTRUCTIVE SURGERY

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved body part • Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending health care provider. • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Elimination or maximum feasible treatment of port wine stains	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- If more than one (1) surgical procedure is performed during the same operative session, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- Congenital means present at birth.
- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."

NOT COVERED:

- repairs of scars and blemishes on skin surfaces
- dentures, regardless of the cause or condition, and any associated services including bone grafts
- dental implants, and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19

SKILLED NURSING FACILITY CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Skilled care ordered by a physician • Room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Coverage is limited to a maximum benefit of 60 days per person per calendar year.

NOT COVERED:

- custodial care, nonskilled care, adult daycare or personal care attendants
- services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care
- services when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience
- treatment, services or supplies that are not medically necessary and appropriate
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care

TRANSPLANT

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Benefits may be provided for covered services furnished by a hospital which are directly and specifically related to the transplantation of the following: medically necessary and appropriate human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures: ▪ allogeneic and syngeneic bone marrow transplant and peripheral stem cell and umbilical cord blood transplant procedures ▪ autologous bone marrow transplant and peripheral blood stem cell transplant procedures ▪ heart ▪ heart-lung ▪ kidney-pancreas transplant performed simultaneously (SPK) ▪ liver - deceased donor and living donor ▪ liver-kidney ▪ lung - single or double ▪ pancreas transplant - deceased donor and living donor segmental • Pancreas Transplant Alone (PTA) • Simultaneous Pancreas-Kidney (SPK) transplant • Pancreas After Kidney (PAK) transplant ▪ small-bowel and small-bowel/liver	You pay nothing of the transplant payment allowance for the transplant admission when you use a Blue Distinction Centers for Transplant (BDCT) provider	You pay 20% coinsurance of the transplant payment allowance after deductible when you use a participating transplant provider NO COVERAGE when you use a nonparticipating provider

NOTES:

- For members diagnosed with End Stage Renal Disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the claims administrator. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.
- Kidney transplants when not done in conjunction with an eligible major organ transplant noted above, and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to "Hospital Inpatient Care," "Office Visit and Professional Services," etc.
- If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:
  - when both the recipient and the donor are members, each is entitled to the benefits of their health care plan;
  - when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this health care plan subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this health care plan to the extent that benefits remain and are available under this health care plan after benefits for the recipient's own expenses have been paid;
  - when only the donor is a member, the donor is entitled to the benefits of this health care plan, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this health care plan; and 2) no benefits will be provided to the non-member transplant recipient; and

NOTES:

- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's health care plan limit.

- For services not included in the transplant payment allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.
- Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures, and should be submitted in writing or faxed to 651-662-1624.
- Eligible transplant services provided by participating transplant providers will be paid at the Blue Distinction Centers for Transplant (BDCT) providers level of benefits when the transplant services are not available at a BDCT provider.
- If you live more than 50 miles from a BDCT provider, there may be a travel benefit available for expenses directly related to a preauthorized transplant.

NOT COVERED:

- services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow and peripheral stem cell transplant procedures that are considered investigative or not medically necessary and appropriate
- living donor organ and/or tissue transplants, except as provided herein
- benefits for travel expenses when you are using a Non-BDCT provider
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this plan
- transplant services you receive from a nonparticipating provider

GENERAL EXCLUSIONS

Except as specifically provided in this health care plan or as the claims administrator is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges noted under "NOT COVERED" in the Benefit Chart and as noted below.

No benefits will be provided for the following:

1. Court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law.
2. Custodial care, nonskilled care, adult daycare or personal care attendants.
3. Services rendered prior to your effective date of coverage.
4. Services which are experimental/investigative in nature, except for certain routine care for approved clinical trials.
5. Treatments, services or supplies which are not medically necessary and appropriate based on the definition of “Medically Necessary and Appropriate” in “Terms You Should Know.”
6. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as provided herein.
7. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as provided herein.
8. Services for palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
9. Services for or related to hearing aid devices and tinnitus maskers for adults age 19 and older.
10. Physical, occupational, and speech therapy services for or related to the treatment of learning disabilities and disorders, except when medically necessary and appropriate and provided by an eligible health care provider.
11. New to market FDA-approved drugs, devices, diagnostics, therapies, and medical treatments until they have been reviewed and approved by the claims administrator and deemed eligible for coverage.
12. To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this health care plan and you elect this coverage as primary.
13. To the extent benefits are provided to members of the armed forces while on active duty or to members in Veteran's Administration facilities for service-connected illness or injury, unless you have a legal obligation to pay.
14. Charges for the covered patient’s failure to keep a scheduled visit.
15. Charges billed by your provider for the completion of a claim form.
16. Any other medical or dental service or treatment or prescription drug, except as provided herein.
17. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle, including a motor vehicle accident, if such treatment or service is eligible, paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable. Charges that are eligible, paid, or payable under any medical payment, automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
18. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
19. Services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury.
20. Services which are not prescribed by or performed by or upon the direction of a professional provider.

21. Services rendered by other than ancillary providers, facility providers or professional providers.
22. Services which are submitted by another professional provider of the same specialty for the same services performed on the same date for the same member.
23. Services that are primarily for the convenience of the member, physician, or health care provider or are more costly than alternative services or sequence of services that are clinically appropriate and are likely to produce equivalent therapeutic or diagnostic results to treat the member's illness, injury, or disease.
24. Services rendered by a provider who is a member of your immediate family.
25. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
26. Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care.
27. Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
28. Tobacco cessation drugs and products without a prescription.
29. Services incurred after the date of termination of your coverage, except as provided herein.
30. Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
31. Services for or related to any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.
32. Services that are provided without charge, including services of the clergy.
33. Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that he or she will not owe the required cost-sharing amount (including, for example, deductibles, copays, and coinsurance) described in this plan.
34. Services for or related to acupuncture, except for medically necessary and appropriate acupuncture services for the treatment of chronic pain (defined as a duration of six (6) months); and for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy.
35. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; etc., and all related material and products for these programs.
36. Services for dependents if you have employee-only coverage.
37. Services that are not within the scope of licensure or certification of a provider.
38. Services that are prohibited by law or regulation.
39. Services for furnishing medical records or reports and associated delivery services.
40. Services for transportation, other than local ambulance service, to the nearest medical facility provider that can provide the necessary services/is equipped to treat the condition, except as provided herein.
41. Ambulance transportation costs that exceed the allowable cost from the place of departure to the nearest medical facility that can provide the necessary service/is equipped to treat the condition.
42. Services for or related to therapeutic massage.
43. Services for or related to experimental infertility treatment procedures, surrogacy services, or cryopreservation of eggs or sperm.
44. Charges for donor ova or sperm.
45. Services for or related to preservation, storage, and thawing of human tissue, including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue.

46. Services provided during an e-visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
47. Services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
48. Services and fees for or related to health clubs and spas.
49. Services for or related to the repair of scars and blemishes on skin surfaces.
50. Services for hippotherapy (equine movement therapy).
51. Maintenance services.
52. Services that do not involve direct patient contact such as delivery services and recordkeeping billed by an out-of-network provider.
53. Services for educational classes or programs, except as required by law.
54. Services for or related to functional capacity evaluations for vocational purposes or the determination of disability or pension benefits.
55. Services for or related to gene therapy (for those considered experimental) as a treatment for inherited or acquired disorders.
56. Services for or related to any treatment, equipment, drug, and/or device that does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment; services for or related to homeopathy, or chelation therapy that is not medically necessary and appropriate.
57. Charges for growth hormone replacement therapy, except for services that meet medical necessity and appropriateness criteria.
58. Services for or related to fetal tissue transplantation.

In addition, under your prescription drug benefits, except as specifically provided in this health care plan or as the claims administrator is mandated or required to provide based on state or federal law, no benefits will be provided for:

59. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
60. Charges for over-the-counter drugs, except those set forth in the predefined preventive schedule. Please refer to "Prescription Drugs" for more information.
61. Charges for food supplements.
62. Charges for any drugs prescribed for cosmetic purposes only.
63. Charges for any drugs which are investigative.
64. Prescription drugs, including but not limited to biological products, biosimilars, and gene or cell therapies, that have an alternative drug available similar in safety and effectiveness and is more cost-effective.
65. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
66. Charges for selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
67. Over-the-counter drugs, except as provided herein.

Medical and Behavioral Health Care Management

The claims administrator reviews services to verify that they are medically necessary and appropriate and that the treatment provided is the proper level of care. All applicable terms and conditions of your plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization or admission notification, or emergency admission notification.

Prior authorization and admission notification are required.

If you are admitted to the hospital due to an emergency, admission notification is required as soon as reasonably possible, no later than two (2) business days, following the admission.

Prior Authorization

Prior authorization is a process that involves a benefits review and determination of medical necessity and appropriateness before a service is rendered. The claims administrator's prior authorization list describes the services for which prior authorization is required. The prior authorization list is subject to change due to changes in the claims administrator's medical policy. The claims administrator reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on the claims administrator's website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. They will direct your call.

Participating Providers in Minnesota and Bordering Counties

For services that require prior authorization participating providers in Minnesota and bordering counties are required to obtain prior authorization for you. Participating providers in Minnesota and bordering counties who do not obtain required prior authorization are responsible for the charges (except where other benefit exclusions apply).

Nonparticipating Providers and Participating Providers Located Outside of Minnesota and Bordering Counties

You are required to obtain prior authorization when you use nonparticipating providers and any provider outside of Minnesota/bordering counties. Some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you or not. If prior authorization is not completed and at the point the claim is processed it is found that services received from a nonparticipating provider or any provider outside of Minnesota/bordering counties were not medically necessary and appropriate, you are liable for all of the charges.

The claims administrator prefers that all requests for prior authorization be submitted in writing to ensure accuracy. **Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.**

Standard review process

The claims administrator requires that you or the provider contact them at least 10 working days prior to the provider scheduling the care/services to determine if the services are eligible. The claims administrator will notify you of their decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

Expedited review process

The claims administrator will use an expedited review process when the application of a standard review could seriously jeopardize your life or health or if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, the claims administrator will notify you as expeditiously as the medical condition requires, but no later than 72 hours from the initial request, unless more information is needed to determine whether the requested benefits are covered. If the expedited determination is to not authorize services, you may submit an expedited appeal. Please refer to "Appeals of Adverse Benefit Determinations" for more information about submitting an expedited appeal.

The claims administrator prefers that all requests for prior authorization be submitted to them in writing to ensure accuracy. Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.

Admission Notifications

- **Admission notification** is a process whereby the provider, or you, inform the claims administrator that you will be admitted for inpatient hospitalization or post-acute care services (e.g., long-term acute care, acute rehabilitation, skilled nursing facility, residential treatment or half-way house). The claims administrator requires that you, or your provider, as determined below, call us prior to being admitted, or as soon as reasonably possible, no later than two (2) business days, following the admission.
- **Emergency admission notification** is a process whereby the provider, or you, inform the claims administrator of an unplanned or emergency admission, no later than two (2) business days, following the admission.

Upon receipt of an admission notification, when required, the claims administrator will provide a review of medical necessity and appropriateness related to a specific request for care or services. As needed during an admission, the claims administrator will review the continued stay to determine medical necessity and appropriateness and to help you when you are discharged

You, or your provider, may also be required to obtain prior authorization for the services or procedures done during a hospital stay; for example, an elective surgery that requires you to be admitted to the hospital. Please refer to "Prior Authorization" in this section to determine if you, or your provider, is responsible for obtaining any required prior authorization(s).

Participating Providers

Participating providers in Minnesota and participating providers outside of Minnesota are required to provide admission notification and emergency admission notification for you. You will not be held responsible if notification is not completed when using participating providers.

Nonparticipating Providers

You are required to provide admission notification to the claims administrator if you are going to receive care from any nonparticipating providers. Some of these providers may provide admission notification for you. Verify with your provider if this is a service they will perform for you or not.

To provide admission notification, contact customer service at the telephone number listed on the back of your member ID card. They will direct your call.

Note: If, at the point the claim is processed, it is found that any services received from a nonparticipating provider were not medically necessary and appropriate, you are liable for all the charges.

Medical and Behavioral Health Care Management Overview

The following chart is an overview of the information outlined in the previous section. For more detail, refer to the previous section.

Services received from:	Prior Authorization	Admission Notification	Emergency Admission Notification
Participating Provider Minnesota/Bordering Counties	Provider is responsible to request this for you and the provider must send the request in writing at least 10 working days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission, or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.

Participating Provider Outside of Minnesota/ Bordering Counties	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 working days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.
Nonparticipating Provider Nationwide	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 working days prior to services.	You are responsible for completing the notification and you must call at least 72 hours prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	You are responsible for completing the notification and you must call as soon as reasonably possible, no later than two (2) business days, following the admission.

HOW YOUR PROGRAM WORKS

Your health care plan lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two (2) levels of health care services: **in-network** or **out-of-network.**

In-Network Care

In-network care is care you receive from providers in the health care plan's in-network.

When you receive health care within the in-network, you enjoy maximum coverage and maximum convenience. You present your member ID card to the provider who submits your claim.

Out-of-Network Care

Out-of-network care is care you receive from providers who are not in the in-network.

Even when you go outside the in-network, you will still be covered for eligible services. However, your benefits generally will be paid at the lower, out-of-network level. Additionally, prior authorization may be required from the claims administrator before services are received. For specific details, please refer to "Health Care Management."

Please note that you may incur significantly higher financial liability when you use nonparticipating providers compared to the cost of receiving care from in-network providers. If you receive services from a nonparticipating provider, you will be responsible for any deductibles or coinsurance plus the difference between what the claims administrator would reimburse for the nonparticipating provider and the actual charges the nonparticipating provider bills. This difference does not apply to your out-of-pocket limit. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on the claims administrator's allowed amount, which is typically lower than the amount billed by the provider. In addition, participating facilities may have nonparticipating professionals practicing at the facility and you may be responsible for significantly higher out-of-pocket expenses for the nonparticipating professional services.

Out-of-Area Care

Your health care plan also provides coverage for you and your eligible dependents who are temporarily away from home, or those dependents who permanently reside away from home.

Services received from providers across the country who are part of the local Blue Cross and Blue Shield BlueCard PPO network will be covered at the higher level of benefits. If you receive covered services from a provider who is not part of the local Blue Cross and Blue Shield BlueCard PPO network, these services will be covered at the lower, out-of-network level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic:

- If the illness or injury is a true emergency, it will be covered at the higher benefit level, regardless of whether the provider is in the local Blue Cross and Blue Shield BlueCard PPO network. If the treatment results in an admission, the local Blue Cross and Blue Shield BlueCard PPO network provider must obtain admission notification from the claims administrator. However, it is important that you confirm the claims administrator's determination of medical necessity and appropriateness. If the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, please refer to "Health Care Management."
- If the illness or injury is not an emergency, you are required to use providers in the local Blue Cross and Blue Shield BlueCard PPO network in order to be covered at the higher benefit level. If you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level of benefits.

General Provider Payment Methods

Participating Providers

Several industry-standard methods are used to pay health care providers. If the provider is "participating" they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

Depending upon your health care plan, a participating provider may be an in-network provider or may be an out-of-network provider. Payment will be based upon which network the participating provider is in for your health care plan.

Please refer to "How Your Program Works" for additional detail on covered services received in the in-network and out-of-network.

- Non-Institutional or Professional (i.e., doctor visits, office visits) Participating Provider Payments
  - **Fee-for-Service -** Providers are paid for each service or bundle of services. Payment is based on the amount of the provider's billed charges.
  - **Discounted Fee-for-Service -** Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.
  - **Discounted Fee-for-Service, Withhold and Bonus Payments -** Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5-20%) of the provider's payment is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider's care. In order to determine cost-effectiveness, a per person per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

  In addition, as an incentive to promote high quality care and as a way to recognize those providers that participate in certain quality improvement projects, providers may be paid a bonus based on the quality of the provider's care to its members. In order to determine quality of care, certain factors are measured, such as member/patient satisfaction feedback on the provider, compliance with clinical guidelines for preventive services or specific disease management processes, immunization administration and tracking, and tobacco cessation counseling.

  Payment for high cost cases and selected preventive and other services may be excluded from the discounted fee-for-service and withhold payment. When payment for these services is excluded, the provider is paid on a discounted fee-for-service basis, but no portion of the provider's payment is withheld.
- Institutional (i.e., Hospital and other Facility provider) Participating Provider Payments
  - Inpatient care
    - **Payments for each Case (case rate) -** Providers are paid a fixed amount based upon the member's diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis ("outlier payment"). This method is similar to the payment methodology used by the federal government to pay providers for Medicare services.
    - **Payments for each Day (per diem) -** Providers are paid a fixed amount for each day the member spends in the hospital or facility provider.
    - **Percentage of Billed Charges** - Providers are paid a percentage of the hospital's or facility provider's billed charges for inpatient or outpatient services, including home services.
  - Outpatient care
    - **Payments for each Category of Services** - Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
    - **Payments for each visit** - Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.
    - **Payments for each Patient** - Providers are paid a fixed amount per person per calendar year for certain categories of outpatient services.

Special Incentive Payments

As an incentive to promote high quality, cost-effective care and as a way to recognize that those providers participate in certain quality improvement projects, providers may be paid extra amounts following the initial adjudication of a claim based on the quality of the provider's care to their members and further based on claims savings that the provider may generate in the course of rendering cost-effective care to its member. Certain providers also may be paid in advance of a claim adjudication in recognition of their efficiency in managing the total cost of providing high quality care to members and for implementing quality improvement programs. In order to determine quality of care, certain factors are measured to determine a provider's compliance with recognized quality criteria and quality improvement.

Areas of focus for quality may include, but are not limited to: services for diabetes care; tobacco cessation; colorectal cancer screening; and breast cancer screening, among others. Cost of care is measured using quantifiable criteria to demonstrate that a provider is meeting specific targets to manage claims costs. These quality and cost of care payments to providers are determined on a quarterly or annual basis and will not directly be reflected in a claims payment for services rendered to an individual member. Payments to providers for meeting quality improvement and cost of care goals and for recognizing efficiency are considered claims payment.

Pharmacy Payment

Four (4) kinds of pricing are compared and the lowest amount of the four (4) is paid:

- the average wholesale price of the prescription drug, less a discount, plus a dispensing fee;
- the pharmacy's retail price;
- the maximum allowable cost the claims administrator determines by comparing market prices (for generic drugs only); or,
- the amount of the pharmacy's billed charge.

Nonparticipating Providers

Nonparticipating providers are not network providers. Payment for covered services provided by a nonparticipating provider will be at the out-of-network level. Please refer to "How Your Program Works" for additional detail on covered services received in the in-network and out-of-network.

When you use a nonparticipating provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A nonparticipating provider does not have any agreement with Blue Cross or another Blue Cross and/or Blue Shield plan. For services received from a nonparticipating provider (other than those described under "Special Circumstances" below), the allowed amount will be based upon one of the following payment options to be determined at the claims administrators' discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar service; (2) a percentage, not less than 100%, of the Medicare Advantage Allowed Charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield plan; or, (5) pricing based on: provider reimbursement databases, median costs from a benchmark of claims, or fee negotiations. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than calculated by another payment option. When the Medicare Allowed Charge or Medicare Advantage Allowed Charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator. The allowed amount for a nonparticipating provider is usually less than the allowed amount for a participating provider for the same service and can be significantly less than the nonparticipating provider's billed charges. You will be paid the benefit under the health care plan and you are responsible for paying the nonparticipating provider. The only exception to this is stated in "Claims Procedures," "Claims Payment." The amount you pay does not apply toward any out-of-pocket limit contained in the plan.

In determining the allowed amount for nonparticipating providers, the claims administrator makes no representations that the allowed amount is a usual, customary or reasonable charge from a provider. Please refer to "Allowed Amount" under "Terms You Should Know" for a more complete description of how payments will be calculated for services provided by nonparticipating providers.

Example

The following table illustrates the different out-of-pocket costs you may incur using nonparticipating versus participating providers. The example presumes that your deductible has been satisfied and that the health care plan covers 80% for participating providers and 60% for nonparticipating providers. It also presumes that the allowed amount for a nonparticipating provider will be less than for a participating provider. The difference in the allowed amount between a Participating and nonparticipating provider could be more or less than the 20% difference in the example below.

	Participating Provider	Nonparticipating Provider
Provider charge:	$150	$150
Allowed amount:	$100	$80
Claims administrator pays:	80% ($80)	60% ($48)
Coinsurance you owe:	20% ($20)	40% ($32)
Difference up to billed charge you owe:	None	$70 ($150 minus $80)
You pay:	$20	$102

Special Circumstances

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care. For example, some hospital-based providers (e.g., anesthesiologists) or independent laboratory providers may not be participating providers. Typically, when you receive care from nonparticipating providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care such as in a participating hospital and were not able to choose the provider who rendered such care (nonparticipating providers in a participating hospital or your physician sending laboratory samples to a nonparticipating lab), Minnesota law provides that you may not be responsible for any amounts above what would have been required to pay (such as cost-sharing and deductibles) had you used a participating provider, unless you gave advance written consent to the nonparticipating provider. If you receive a bill from a nonparticipating provider while using a participating hospital or facility, and you did not provide written consent to receive the nonparticipating provider's services, you should submit the bill to the claims administrator for processing. If you have questions, please contact customer service at the telephone number listed on the back of your member ID card. The extent of reimbursement in certain medical emergency circumstances may also be subject to state and federal law – please refer to "Emergency Care" for coverage of benefits.

The above is a general summary of our provider payment methodologies only. Further, while efforts are made to keep this form as up-to-date as possible, provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary.

Please note that some of these payment methodologies may not apply to your particular plan.

Women's Health and Cancer Rights Act

Under the federal Women's Health and Cancer Rights Act of 1998 and Minnesota law, you are entitled to the following services:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prosthesis and physical complications at all stages of mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and patient.

Coverage may be subject to annual deductible, copay, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

Coverage of Health Care Services on the Basis of Gender

Federal law prohibits denying or limiting health services, that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Eligible, covered services must be medically necessary and appropriate, and remain subject to any requirements outlined in the claims administrator's medical policy and/or federal law.

Inter-Plan Arrangements

Out-of-Area Services

Overview

The claims administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These inter-plan arrangements work based on rules and

procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area the claims administrator serves, the claim for those services may be processed through one of these inter-plan arrangements. The inter-plan arrangements are described below.

When you receive care outside of the claims administrator's service area, you will receive it from one of two (2) kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. The claims administrator explains below how the claims administrator pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through inter-plan arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the plan administrator to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive covered health care services within the geographic area served by a Host Blue, the claims administrator will remain responsible for doing what the claims administrator agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Whenever you receive covered health care services outside the claims administrator's service area and the claim is processed through the BlueCard program, the amount you pay for covered health care services is calculated based on the lower of:

- the billed charges for covered services; or,
- the negotiated price that the Host Blue makes available to the claims administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the claims administrator has used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered health care services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to the claims administrator through average pricing or fee schedule adjustments. Additional information is available upon request.

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

If the claims administrator has entered into a Negotiated Arrangement with a Host Blue to provide value-based programs to employer on your behalf, the claims administrator will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard program.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the claims administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside the Claims Administrator's Service Area

Member Liability Calculation

When covered health care services are provided outside of the claims administrator's service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating

provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment the claims administrator will make for the covered health care services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health care services. Blue Cross Blue Shield Global Core is unlike the BlueCard program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered health care services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the claims administrator, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week.

Out-of-Country Benefits

Eligible services coordinated through the Blue Cross Blue Shield Global Core program (please refer to "Inter-Plan Arrangements," "Blue Cross Blue Shield Global Core") will process at the network level of coverage.

Call the Blue Cross Blue Shield Global Core service center within 24 hours of a medical emergency at 1-804-673-1177. You will be advised by the service center if services are not eligible under this program.

If you do not call the Blue Cross Blue Shield Global Core service center or services are not eligible under this program, eligible services will process at the out-of-network level of benefits.

Services not covered under the plan will not be considered for benefits.

Your Provider Network

Your provider network is your key to receiving the higher level of benefits. The network includes: thousands of physicians; a wide range of specialists; a wide variety of mental health and substance use disorder providers; community and specialty hospitals; and laboratories in the health care plan service area.

To determine if your physician is in-network, call the customer service toll-free telephone number listed on the back of your member ID card.

Getting your care "through the network" also assures you get quality care. All physicians are carefully evaluated before they are accepted into the network. The claims administrator considers educational background, office procedures and

performance history to determine eligibility. Then the claims administrator monitors care on an ongoing basis through office record reviews and member satisfaction surveys.

Please note that while you or a family member can use the services of any in-network physician or specialist without a referral and receive the maximum coverage under your health care plan, you are encouraged to select a personal physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Remember:
If you want to enjoy the higher level of benefits, it is *your* responsibility to ensure that you receive in-network care. You may want to double-check any provider recommendations to make sure the doctor or facility provider is in-network. Your provider directory lists in-network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is an in-network provider for your particular plan. Not every provider is an in-network provider for every plan. For a list of providers in the directory, visit www.bluecrossmnonline.com ("Member Log in" then "Find a Doctor") or call the customer service toll-free telephone number listed on the back of your member ID card. For benefit information, please refer to "Benefit Overview."

How to Get Your Physicians' Professional Qualifications

To view Board Certification information, hospital affiliation or other professional qualifications of your provider, visit your member website at www.bluecrossmnonline.com, or contact customer service at the telephone number listed on the back of your member ID card.

In-Network Pharmacies

- **Retail Pharmacy:** Participating retail pharmacies have an arrangement with the claims administrator to provide prescription drugs to you at an agreed upon price. When you purchase covered prescription drugs from an in-network pharmacy applicable to your health care plan, present your prescription and ID card to the pharmacist. (Prescriptions that the pharmacy receives by telephone from your physician or dentist may also be covered.) You should request and retain a receipt for any amounts you have paid if needed for income tax or any other purpose.

  If you travel within the United States and need to refill a prescription, contact customer service at the telephone number listed on the back of your member ID card for help. They can help you find an in-network pharmacy near the area you are visiting. You also can use the member website to find a pharmacy. Once you have the name and address of the in-network pharmacy, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill process. **Note: Save the new medicine container. This will make it easier to transfer the prescription back to your pharmacy at home.**

- **90dayRx:** 90dayRx Pharmacy includes 90dayRx participating retail pharmacy and Mail Order Pharmacy. This option offers savings and convenience for prescriptions you may take on an ongoing, long-term basis.
  - To utilize a 90dayRx participating retail pharmacy, verify that your pharmacy participates in the network and present your prescription for a 90-day fill of the eligible prescription medication.
  - To start using mail order pharmacy:
    - Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year, if appropriate.
      - Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling customer service or from your member website. After logging in, click on "Fill Rx" at the top of the home page. Then click on "Health & Benefits Information" and select the "Print Forms" link.

    Send the completed forms and your payment to the address listed on the mail order form. It usually takes about five (5) days to get your prescription after it has been processed. Your mail order will include directions for ordering refills.

- **Specialty Pharmacy Network Supplier:** The specialty pharmacy network supplier has an agreement, with the claims administrator pertaining to the payment and exclusive dispensing of selected specialty prescription drugs provided to you. Please refer to "Specialty Drugs" in "Terms You Should Know" for a list of the selected specialty prescription drug categories.

Continuity of Care

Continuity of Care for New Members

If you are a member of a group that is new to the claims administrator, this section applies to you. If you are currently receiving care from an out-of-network physician or specialist, you may request to continue to receive care from this physician for a special medical need or condition for a reasonable period of time before transferring to an in-network physician as required under the terms of your coverage under the health care plan. The claims administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician, advanced practice nurse, or physician assistant certifies that your life expectancy is 180 days or less. The claims administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:
1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or,
6. are receiving services from a provider that speaks a language other than English.

Continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

Transition to In-network Providers

The claims administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the claims administrator's prior authorization requirements and 2) provide the claims administrator with necessary medical information related to your care.

Continuity of Care does not apply to services that are not covered under the health care plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one plan to another.

Provider Termination for Cause

If it is known that the claims administrator has terminated its relationship with your provider for cause, the claims administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

Continuity of Care for Current Members

If you are a current member or dependent, this section applies to you. If the relationship between your in-network clinic or physician and the claims administrator ends, rendering your clinic or provider out-of-network, and the termination was by the claims administrator and was not for cause, you may request to continue to receive care for a special medical need or condition for a reasonable period of time before transferring to an participating provider as required under the terms of your coverage under the health care plan. The claims administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician, advanced practice nurse, or physician assistant certifies that your life expectancy is 180 days or less. The claims administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:
1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or,

6. are receiving services from a provider that speaks a language other than English.

Continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

Transition to In-network Providers

The claims administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the claims administrator's prior authorization requirements and 2) provide the claims administrator with necessary medical information related to your care.

Continuity of Care does not apply to services that are not covered under the health care plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one plan to another.

Provider Termination for Cause

If it is known that the claims administrator has terminated its relationship with your provider for cause, the claims administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

Plan Administration

Plan Administrator

The general administration of the health care plan and the duty to carry out its provisions is vested in the employer. The board of directors will perform such duties on behalf of the employer, provided it may delegate such duty or any portion thereof to a named person, including employees and agents of the employer, and may from time to time revoke such authority and delegate it to another person. Any delegation of responsibility must be in writing and accepted by the designated person. Notwithstanding any designation or delegation of final authority with respect to claims, the plan administrator generally has final authority to administer the health care plan.

Powers and Duties of the Plan Administrator

The plan administrator will have the authority to control and manage the operation and administration of the health care plan. This will include all rights and powers necessary or convenient to carry out its functions as plan administrator. Without limiting that general authority, the plan administrator will have the express authority to:

1. construe and interpret the provisions of the health care plan and decide all questions of eligibility;
2. prescribe forms, procedures, policies, and rules to be followed by you and other persons claiming benefits under the health care plan;
3. prepare and distribute information to you explaining the health care plan;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the health care plan;
5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the health care plan; and
6. retain such actuaries, accountants, consultants, third party administration service providers, legal counsel, or other specialists, as it may deem appropriate or necessary for the effective administration of the health care plan.

Actions of the Plan Administrator

The plan administrator may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the plan administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the health care plan, except with respect to claim determinations where final authority has been delegated to the claims administrator. All rules and decisions of the plan administrator will be uniformly and consistently applied so that all individuals who are similarly situated will receive substantially the same treatment.

The plan administrator or the employer may contract with one (1) or more service agents, including the claims administrator, to assist in the handling of claims under the health care plan and/or to provide advice and assistance in the general administration of the health care plan. Such service agent(s) may also be given the authority to make payments of benefits under the health care plan on behalf of and subject to the authority of the plan administrator. Such service agent(s) may also be given the authority to determine claims in accordance with procedures, policies, interpretations, rules, or practices made, adopted, or approved by the plan administrator.

Nondiscrimination

The health care plan shall not discriminate in favor of "highly compensated employees" as defined in Section 105(h) of the Internal Revenue Code, as to eligibility to participate or as to benefits.

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:00 a.m. United States Central Time and ends at 12:00 a.m. United States Central Time the following day.

Termination or Changes to the Plan

No agent can legally change the health care plan or waive any of its terms.

The employer reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to terminate, modify or amend, in whole or in part, any or all provisions of the health care plan, provided, however that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the health care plan. Any amendment to this health care plan may be effected by a written resolution adopted by the plan administrator. The plan administrator will communicate any adopted changes to the employees.

Funding

This plan is a self-insured medical plan funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the claims administrator. Your contributions toward the cost of coverage under the health care plan will be determined by the employer each year. The claims administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The claims administrator's payment of claims is contingent upon the plan administrator continuing to provide sufficient funds for benefits.

Controlling Law

Except as they may be subject to federal law, including ERISA, any questions, claims, disputes, or litigation concerning or arising from the health care plan will be governed by the laws of the State of Minnesota.

Fraudulent Practices

Coverage for you or your dependent will be terminated if you or your dependent engage in fraud of any type, including, but not limited to, submitting fraudulent misstatements about your medical history or eligibility status on the application for coverage; submitting fraudulent, altered, or duplicate billings for personal gain; and/or allowing another party not eligible for coverage under the health care plan to use your or your dependent's coverage.

Payments Made in Error

Payments made in error or overpayments may be recovered by the claims administrator as provided by law or equity. This includes the right to recoup from any future benefits to be paid to or on behalf of you or your eligible dependents. Payment made for a specific service or erroneous payment shall not make the claims administrator or the plan administrator liable for further payment for the same service.

Your claims may be reprocessed due to errors in the allowed amount paid to network providers, out-of-network participating providers, or nonparticipating providers. Claim reprocessing may result in changes to the amount you paid at the time your claim was originally processed.

Liability for Health Care Expenses

Charges That Are Your Responsibility

In-Network Providers

When you use in-network providers for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

1. deductibles and coinsurance;
2. copays;
3. charges that exceed the benefit maximum; and
4. charges for services that are not covered.

Out-of-Network Providers

Out-of-Network Participating Providers

When you use out-of-network participating providers for covered services, payment is based on the allowed amount. You may not be required to pay for charges that exceed the allowed amount. All out-of-network participating providers in Minnesota accept the claims administrator's payment based on the allowed amount. Most out-of-network participating providers outside Minnesota accept the claims administrator's payment based on the allowed amount. However, contact your out-of-network participating provider outside Minnesota to verify if they accept the claims administrator's payment based on the allowed amount (to determine if you will have additional financial liability). You are required to pay the following amounts:

1. charges that exceed the allowed amount if the out-of-network participating provider outside Minnesota does not accept the claims administrator's payment based on the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum; and
5. charges for services that are not covered.

Nonparticipating Providers

When you use nonparticipating providers for covered services, payment is still based on the allowed amount. However, because a nonparticipating provider has not entered into a network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan, the nonparticipating provider is not obligated to accept the allowed amount as payment in full. This means that you may have substantial out-of-pocket expense when you use a nonparticipating provider. You are required to pay the following amounts:

1. charges that exceed the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum;
5. charges for services that are not covered including services that the claims administrator determined are not covered based on claims coding guidelines; and
6. charges for services that are investigative or not medically necessary and appropriate.

Medical Policy Committee and Medical Policies

The claims administrator applies medical policies in order to determine benefits consistently for members. Internally developed policies are subject to approval by the claims administrator's Medical Policy Committee, which consists of independent community physicians who represent a variety of medical specialties as well as a clinical psychologist and pharmacist. The remaining policies are approved by other external specialists. For all policies, the claims administrator's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. From time-to-time, new medical policies may be created or existing medical policies may change. Covered benefits will be determined in accordance with the claims administrator's policies in effect at the time treatment is rendered or, if applicable, prior authorization may also be required. Internally developed medical policies can be found at the member website. All medical policies are available upon request.

Who is Eligible

Please refer to the plan administrator for employee/dependent eligibility criteria.

Special Enrollment Periods

Special enrollment periods are periods when an eligible employee or dependent may enroll in the health plan under certain circumstances **after they were first eligible for coverage**. In order to enroll the eligible employee or dependent **must notify the claims administrator within 30 days** of the triggering event, unless otherwise noted below. If you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order you must request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Coverage will be made effective in accordance with applicable regulatory requirements. The eligible circumstances are:

Special Enrollment Triggering Event
Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or rescission): • loss of eligibility for employer-sponsored coverage • plan no longer offers benefits • termination of all employer contributions • termination of employment or reduction in hours • legal separation or divorce • loss of dependent child status • death of employee • move outside HMO or ACO service area • exceeding the plan's lifetime maximum • employer bankruptcy • COBRA exhaustion • employee becomes entitled to Medicare
Minimum Essential Coverage includes coverage under specified government sponsored plans (including Medicare and Medicaid), employer-sponsored coverage, individual market policies, grandfathered coverage, and other coverage recognized by the secretary of the U.S. Department of Health and Human Services.
Gaining or becoming a dependent due to marriage.

Special Enrollment Triggering Event
Gaining a dependent due to birth, adoption, placement for adoption, or placement for foster care.
An individual who loses or gains eligibility for medical assistance (Medicaid) or Children's Health Insurance Program (CHIP) must notify the claims administrator within 60 days.
Child support order or other court order to provide coverage.

Changes in Membership Status

For the health care plan to administer consistent coverage for you and your dependents, you must keep your Employee Benefit Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Leave of Absence or Layoff

Upon your return to work following a leave of absence or layoff that continued beyond the period of your coverage, your employer may, in some cases, allow you to resume your coverage. You should consult with your plan administrator/employer to determine whether your group health care plan has adopted such a policy.

Termination of Your Coverage

Coverage ends on the earliest of the following dates:

1. For you and your dependents, the date on which the health care plan terminates.
2. For you and your dependents, the On the day following the last day the Member is an Employee of the Group:
    a. required charges for coverage were paid, if payment is not received when due. Your payment of charges to the employer does not guarantee coverage unless the claims administrator receives full payment when due. If the claims administrator terminates coverage for all employees in the health care plan for nonpayment of the charges, the claims administrator will give all employees a 30 day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months.
    b. you are no longer eligible.
    c. you enter military service for duty lasting more than 31 days.
    d. you request that coverage be terminated.
    e. you retire.
3. For the spouse, the date the spouse is no longer eligible for coverage. This is the On the day following the last day the Member is an Employee of the Group the employee and spouse divorce or legally separate or terminate their civil union.
4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the On the day following the last day the Member is an Employee of the Group:
    a. a covered stepchild is no longer eligible because the employee and spouse divorce or legally separate.
    b. a covered dependent is no longer eligible because the employee and civil union spouse terminate their civil union.
    c. the dependent child reaches the dependent-child age limit.
    d. the disabled dependent is no longer eligible.

Extension of Benefits

If you or your dependent is confined as an inpatient on the date coverage ends due to the replacement of the claims administrator, the health care plan will automatically extend coverage until the date you or your dependent is discharged from the facility or the date plan maximums are reached, whichever is earlier. Coverage is extended only for the person who is confined as an inpatient, and only for inpatient charges incurred during the admission. For purposes of this provision, "replacement" means that the administrative service agreement with the claims administrator has been terminated and your employer maintains continuous group coverage with a new claims administrator or insurer.

Continuation of Coverage

You or your covered dependents may continue this coverage if coverage ends due to one of the qualifying events listed below. You and your eligible dependents must be covered on the day before the qualifying event in order to continue coverage.

Qualifying Events

If you are the ***employee*** and are covered, you have the right to elect continuation coverage if you lose coverage because of any one (1) of the following qualifying events:

- Voluntary or involuntary termination of your employment (for reasons other than gross misconduct).
- Reduction in the hours of your employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment).

If you are the ***spouse/ex-spouse*** of a covered ***employee***, you have the right to elect continuation coverage if you lose coverage because of any of the following qualifying events:

- The death of the ***employee***.
- A termination of the ***employee's*** employment (as described above) or reduction in the ***employee's*** hours of employment.
- Entering of decree or judgment of divorce or legal separation from the ***employee***. (This includes if the ***employee*** terminates your coverage in anticipation of the divorce or legal separation. A later divorce or legal separation is considered a qualifying event even though you lost coverage earlier. You must notify the plan administrator within 60 days after the later divorce or legal separation and establish that your coverage was terminated in anticipation of the divorce or legal separation. Continuation coverage may be available for the period after the divorce or legal separation.)
- The ***employee*** becomes enrolled in Medicare.

A ***dependent child*** of a covered ***employee*** has the right to elect continuation coverage if he or she loses coverage because of any of the following qualifying events:

- The death of the ***employee***.
- The termination of the ***employee's*** employment (as described above) or reduction in the ***employee's*** hours of employment with the employer.
- Parents' divorce or legal separation.
- The ***employee*** becomes enrolled in Medicare.
- The dependent ceases to be a "dependent child" under this plan.

Your Notice Obligations

You and your dependents must notify the employer of any of the following events within 60 days of the occurrence of the event:

- divorce or legal separation; or,
- a dependent child no longer meets the health care plan's eligibility requirements.

If you or your dependents do not provide this required notice, any dependent who loses coverage is NOT eligible to elect continuation coverage. Furthermore, if you or your dependents do not provide this required notice, you or your dependent must reimburse any claims mistakenly paid for expenses incurred after the date coverage actually terminates.

Note: Disability Extensions also require specific notice. See below for these notification requirements.

When you notify the employer of a divorce, legal separation, or a loss of dependent status, the employer will notify the affected family member(s) of the right to elect continuation coverage. If you notify the employer of a qualifying event or disability determination and the employer determines that there is no extension available, the employer will provide an explanation as to why you or your dependents are not entitled to elect continuation coverage.

Employer's and Plan Administrator's Notice Obligations

The employer has 30 days to notify the plan administrator of events they know have occurred, such as termination of employment or death of the ***employee***. This notice to the plan administrator does not occur when the plan administrator is the ***employer.*** After plan administrators are notified of the qualifying event, they have 14 days to send the qualifying event notice. Qualified beneficiaries have 60 days to elect continuation coverage. The 60-day time frame begins on the date coverage ends due to the qualifying event or the date of the qualifying event notice, whichever is later.

The employer will also notify you and your dependents of the right to elect continuation coverage after receiving notice

that one of the following events occurred and resulted in a loss of coverage: the ***employee's*** termination of employment (other than for gross misconduct), reduction in hours, death, or the ***employee's*** becoming enrolled in Medicare.

Election Procedures

You and your dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after the plan administrator provides you or your family member with notice of the right to elect continuation coverage. If you or your dependents do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.

You or your dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, a spouse/ex-spouse may not decline coverage for the other spouse/ex-spouse and a parent cannot decline coverage for a non-minor dependent child who is eligible to continue coverage. In addition, a dependent may elect continuation coverage even if the covered ***employee*** does not elect continuation coverage.

You and your dependents may elect continuation coverage even if covered under another employer-sponsored group health plan or enrolled in Medicare.

How to Elect

Contact the employer to determine how to elect continuation coverage.

Type of Coverage

Generally, continuation coverage is the same coverage that you or your dependent had on the day before the qualifying event. Anyone who is not covered under the health care plan on the day before the qualifying event is generally not entitled to continuation coverage. Exceptions include: 1) when coverage was eliminated in anticipation of a divorce or legal separation, the later divorce or legal separation is considered a qualifying event even though the ex-spouse/spouse lost coverage earlier; and 2) a child born to or placed for adoption with the covered ***employee*** during the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary's maximum continuation period.

Qualified beneficiaries are provided the same rights and benefits as similarly-situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly-situated active employees or their dependents, then continuation coverage will be modified in the same way. Examples include: 1) If the employer offers an open enrollment period that allows active employees to switch between plans without being considered late entrants, all qualified beneficiaries on continuation are allowed to switch plans as well; and 2) If active employees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage, qualified beneficiaries who get married while on continuation are afforded this same right.

Maximum Coverage Periods

Continuation coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of Continuation Coverage Before the End of the Maximum Coverage Period." In other instances, the maximum coverage period can be extended as described under the heading "Extension of Maximum Coverage Periods."

18 Months. If you or your dependent loses coverage due to the ***employee's*** termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the first of the month following termination or reduction in hours.

36 Months. If a dependent loses coverage because of the ***employee's*** death, divorce, legal separation, the ***employee*** became enrolled in Medicare or because of a loss of dependent status under the health care plan, then the maximum coverage period (for spouse and dependent child) is three (3) years from the date of the qualifying event.

Continuation Premiums

Premiums for continuation can be up to the group rate plus a two (2) percent administration fee. In the event of a dependent's disability, the premiums for continuation for the employee and dependents can be up to 150 percent of the group rate for months 19-29 if the disabled dependent is covered. All premiums are paid directly to the employer.

Extension of Maximum Coverage Periods

Maximum coverage periods of 18 or 36 months can be extended in certain circumstances.

- ***Disability Extension***: This extension is applicable when the qualifying event is the ***employee's*** termination of

employment or reduction of hours, and the extension applies to all qualified beneficiaries. If you or your dependent who is a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of continuation, then the continuation period for all qualified beneficiaries is extended to 29 months from the date coverage terminated.

Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the plan administrator of the SSA disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the ***employee's*** termination of employment or reduction of hours; 3) the date on which the qualified beneficiary loses (or would lose) coverage under the health care plan as a result of the qualifying event; and 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the administrator. **Notice Obligation:** The qualified beneficiary must notify the plan administrator of the Social Security disability determination before the end of the 18-month period following the qualifying event (the ***employee's*** termination of employment or reduction of hours).

Notice Obligation: If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the plan administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of: 1) the first day of the month following 30 days after a final determination by the SSA that the formerly disabled qualified beneficiary is no longer disabled; or, 2) the end of the coverage period that applies without regard to the disability extension.

- ***Multiple Qualifying Events***: This extension is applicable when the initial qualifying event is the ***employee's*** termination of employment or reduction of hours and is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month maximum coverage period (i.e., death of the ***employee,*** divorce, legal separation, the ***employee*** becoming enrolled in Medicare or a dependent child losing dependent status). The extension applies to the ***employee's*** dependents who are qualified beneficiaries.

  When a second qualifying event occurs that gives rise to a 36-month maximum coverage period for the dependent, the maximum coverage period (for the dependent) becomes three (3) years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the plan administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension will occur.

- ***Pre-Termination or Pre-Reduction Medicare Enrollment:*** This extension applies when the qualifying event is the reduction of hours or termination of employment that occurs within 18 months after the date of the ***employee's*** Medicare enrollment. The extension applies to the ***employee's*** dependents who are qualified beneficiaries.

  If the qualifying event occurs within 18 months after the ***employee*** becomes enrolled in Medicare, regardless of whether the ***employee's*** Medicare enrollment is a qualifying event (causing a loss of coverage under the health care plan), the maximum period of continuation for the ***employee's*** dependents who are qualified beneficiaries is three (3) years from the date the ***employee*** became enrolled in Medicare. Example: ***employee*** becomes enrolled in Medicare on January 1. ***Employee's*** termination of employment is May 15. The ***employee*** is entitled to 18 months of continuation from the date coverage is lost. The ***employee's*** dependents are entitled to 36 months of continuation from the date the ***employee*** is enrolled in Medicare.

  If the qualifying event is more than 18 months after Medicare enrollment, is the same day as the Medicare enrollment, or occurs before Medicare enrollment, no extension is available.

- ***Employer's Bankruptcy****:* The bankruptcy rule, technically, is an initial qualifying event rather than an extending rule. However, because it would result in a much longer maximum coverage period than 18 or 36 months, it is included here. If the employer files Chapter 11 bankruptcy, it may trigger COBRA coverage for certain retirees and their related qualified beneficiaries. A retiree is entitled to coverage for life. The retiree's spouse and dependent children are entitled to coverage for the life of the retiree, and if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's spouse is covered by the health care plan, then that surviving spouse is entitled to coverage for life.

Termination of Continuation Coverage Before the End of Maximum Coverage Period

Continuation coverage of the ***employee*** and dependents will automatically terminate when any one of the following events occur:

- The employer no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due.

- After electing continuation, you or your dependents become covered under another group health plan that has an exclusion or limitation with respect to any preexisting condition that you have. Your continuation coverage will terminate after any applicable exclusion or limitation no longer applies.
- After electing continuation coverage, you or your dependent becomes entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
- If during a 29-month maximum coverage period due to disability, the SSA makes the final determination that the qualified beneficiary is no longer disabled.
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered ***employees*** or their dependents whether or not they are on continuation coverage.
- Voluntarily canceling your continuation coverage.

When termination takes effect earlier than the end of the maximum period of continuation coverage, a notice will be sent from the plan administrator. The notice will contain the reason continuation coverage has been terminated, the date of the termination, and any rights to elect alternative coverage that may be available.

Children Born to or Placed for Adoption with the Covered Employee During Continuation Period

A child born to, adopted by or placed for adoption with a covered ***employee*** during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered ***employee*** is a qualified beneficiary and has elected continuation coverage for himself/herself. The child's continuation coverage begins on the date of birth, adoption or placement for adoption as outlined in "Who is Eligible," and it lasts for as long as continuation coverage lasts for other family members of the ***employee***.

Open Enrollment Rights and Special Enrollment Rights

Qualified beneficiaries who have elected continuation will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. Special enrollment rights apply to those who have elected continuation. Except for certain children described above, dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries - their coverage will end at the same time that coverage ends for the person who elected continuation and later added them as dependents.

Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes

If your or your dependents address changes, you *must* notify the plan administrator in writing so the plan administrator may mail you or your dependent important continuation notices and other information. Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the terms of the health care plan, you or your dependent *must* notify the plan administrator in writing. In addition, you must notify the plan administrator if a disabled ***employee*** or family member is no longer disabled.

Special Second Election Period

Special continuation rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect continuation coverage for themselves and certain family members (if they did not already elect continuation coverage) during a special second election period. This election period is the 60-day period beginning on the first day of the month in which an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within six (6) months of losing coverage. Please contact the plan administrator for additional information.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustments assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under USERRA. This continuation right runs concurrently with your continuation right under COBRA and allows you to extend an 18-month continuation period to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the Commissioned Corps of the Public Health Services and any other category of persons designated by the President of

the United States.

Questions

If you have general questions about continuation of coverage, please call the telephone number on the back of your identification card for assistance.

Overview

The following chart is an overview of the information outlined in the previous section. For more detail, please refer to the previous section.

Qualifying Event/Extension	Who May Continue	Maximum Continuation Period
Employment ends (for reasons other than gross misconduct) Reduction in hours of employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment)	Employee and dependents	Earlier of: 1. 18 months, or 2. Enrollment date in other group coverage.
Divorce or legal separation	Ex-spouse/spouse who was covered on the day before the entry of a valid decree of dissolution or marriage and any dependent children that lose coverage	Earlier of: 1. 36 months; or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Death of employee	Surviving spouse and dependent children	Earlier of: 1. 36 months; or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end if the employee had lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to the employee's enrollment in Medicare	All dependents	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Retirees of the employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree	Lifetime continuation.
	Dependents	Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Extensions to 18-month maximum continuation period: Disability, as determined by the Social Security Administration, of employee or dependent(s)	Disabled individual and all other covered family members	Earliest of: 1. 29 months after the employee leaves employment, or 2. Date total disability ends, or 3. Date coverage would otherwise end.

Coordination of Benefits

This section applies when you have health care coverage under more than one (1) plan, as defined below. If this section applies, you should look at the Order of Benefits Rules first to determine which plan determines benefits first. Your benefits under this plan are not reduced if the Order of Benefits Rules require this plan to pay first. Your benefits under this plan may be reduced if another plan pays first.

Definitions

These definitions apply only to this section.

1. "Plan" is any of the following that provides benefits or services for, or because of, medical or dental care or treatment:
   a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage;
   b. coverage under a government plan or one required or provided by law;
   c. individual coverage; or,
   d. the medical payment ("medpay") or personal injury protection benefit available to you under an automobile insurance policy.

   "Plan" does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). "plan" does not include any benefits that, by law, are excess to any private or other nongovernmental program.

   "Plan" does not include hospital indemnity, specified accident, specified disease, or limited benefit insurance policies.

   Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two (2) parts and this section applies only to one (1) part, each of the parts is a separate plan.
2. "This plan" means the part of the plan document that provides health care benefits.
3. "Primary plan/secondary plan" is determined by the Order of Benefits Rules.

   When this plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

   When you are covered under more than two (2) plans, this plan may be a primary plan as to some plans, and may be a secondary plan as to other plans.

   a. NOTES: If you are covered under this plan and Medicare: this plan will comply with the Medicare Secondary Payor ("MSP") provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which plan is a primary plan and which is a Secondary plan. Medicare will be primary and this plan will be secondary only to the extent permitted by MSP rules. When Medicare is the primary plan, this plan will coordinate benefits up to Medicare's allowed amount.
   b. If you are covered under this plan and TRICARE: this plan will comply with the TRICARE provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which plan is a primary plan and which is a secondary plan. TRICARE will be primary and this plan will be secondary only to the extent permitted by TRICARE rules. When TRICARE is the primary plan, this plan will coordinate benefits up to TRICARE'S allowed amount.
4. "Allowable expense" means the necessary, reasonable, and customary item of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. "Allowable expense" does not include an item of expense that exceeds benefits that are limited by statute or this plan. "Allowable expense" does not include outpatient prescription drugs, except those eligible under Medicare (see number 3 above).

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.
5. "Claim determination period" means a calendar year. However, it does not include any part of a year the person is not covered under this plan, or any part of a year before the date this section takes effect.

Order of Benefits Rules

1. General: When a claim is filed under this plan and another plan, this plan is a Secondary plan and determines benefits after the other plan, unless:
   a. the other plan has rules coordinating its benefits with this plan’s benefits; and

b. the other plan's rules and this plan's rules, in part 2. below, require this plan to determine benefits before the other plan.

2. Rules: This plan determines benefits using the first of the following rules that applies:
   a. The plan that covers a person as automobile insurance medical payment ("medpay") or personal injury protection coverage determines benefits before a plan that covers a person as a group health plan enrollee.
   b. Non-dependent/dependent: The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.
   c. Dependent child of parents not separated or divorced: When this plan and another plan cover the same child as a dependent of different persons, called "parents":
      1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but,
      2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

      However, if the other plan does not have this rule for children of married parents, and instead the other plan has a rule based on the gender of the parent, and if as a result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.
   d. Dependent child of parents divorced or separated: If two (2) or more plans cover a dependent child of divorced or separated parents, this plan determines benefits in this order:
      1) first, the plan of the parent with physical custody of the child;
      2) then, the plan that covers the spouse of the parent with physical custody of the child;
      3) finally, the plan that covers the parent not having physical custody of the child; or,
      4) in the case of joint physical custody, c. above applies.

      However, if the court decree requires one (1) of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.
   e. Active/inactive employee: The plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) determines benefits before a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.
   f. Longer/shorter length of coverage: If none of the above determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for a shorter time.

Effect on Benefits of This Health Care Plan

When this section applies:

1. When the Order of Benefits Rules require this health care plan to be a secondary plan, this part applies. Benefits of this health care plan may be reduced.
2. Reduction in this plan's benefits may occur under circumstances such as the following:

   When the sum of:
   a. the benefits payable for allowable medical expenses under this health care plan, without applying coordination of benefits, and,
   b. the benefits payable for allowable medical expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made, exceed those allowable medical expenses in a claim determination period. In that case, the benefits of this health care plan are reduced so that benefits payable under all plans do not exceed allowable medical expenses.

   When medical benefits of this health care plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of this health care plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. The claims administrator has the right to decide which facts are needed. The claims administrator may get needed facts from, or give them to, any other organization or person. They do not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts needed to pay the claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If this

happens, this plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under this plan. This plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If this plan pays more than it should have paid under these coordination of benefit rules, this plan may recover the excess from any of the following:

1. the persons this plan paid for whom this plan has paid;
2. insurance companies; and
3. other organizations.

The amount paid includes the reasonable cash value of any benefits provided in the form of services.

Reimbursement and Subrogation

This plan maintains both a right of reimbursement and a separate right of subrogation**. As an express condition of your participation in this plan, you agree that the health care plan has the subrogation rights and reimbursement rights explained below.**

The Health Care Plan's Right of Subrogation

If you or your dependents receive benefits under this plan arising out of an illness or injury for which a responsible party is or may be liable, this plan shall be subrogated to your claims and/or your dependents' claims against the responsible party.

Obligation to Reimburse the Health Care Plan

You are obligated to reimburse the health care plan in accordance with this provision if the health care plan pays any benefits and you, or your dependent(s), heirs, guardians, executors, trustees, or other representatives recover compensation or receive payment related in any manner to an illness, accident or condition, regardless of how characterized, from a responsible party, a responsible party's insurer or your own (first party) insurer. You must reimburse the health care plan for 100 percent of benefits paid by the health care plan before you or your dependents, including minors, are entitled to keep or benefit by any payment, regardless of whether you or your dependent has been fully compensated and regardless of whether medical or dental expenses are itemized in a settlement agreement, award or verdict.

You are also obligated to reimburse the health care plan from amounts you receive as compensation or other payments as a result of settlements or judgments, including amounts designated as compensation for pain and suffering, non-economic damages and/or general damages. The health care plan is entitled to recover from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured motorist's plan, a homeowner's plan, a renter's plan, or a liability plan) that is or may be liable for:

1. the accident, injury, sickness, or condition that resulted in benefits being paid under the health care plan; and/or,
2. the medical, dental, and other expenses incurred by you or your dependents for which benefits are paid or will be paid under the health care plan.

Until the health care plan has been fully reimbursed, all payments received by you, your dependents, heirs, guardians, executors, trustees, attorneys or other representatives in relation to a judgment or settlement of any claim of yours or of your dependent(s) that arises from the same event as to which payment by the health care plan is related shall be held by the recipient in constructive trust for the satisfaction of the health care plan's subrogation and/or reimbursement claims.

Complying with these obligations to reimburse the health care plan is a condition of your continued coverage and the continued coverage of your dependents.

Duty to Cooperate

You, your dependents, your attorneys or other representatives must cooperate to secure enforcement of these subrogation and reimbursement rights. This means you must take no action - including, but not limited to, settlement of any claim - that prejudices or may prejudice these subrogation or reimbursement rights. As soon as you become aware of any claims for which the health care plan is or may be entitled to assert subrogation and reimbursement rights, you must inform the health care plan by providing written notification to the claims administrator of:

1. the potential or actual claims that you and your dependents have or may have;
2. the identity of any and all parties who are or may be liable; and

3. the date and nature of the accident, injury, sickness or condition for which the health care plan has or will pay benefits and for which it may be entitled to subrogate or be reimbursed.

You and your dependents must provide this information as soon as possible, and in any event, before the earlier of the date on which you, your dependents, your attorneys or other representatives:

1. agree to any settlement or compromise of such claims; or,
2. bring a legal action against any other party.

You have a continuing obligation to notify the claims administrator of information about your efforts or your dependents' efforts to recover compensation.

In addition, as part of your duty to cooperate, **you and your dependents must complete and sign all forms and papers, including a Reimbursement Agreement,** as required by the health care plan and provide any other information required by the health care plan. A violation of the reimbursement agreement is considered a violation of the terms of the health care plan.

The health care plan may take such action as may be necessary and appropriate to preserve its rights, including bringing suit in your name or intervening in any lawsuit involving you or your dependent(s) following injury. The health care plan may require you to assign your rights of recovery to the extent of benefits provided under the health care plan. The health care plan may initiate any suit against you or your dependent(s) or your legal representatives to enforce the terms of this plan. The health care plan may commence a court proceeding with respect to this provision in any court of competent jurisdiction that the health care plan may elect.

Attorney's Fees and Other Expenses You Incur

The health care plan will not be responsible for any attorneys' fees or costs incurred by you or your dependents in connection with any claim or lawsuit against any party, unless, prior to incurring such fees or costs, the health care plan in the exercise of its sole and complete discretion has agreed in writing to pay all or some portion of fees or costs. The common fund doctrine or attorneys' fund doctrine shall not govern the allocation of attorney's fees incurred by you or your dependents in connection with any claim or lawsuit against any other party and no portion of such fees or costs shall be an offset against the health care plan's right to reimbursement without the express written consent of the claims administrator.

The plan administrator may delegate any or all functions or decisions it may have under this Reimbursement and Subrogation section to the claims administrator.

What May Happen to Your Future Benefits

If you or your dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, without first reimbursing the health care plan, the health care plan in the exercise of its sole and complete discretion, may determine that you, your dependents, your attorneys or other representatives have failed to cooperate with the health care plan's subrogation and reimbursement efforts. If the health care plan determines that you have failed to cooperate the health care plan may decline to pay for any additional care or treatment for you or your dependent(s) until the health care plan is reimbursed in accordance with the health care plan terms or until the additional care or treatment exceeds any amounts that you or your dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to treatment related to the injury, but will apply to all benefits otherwise payable under the health care plan for you and your dependents.

Interpretation

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

IDENTIFICATION (ID) CARD

If your card is lost or stolen, please contact customer service immediately. You can also request additional or replacement cards online by logging onto www.bluecrossmnonline.com.

HOW TO FILE A CLAIM

Under Department of Labor regulations, claimants are entitled to a full and fair review of any claims made under this plan. The claims procedures described in this benefit booklet are intended to comply with those regulations by providing reasonable procedures governing the filing of claims, notification of benefit decisions, and appeals of adverse benefit determinations. A claimant must follow these procedures in order to obtain payment of benefits under this plan. If the claims administrator, in its sole discretion, determines that a claimant has not incurred a covered expense or that the benefit is not covered under this plan, no benefits will be payable under this plan. All claims and questions regarding claims should be directed to the claims administrator.

Types of Claims

A "claim" is any request for a plan benefit made in accordance with these claims procedures. You become a "claimant" when you make a request for a plan benefit in accordance with these claims procedures. There are four (4) types of claims, each with different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim.

Pre-Service Claim

A "pre-service claim" is any request for a plan benefit where the plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. If the plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no "pre-service claim." The claimant simply follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Urgent Care Claim

An "urgent care claim" is a special type of pre-service claim. An "urgent care claim" is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The claims administrator will determine whether a pre-service claim involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim.

IMPORTANT: If a claimant needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the claims administrator for prior approval. The claimant should obtain such care without delay.

Concurrent Care Claim

A "concurrent care claim" arises when the claims administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the claims administrator determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the claims administrator has approved. If the plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the claims administrator to request an extension of a course of treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Post-Service Claim

A "post-service claim" is any request for a plan benefit that is not a pre-service claim or an urgent care claim.

Change in Claim Type

The claim type is determined when the claim is initially filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim. It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding the type of claim and/or what claims procedure to follow, contact the claims administrator.

Filing Claims

Except for urgent care claims, discussed below, a claim is made when a claimant (or authorized representative) submits a request for plan benefits to the claims administrator. A claimant is not responsible for submitting claims for services received from network or out-of-network participating providers. These providers will submit claims directly to the local Blue Cross and Blue Shield plan on the claimant's behalf and payment will be made directly to these providers. If a claimant receives services from nonparticipating providers, they may have to submit the claims themselves. If the provider does not submit the claims on behalf of the claimant, the claimant should send the claims to the claims administrator. The necessary forms may be obtained by contacting the claims administrator. A claimant may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that they have incurred a covered expense that is eligible for reimbursement.

Payment of a claim does not preclude the right of the claims administrator to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

Urgent Care Claims

An urgent care claim may be submitted to the claims administrator by calling the telephone number located on the back of your ID card.

Pre-Service Claims

A pre-service claim (including a Concurrent Care claim that is also a pre-service claim) is considered filed when the request for approval of treatment or services is made and received by the claims administrator.

Post-Service Claims

A post-service claim must be filed within 30 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment or product to which the claim relates.

Incorrectly Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly-filed pre-service claim, the claims administrator will notify the claimant as soon as possible but no later than five (5) days following receipt of the incorrectly-filed claim; and (b) in the case of an incorrectly-filed urgent care claim, the claims administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incorrectly-filed claim. The notice will explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless the claimant specifically requests written notice.

Timeframes for Deciding Claims

Urgent Care Claims

The claims administrator will decide an urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-Service Claims

The claims administrator will decide a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request

If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments, the claims administrator will decide the claim within 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

Concurrent Care Reduction or Early Termination

The claims administrator's decision to reduce or terminate an approved course of treatment is an adverse benefit determination that a claimant may appeal under these claims procedures, as explained below. The claims administrator will notify the claimant of the decision to reduce or terminate an approved course of treatment sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse benefit determination and receive a decision on appeal before the reduction or termination.

Post-Service Claims

The claims administrator will decide a post-service claim within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

A claimant may voluntarily agree to extend the timeframes described above. In addition, if the claims administrator is not able to decide a pre-service or post-service claim within the timeframes described above due to matters beyond its control, these timeframes may be extended for up to 15 days, provided the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The notice will describe the matters beyond the claims administrator's control that justify the extension and the date by which the claims administrator expects to render a decision. No extension of time is permitted for urgent care claims.

Incomplete Claims

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. If an urgent care claim is incomplete, the claims administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The notice may be oral unless the claimant specifically requests written notice. The claims administrator will decide the claim as soon as possible but no later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

If a pre-service or post-service claim is incomplete, the claims administrator will notify the claimant as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. The timeframe for deciding the claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to the claims administrator. The claims administrator will decide the claim following receipt of the requested information and provide the claimant with written notice of the decision.

Notification of Initial Benefit Decision

The claims administrator will provide the claimant with written notice of an adverse benefit determination on a claim. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit. The claims administrator will provide the claimant written notice of the decision on a pre-service or urgent care claim whether the decision is adverse or not. The claims administrator may provide the claimant with oral notice of an adverse benefit determination on an urgent care claim, but written notice will be furnished no later than three (3) days after the oral notice.

Right of Examination

The claims administrator and the plan administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The plan pays for the examination whenever either the claims administrator or the plan administrator requests the examination. A claimant's failure to comply with this request may result in denial of the claimant's claim.

Appeals of Adverse Benefit Determinations

Appeal Procedures

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination.

The claims administrator will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, or a rescission of coverage;
2. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;
3. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;
4. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;

5. The claims administrator will give no deference to the initial benefit decision;
6. The claims administrator will 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 decision;
7. The claims administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;
8. The claims administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the claims administrator did not rely upon their advice;
9. The claims administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the claims administrator;
10. The claims administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination;
11. The claims administrator will provide a claimant any new rationale for an adverse benefit determination prior to making a final benefit determination; and
12. The claims administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the plan administrator.

Filing Appeals

A claimant must file an appeal within 180 days following receipt of the notice of an adverse benefit determination. A claimant's failure to comply with this important deadline may cause the claimant to forfeit any right to any further review under these claims procedures or in a court of law. An appeal is filed when a claimant (or authorized representative) submits a written request for review to the claims administrator. A claimant is responsible for submitting proof that the claim for benefits is covered and payable under the plan.

Urgent Care Appeals

An urgent care appeal may be submitted to the claims administrator by telephone at 1-866-873-5943. The claims administrator will transmit all necessary information, including the claims administrator's determination on review, by telephone, fax, or other available similar methods.

Timeframes for Deciding Appeals

Urgent Care Claims

The claims administrator will decide the appeal of an urgent care claim as soon as possible, taking into account the medical emergencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

The claims administrator will decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

Post-Service Claims

The claims administrator will decide the appeal of a post-service claim within a reasonable period, but no later than 60 days after receipt of the written request for review.

Concurrent Care Claims

The claims administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. The claims administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

Notification of Appeal Decision

The claims administrator will provide the claimant with written notice of the appeal decision. The notification will include the reason for the final adverse benefit determination, reference to the relevant plan provision(s) and other information as required by ERISA. The claims administrator may provide the claimant with oral notice of an adverse decision on an urgent care claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. If the claimant does not receive a written response to the appeal within the timeframes described above, the claimant may assume that the appeal has been denied. Unless these procedures are deemed to be exhausted, the decision by the claims administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures must be exhausted before any legal action is commenced**.

Following notification of the appeal decision, a claimant may appeal further to a voluntary internal appeal or to an external appeal (for eligible claims). An adverse benefit determination relating to a claimant's failure to meet eligibility requirements is not eligible for external review.

Voluntary Appeals

A voluntary appeal may be available to a claimant receiving an adverse decision on a pre-service or post-service claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse pre-service or post-service claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the claims administrator. The claims administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeal process, contact the claims administrator.

External Review

Standard External Review

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

1. Within five (5) business days following the date of receipt of the external review request, the claims administrator will complete a preliminary review of the request to determine whether:
   a. you are or were covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;
   b. the adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the plan;
   c. you have exhausted the plan's internal appeal process (unless exhaustion is not required); and
   d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If your request is not complete, but eligible, the claims administrator will tell you what information or materials are needed to complete the request and will give you 48 hours (or more) to provide the required information.
2. The claims administrator will assign an accredited independent review organization (IRO) to conduct the external review.

   The IRO will utilize legal experts where appropriate to make coverage determinations under the plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

   The claims administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

   The IRO will review all of the information and documents timely received and is not bound by the claims administrator's prior determination. The IRO may consider the following in reaching a decision:
   a. your medical records;
   b. the attending health care professional's recommendation;
   c. reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider;
   d. the terms of the plan;
   e. evidence-based practice guidelines;

f. any applicable clinical review criteria developed and used by the claims administrator; and
g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

1. You may request an expedited external review when you receive:
   a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or,
   b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. Immediately upon receipt of the request for expedited external review, the claims administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.
3. When the claims administrator determines that your request is eligible for external review an IRO will be assigned. The claims administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

   The IRO must consider the information or documents provided and is not bound by the claims administrator’s prior determination.
4. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO’s notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the plan.

Additional Provisions

Authorized Representative

A claimant may appoint an "authorized representative" to act on his or her behalf solely with respect to an appeal of an adverse benefit determination or an inquiry concerning an adverse benefit decision. To appoint an authorized representative, a claimant must complete a form that can be obtained from the claims administrator. However, in connection with an urgent care claim, the claims administrator will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. Once an authorized representative is appointed, all future communication from the claims administrator will be made with the representative rather than the claimant, unless the claimant provides specific written direction otherwise. An assignment for purposes of payment (e.g., to a health care professional) does not constitute an appointment of an authorized representative under these claims procedures. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant.

A claimant may not assign to any other person or entity his or her right to legally challenge any decision, action, or inaction of the claims administrator.

Claims Payment

When a claimant uses network or out-of-network participating providers, the plan pays the provider. When a claimant uses a nonparticipating provider, the plan pays the claimant. A claimant may not assign his or her benefits to a nonparticipating provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the plan pay a nonparticipating provider for covered services for a child. When the plan pays the provider at the request of the custodial parent, the plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and certain institutional and medical/surgical providers outside the state of

Minnesota at the discretion of the claims administrator.

The plan does not pay claims to providers or to employees for services received in countries that are sanctioned by the United States Department of Treasury's Office of Foreign Assets Control (OFAC), except for medical emergency services when payment of such services is authorized by OFAC. Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

No Third Party Beneficiaries

The plan benefits described in this benefit booklet are intended solely for the benefit of you and your covered dependents. No person who is not a plan participant or dependent of a plan participant may bring a legal or equitable claim or cause of action pursuant to this benefit booklet as an intended or third party beneficiary or assignee hereof.

Release of Records

Claimants agree to allow all health care providers to give the claims administrator needed information about the care that they provide to them. This includes information about care received prior to the claimants enrollment with the claims administrator where necessary. The claims administrator may need this information to process claims, conduct utilization review, care management, quality improvement activities, reimbursement and subrogation, and for other health plan activities as permitted by law. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant's failure to provide authorization or requested information may result in denial of the claimant's claim.

Right of Examination

The claims administrator and the plan administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The plan pays for the examination whenever either the claims administrator or the plan administrator requests the examination. A claimant's failure to comply with this request may result in denial of the claimant's claim.

PRIVACY OF PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) is individually identifiable information created or received by a health care provider or a Health Care plan. This information is related to your past, present, or future health or the payment for such health care. PHI includes demographic information that either identifies you or provides a reasonable basis to believe that it could be used to identify you.

Restrictions on the Use and Disclosure of Protected Health Information

The employer may not use or disclose PHI for employment-related actions or decisions. The employer may only use or further disclose PHI as permitted or required by law and will report any use or disclosure of PHI that is inconsistent with the allowed uses and disclosures.

Separation Between the Employer and the Plan

The employees, classes of employees or other workforce members below will have access to PHI only to perform the plan administration functions that the employer provides for the plan. The following may be given access to PHI: plan administrator.

This list includes every employee or class of employees or other workforce members under the control of the employer who may receive PHI relating to the ordinary course of business.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that is in violation of these provisions. The employer will promptly report such instances to the plan and will cooperate to correct the problem. The employer will impose appropriate disciplinary actions on each employee or workforce member and will reduce any harmful effects of the violation.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) STATEMENT OF RIGHTS

As a participant in the plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants will be entitled to:

Receive Information About Your Plan and Benefits

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

b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated benefit booklet. The Administrator may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this benefit booklet and the documents governing the plan on the rules governing your continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

IMPORTANT PLAN INFORMATION

Plan Name:	Intact Services USA LLC HRA Plan
Type of Plan:	A group health Plan (a type of welfare benefits Plan that is subject to the provisions of ERISA)
ERISA Plan Year:	January 1 through December 31
Plan Number:	506
Funding Medium:	This Plan is self-funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the Claims Administrator. Your contribution toward the cost of coverage under the Plan will be determined by the employer each year. The Claims Administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The Claims Administrator's payment of Claims is contingent upon the Plan Administrator continuing to provide sufficient funds for benefits.
Type of Plan Administration:	Claims are administered by Blue Cross and Blue Shield of Minnesota pursuant to a contract between the Plan and Blue Cross and Blue Shield of Minnesota.
Plan Sponsor:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441-6533 (952) 852-2431
Plan Sponsor's Employer Identification Number:	26-3300555
Plan Administrator:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441-6533 (952) 852-2431
Named Fiduciary for Claims Purposes:	Blue Cross
Named Fiduciary for all other Purposes:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441-6533 (952) 852-2431
Agent for Services of Legal Process:	General Counsel Intact Services USA Services, LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441-6533 (952) 852-2431 Service of legal process may also be made on the Plan Administrator.
Plan Document:	The Plan and its attachments, if any, constitute the written Plan document required by ERISA §402.

TERMS YOU SHOULD KNOW

90dayRx - Participating 90dayRx retail pharmacies and mail service pharmacy used for the dispensing of a supply of long-term prescription drug refills.

Accountable Care Organization (ACO) - A group of physicians, other health care professionals, hospitals, and other health care providers that accept a shared responsibility to deliver a broad set of medical services to a defined set of patients.

Admissions - A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.

Advanced Practice Nurses - Licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).

Aftercare/Continuing Care Services - The stage following discharge, when the patient no longer requires services at the intensity required during primary treatment.

Allowed Amount - The amount that payment is based on for a given covered service of a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as provided in "Benefit Overview." For in-network providers, the allowed amount is the negotiated amount of payment that the in-network provider has agreed to accept as full payment for a covered service at the time your claim is processed. The claims administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at in-network providers as a result of expected settlements or other factors. The negotiated amount of payment with in-network providers for certain covered services may not be based on a specified charge for each service. Through annual or other global settlements, rebates, prospective payments or other methods, the claims administrator may adjust the amount due to in-network providers without reprocessing individual claims. These annual or other global adjustments will not cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the claims administrator, and the percentage of the allowed amount paid by the claims administrator is lower than the stated percentage for the covered service. If the payment to the provider is increased, the claims administrator pays that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

The allowed amount for all nonparticipating providers

For nonparticipating providers, the allowed amount may also be determined by the provider type, provider location, and the availability of certain pricing methods. The allowed amount may not be based upon or related to a usual, customary or reasonable charge. The claims administrator will pay the stated percentage of the allowed amount for a covered service. In most cases, the claims administrator will pay this amount to you. The determination of the allowed amount is subject to all business rules as defined in the claims administrator's provider policy and procedure manual. As a result, the claims administrator may bundle services, take multiple procedure discounts and/or other reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The allowed amount for nonparticipating providers in Minnesota

For nonparticipating provider services within Minnesota, except those described under special circumstances below, the allowed amount will be based upon one of the following payment options to be determined at the claims administrator's discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; or, (3) pricing based upon a nationwide provider reimbursement database. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator.

The allowed amount for nonparticipating provider services outside Minnesota

For nonparticipating provider physician or clinic services outside of Minnesota, except those described under special circumstances below, the allowed amount will be based upon one of the following payment options to be determined at the claims administrator's discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; (3) pricing determined by another Blue Cross or Blue Shield plan; or, (4) fee negotiations. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator.

Special circumstances

There may be circumstances where you require immediate medical or surgical care and you do not have the opportunity to select the provider of care, such as in the event of a medical emergency. Some hospital-based providers (e.g., anesthesiologists) may not be participating providers. Typically, when you receive care from nonparticipating providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care, and were not able to choose the provider who rendered such care, the claims administrator may pay an additional amount. The extent of reimbursement in these circumstances may also be subject to federal law. The extent of reimbursement in certain medical emergency circumstances may also be subject to state and federal law - please refer to "Emergency Care" for coverage of benefits.

If you have questions about the benefits available for services to be provided by a nonparticipating provider, you will need to speak with your provider and you may contact customer service at the telephone number listed on the back of your member ID card for more information.

Applied Behavioral Analysis - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Artificial Insemination (AI) - The introduction of semen from a donor (which may have been a preserved specimen), into a woman's vagina, cervical canal, or uterus by means other than sexual intercourse.

Assisted Fertilization - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, artificial insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

Attending Health Care Professional - A health care professional with primary responsibility for the care provided to a sick or injured person.

Autism Spectrum Disorders - Any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Behavioral Health Care Treatment - Treatment for mental health disorders and substance use disorder/addiction diagnoses as listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. Does not include developmental disability.

Biological Products - Products that are regulated by the Food and Drug Administration (FDA) and are medicines made from living organisms through highly complex manufacturing processes and must be handled and administered under carefully monitored conditions. There are a wide variety of biological products such as drugs, gene and cell therapies and vaccines.

Biosimilars - Products that are regulated by the Food and Drug Administration (FDA) and are highly similar to the reference biological brand name product in terms of safety, purity and potency, but may have minor differences in clinically inactive components.

BlueCard Program - A Blue Cross and Blue Shield program which allows you to access covered health care services while traveling outside of your service area. You must use in-network providers of a Host Blue and show your member ID card to secure BlueCard program access.

Board-Certified - A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board representing their specialty.

Brand Drug - A recognized trade name prescription drug product, usually either the innovator product for new prescription drugs still under patent protection or a more expensive product marketed under a brand name for multi-source prescription drugs and noted as such in the pharmacy database used by the claims administrator.

Calendar Year - The period starting on January 1st of each year and ending at midnight December 31st of that year.

Care Coordination - Organized, information-driven patient care activities intended to facilitate the appropriate responses to your health care needs across the continuum of care.

Care/Case Management Plan- A plan for health care services developed for a specific patient by a care/case manager after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.

Chronic Condition - Any physical or mental condition that requires long-term monitoring and/or management to control symptoms and to shape the course of the disease.

Claim - A request for prior authorization or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

- **Pre-service claim -** A request for prior authorization or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent care claim -** A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. Whether a request involves an urgent care claim will be determined by your attending health care provider.
- **Post-service claim -** A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Claims Administrator - Blue Cross and Blue Shield of Minnesota (Blue Cross).

Coinsurance - The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays until you reach your out-of-pocket limits. For covered services from participating providers, coinsurance is calculated based on the lesser of the allowed amount or the participating provider's billed charge. Because payment amounts are negotiated with in-network providers to achieve overall lower costs, the allowed amount for participating providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for participating providers, the percentage of the allowed amount paid by us will be greater than the stated percentage.

For covered services from nonparticipating providers, coinsurance is calculated based on the allowed amount. In addition, you are responsible for any excess charge over the allowed amount.

Your coinsurance and deductible amount will be based on the negotiated payment amount we have established with the provider or the provider’s charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements we may receive from other parties.

Coinsurance Example:
You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim:

For instance, when Blue Cross pays 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount. In addition, you would be responsible for any excess charge over our allowed amount when a nonparticipating provider is used. For example, if a nonparticipating provider ordinarily charges $100 for a service, but our allowed amount is $95, Blue Cross will pay 80% of the allowed amount ($76). You must pay the 20% coinsurance on the Blue Cross allowed amount ($19), plus the difference between the billed charge and the allowed amount ($5), for a total responsibility of $24.

Remember, if participating providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Blue Cross allowed amount. If nonparticipating providers are used, your out of pocket costs will be higher as shown in the example above.

Compound Drug - A prescription where two (2) or more drugs/medications are mixed together. All of these drugs/medications must be FDA-approved. The end product must not be available in an equivalent commercial form. A prescription will not be considered as a compound prescription if it is reconstituted or if, to the active ingredient, only water or sodium chloride solutions are added. The compound drug must also be FDA-approved for use in the condition being treated and in the dosage form being dispensed.

Copay - The dollar amount you must pay for certain covered services. The "Benefit Overview" lists the copays and services that require copays. A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.

Cosmetic Services - Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.

Covered Drug List - The claims administrator’s covered drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the claims administrator’s Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee.

Covered Services - A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.

Custodial Care - Care provided primarily for maintenance of the member or which is designed essentially to assist the member in meeting activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Cycle - One (1) partial or complete fertilization attempt extending through the implantation phase only.

Day Treatment - Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.

Deductible - The deductible is a specified dollar amount you must pay for most covered services each calendar year before the health care plan begins to provide payment for benefits. Services such as prenatal care, pediatric preventive care, and primary network preventive care services for adults are not subject to the deductible. Please refer to "Benefit Overview" for the deductible amount. If applicable, the dollar amount reimbursed or paid by a coupon for specialty drugs will not count toward your deductible.

Dependent - Your spouse, child to the dependent child age limit provided in "Who is Eligible," child whom you or your spouse have adopted or been appointed legal guardian to the dependent child age limit provided in "Who is Eligible,", grandchild who meets the eligibility requirements as provided in "Who is Eligible" to the dependent child age limit provided in "Who is Eligible," disabled dependent or dependent child as provided in " Who is Eligible," or any other person whom state or federal law requires be treated as a dependent under this health coverage.

Designated Agent - An entity that has contracted, either directly or indirectly, with the claims administrator to perform a function and/or service in the administration of this health care plan. Such function and/or service may include, but is not limited to, medical management and provider referral.

Durable Medical Equipment - Medical equipment prescribed by a physician that meets each of the following requirements:

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. generally not useful in the absence of illness or injury;
4. determined to be reasonable and necessary; and
5. represents the most cost-effective alternative.

Enrollment Date - The first day of coverage, or if there is a waiting period, the first day of the waiting period (typically the date employment begins).

E-Visit - A member-initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established member.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, prescription drug, device or supply (intervention) which is not determined by the claims administrator to be medically effective for the condition being treated. The claims administrator will consider an intervention to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date. Medical researchers constantly experiment with new medical equipment, prescription drugs and other technologies. In turn, health care plans must evaluate these technologies. The claims administrator believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. Certain routine patient costs for participation in an approved clinical trial will not be considered experimental/investigative. Routine patient costs include items and services that would be covered if the member was not enrolled in an approved clinical trial.

Facility - A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, a home health care agency, or freestanding birthing center when services are billed on a facility claim.

Foot Orthoses - Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity, protect against injury, or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom-made. Pre-fabricated orthoses are manufactured in quantity and are not designed for a specific member. A custom-fitted orthosis is specifically made for an individual member.

Freestanding Ambulatory Surgical Center - A provider that facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by, or under the direction of, a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor's office, or other health care professional's office.

Generic Drug - A prescription drug that is available from more than one manufacturing source and accepted by the FDA as a substitute for those products having the same active ingredients as a brand drug and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orange Book, and

noted as such in the pharmacy database used by the claims administrator.

Habilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.

Halfway House - Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.

Health Care Provider - A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech, and occupational therapists, licensed nutritionists, licensed registered dieticians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facilities licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.

Home Health Care Agency - A Medicare-approved or other preapproved facility that sends health care professionals and home health aides into a person's home to provide health services.

Hospice Care - A coordinated set of services provided at home or in an inpatient hospital setting for covered individuals suffering from a terminal disease or condition.

Hospital - A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.), or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.

Host Blue - A Blue Cross and/or Blue Shield organization outside of Minnesota that has contractual relationships with in-network providers in its designated service area that require such in-network providers to provide services to members of other Blue Cross and/or Blue Shield organizations.

Illness - A sickness, injury, pregnancy, mental illness, substance use disorder, or condition involving a physical disorder.

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

Infertility - The medically documented inability to conceive with unprotected sexual intercourse between a male and female partner for a period of at least 12 months. The inability to conceive may be due to either the male or female partner.

In-Network - Depending on where you receive services, the in-network is designated as one of the following:

- When you receive services within the health care plan service area, the designated in-network for professional providers and facility providers is the Aware network.
- When you receive services within the claims administrator’s service area, the designated in-network for professional providers and facility providers is the Aware network.
- When you receive services outside Minnesota, the designated participating in-network for professional providers and facility providers is the local BlueCard PPO network.

In-Network Provider - An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, the claims administrator or with any licensee of the Blue Cross and Blue Shield Association located out-of-area, pertaining to payment as a participant in a network for covered services rendered to a member.

Inpatient Care - Care that provides 24-hour-a-day professional registered nursing (R.N.) services for short-term medical and behavioral health services in a hospital setting.

Intensive Outpatient Programs (IOPs) - A behavioral health care service setting that provides structured, multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance use disorder treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.

Lifetime Maximum - The cumulative maximum payable for covered services incurred by a member during their lifetime or by each covered dependent during their lifetime under all health care plans with the employer. The lifetime maximum does not include amounts which are the member's responsibility, such as deductibles, coinsurance, copays, and other amounts. Please refer to "Benefit Overview" for specific dollar maximums on certain services.

Mail Service Pharmacy - A pharmacy that dispenses prescription drugs through the U.S. Mail.

Maintenance Services - Services that are neither habilitative nor rehabilitative that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and appropriate and part of specialized therapy for the member's condition.

Marital/Couples Therapy/Counseling - Behavioral health care services for the primary purpose of working through relationship issues.

Marital/Couples Training - Services for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.

Medical Emergency - Medically necessary and appropriate care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the member in serious jeopardy.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease; and (iii) not primarily for the convenience of the member, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease. The claims administrator reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless the claims administrator determines that the service, supply or covered medication is medically necessary and appropriate.

With respect to mental health care services: services appropriate, in terms of type, frequency, level, setting, and duration, to the member's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary and appropriate care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

(1) help restore or maintain the member's health; or,
(2) prevent deterioration of the member's condition.

Medicare - A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B, and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B, and D do not pay the entire cost of services and are subject to cost-sharing requirements and certain benefit limitations.

Mental Illness - A mental disorder as defined in the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. It does not include substance dependence, nondependent

substance use disorder, or developmental disability.

Nonparticipating Provider - A provider who has not entered into an in-network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

Out-of-Network Participating Provider - Providers who have a contract with the claims administrator or the local Blue Cross and/or Blue Shield plan (participating providers), but are not in-network providers because the contract is not specific to this plan.

Out-of-Network Provider - A provider with a Blue Cross contract that is not specific to this plan; and nonparticipating providers.

Out-of-Pocket Limit - The out-of-pocket limit refers to the specified dollar amount of member cost-sharing incurred for covered services in a calendar year. When the specified dollar amount is attained, the claims administrator begins to pay 100% of the allowed amount for all covered expenses. Please refer to "Benefit Overview" for the out-of-pocket limit. If applicable, the dollar amount reimbursed or paid by a coupon for specialty drugs will not count toward your out-of-pocket limit.

Outpatient Behavioral Health Treatment Facility - A facility that provides outpatient treatment by, or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance use disorder, or addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

Outpatient Care - Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.

Palliative Care - Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance use disorder services on a planned and regularly scheduled basis in a facility provider designed for a member or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

Participating Pharmacy - A pharmaceutical provider that participates in a network for the dispensing of prescription drugs.

Participating Provider - A provider who has entered into either a specific network contract or a general broader network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

Physician - A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.

Place of Service - Industry standard claim submission standards (established by the Medicare program) used by clinic and hospital providers.

Plan - The plan of benefits established by the plan administrator.

Plan Year - A 12-month period which begins on the effective date of the plan and each succeeding 12-month period thereafter.

Preferred Drug List - The claims administrator’s preferred drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the claims administrator’s Pharmacy and Therapeutics Committee

made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. This list can change throughout the year.

Prescription Drugs - Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.

Provider - A health care professional or facility licensed, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that provider. Provider also includes home infusion therapy providers, pharmacies, medical supply companies, independent laboratories and ambulances.

Rehabilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to regain, maintain, or prevent deterioration of daily living skills or functions acquired but then lost or impaired due to an illness, injury, or disabling condition.

Rescission - A cancellation or discontinuation of coverage.

Residential Behavioral Health Treatment Facility - A facility licensed under state law in the state in which it is located that provides inpatient treatment by, or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance use disorder, or substance addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

Respite Care - Short-term inpatient or home care provided to the member when necessary to relieve family members or other persons caring for the member.

Retail Health Clinic - A clinic located in a retail establishment or worksite that provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or facility provider. Retail health clinics are staffed by eligible nurse practitioners or other eligible health care providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.

Retail Pharmacy - Any licensed pharmacy that you can physically enter to obtain a prescription drug.

Self-Administered Drugs - Medications you would normally take on your own, such as drugs you might take every day to treat high blood pressure. These are drugs that can be safely taken by mouth or administered by injection, inhaled, inserted, or applied topically and are covered under your pharmacy/prescription drug benefit. These drugs do not require direct supervision or administration by a health care provider, regardless of whether initial medical supervision or training is required.

Services - Health care services, procedures, treatments, durable medical equipment, medical supplies, and prescription drugs, including specialty drugs.

Skilled Care - Services rendered other than in a skilled nursing facility that are medically necessary and appropriate and provided by a licensed nurse or other licensed health care professional. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring, that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed nurse, shall not be regarded as skilled care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed nurse provides the service. Only the skilled care component(s) of combined services that include non-skilled care are covered under the plan.

Skilled Nursing Care - Extended Hours - Extended hours home care (skilled nursing services) are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member’s home. skilled nursing care - extended hours services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's heath status and outcomes. The frequency of

the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.

Skilled Nursing Care - Intermittent Hours - Intermittent skilled nursing services consist of up to two (2) consecutive hours per date of service in the member's home provided by a licensed registered nurse or licensed practical nurse who are employees of an approved home health care agency.

Skilled Nursing Facility - A Medicare-approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital/facility stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.

Skills Training - Training of basic living and social skills that restore a patient's skills essential for managing his or her illness, treatment, and the requirements of everyday independent living.

Specialist/Specialty Physician - A physician who limits his or her practice to a particular branch of medicine or surgery.

Specialty Drugs - Specialty drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Specialty drugs are drugs including, but not limited to drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia.

Specialty Pharmacy Network Supplier - A pharmaceutical specialty provider that has an agreement with the claims administrator pertaining to the payment and exclusive dispensing of selected specialty prescription drugs provided to you.

Step Therapy - Step therapy includes, but is not limited to, medications in specific categories or drug classes. If your physician prescribes one of these medications, there must be documented evidence that you have tried another eligible medication that is safe, more clinically effective, and in some cases more cost-effective before the step therapy medication will be paid under the drug benefit.

Substance Use Disorder and/or Addictions - Alcohol, drug dependence or other addictions as defined in the most current editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.

Supervised Employees - Health care professionals employed by a doctor of medicine, osteopathy, chiropractic, dental surgery, or a Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S., or mental health professional must be physically present and immediately available in the same office suite more than 50% of each day when the employed health care professional is providing services. Independent contractors are not eligible.

Supply - Equipment that must be medically necessary and appropriate for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.

Supplies do not include such things as:
1. alcohol swabs;
2. cotton balls;
3. incontinence liners/pads;
4. Q-tips;
5. adhesives; and
6. informational materials.

Surrogate Pregnancy - An arrangement whereby a woman who is not covered under this plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise.

Telemedicine Services - Telemedicine services may also be referred to as televideo consultations or telehealth services. These services provide real-time interaction between a distant site physician/medical practitioner and the member both of whom are not in the same location but are actively communicating through interactive audio and video channels.

Tobacco Cessation Drugs and Products - Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.

Totally Disabled (or Total Disability) - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your Immediate Family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

Treatment - The management and care of a patient for the purpose of combating illness or injury. Treatment includes medical care, surgical care, diagnostic evaluation, giving medical advice, monitoring and taking medication.

Value-Based Program - An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Waiting Period - The period of time that must pass before you or your dependents are eligible for coverage under this plan.

The Blue Cross® and Blue Shield® Association is an association of independent Blue Cross and Blue Shield plans.

You are hereby notified, your health care benefit program is between the employer, on behalf of itself and its employees and Blue Cross and Blue Shield of Minnesota. Blue Cross is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Blue Cross Blue Shield shall be liable to the employer, on behalf of itself and its employees, for any Blue Cross Blue Shield obligations under your health care benefit program.

For employees of:

Intact Services USA LLC

HSA Plan

THIS HEALTH CARE PLAN IS INTENDED FOR USE WITH A FINANCIAL ACCOUNT

PLEASE READ YOUR BENEFIT BOOKLET CAREFULLY

LANGUAGE ACCESS SERVICES

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ္ပါကတိၤကညီကျိာ်ဒီး, တၢ်ကဟ့ဉ်နၤကျိာ်တၢ်မၤစၢၤကလိတဖဉ်နှဉ်လီၤ. ကိး: 1-866-251-6744 လၢ TTYအဂီၢ်, ကိး: 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ລໍາລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមែន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih áǫįęęǫįǫąǫęįą. TTY biniiyégo éí íáájį' béésh bee hodíílnih.

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

The claims administrator complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The claims administrator provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with the claims administrator.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact the claims administrator at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312
- Grievance forms are available by contacting the claims administrator at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting the claims administrator at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

CUSTOMER SERVICE

Whether it is for help with a claim or a question about your benefits, you can call your customer service telephone number or log onto the claims administrator's member website both located on the back of your ID card.

A customer service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

The customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters.

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WELCOME

This benefit booklet provides you with the information you need to understand your health care plan. You are encouraged to take the time to review this information so you understand how your health care plan works.

This benefit booklet replaces all other certificates/benefit booklets you have received from the plan administrator before the effective date. For purposes of this benefit booklet, "you" or "your" refers to the employee named on the identification (ID) card and other covered dependents. Employee is the person for whom the employer has provided coverage. Dependent is a covered dependent of the employee.

The plan administrator has contracted with the claims administrator to provide coverage for its employees and their dependents. Terms are defined in "Terms You Should Know."

This benefit booklet explains the health care plan, eligibility, notification procedures, covered services, and expenses that are not covered. It is important that you read this entire benefit booklet carefully. If you have questions about your coverage, please contact customer service at the telephone number listed on the back of your member ID card or log onto your claims administrator's member website at www.bluecrossmnonline.com.

This plan, financed and administered by Intact Services USA LLC, is a self-insured medical plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) is the claims administrator and provides administrative services only. The claims administrator does not assume any financial risk or obligation with respect to claims. Coverage is subject to all terms and conditions of this benefit booklet, including medical necessity and appropriateness.

If you have any questions on your health care plan, please contact customer service at the telephone number listed on the back of your member ID card.

MEMBER RIGHTS AND RESPONSIBILITES

You have the right as a health care plan member to:

- be treated with respect, dignity and privacy;
- have available and accessible medically necessary and appropriate covered services, including emergency services, 24 hours a day, seven (7) days a week;
- be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for treatment;
- participate with your health care provider in decisions about your treatment;
- give your health care provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity);
- refuse treatment;
- privacy of medical and financial records maintained by the health care plan, the claims administrator and its health care providers in accordance with existing law;
- receive information about the health care plan, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at the health care plan, the claims administrator or at the clinic that you can contact with any concerns about services;
- file an appeal with the claims administrator and receive a prompt and fair review; and
- initiate a legal proceeding when experiencing a problem with the health care plan or its providers.

You have the responsibility as a health care plan member to:

- know your health care plan benefits and requirements;
- provide, to the extent possible, information that the health care plan, the claims administrator and its providers need in order to care for you;
- understand your health problems and work with your doctor to set mutually agreed upon treatment goals;
- follow the treatment plan prescribed by your health care provider or to discuss with your provider why you are unable to follow the treatment plan;
- provide proof of coverage when you receive services and to update the clinic with any personal changes;
- pay copays at the time of service and to promptly pay deductibles, coinsurance and, if applicable, charges for services that are not covered; and
- keep appointments for care or to give early notice if you need to cancel a scheduled appointment.

BENEFIT OVERVIEW

Your Benefits

This benefit booklet outlines the general coverage under this plan. Please be certain to check the "Benefit Chart" section to identify specifically covered benefits. All services must be medically necessary and appropriate to be covered.

Please also review the "Not Covered" sections of the Benefit Chart and "General Exclusions" to determine services that are not covered. Some services and supplies are not covered, even if a provider considers them to be medically necessary and appropriate.

The "Terms You Should Know" section defines terms used in this benefit booklet. If you have questions, contact customer service using the telephone number listed on the back of your member ID card.

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during your covered calendar year will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

Benefit Period

Your health care plan's benefit period is based on a calendar year. The calendar year is January 1 to December 31.

During this time, charges for covered services must be incurred in order to be eligible for payment by Blue Cross. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Networks	
Your provider directory lists network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is network for your particular plan. Not every provider is network for every plan. For a list of providers in the directory, visit www.bluecrossmnonline.com ("Member Log in" then "Find a Doctor") or contact customer service at the telephone number listed on the back of your member ID card.	

• In-Network Providers
  ▪ In Minnesota
  ▪ Outside Minnesota
	
	Aware network providers
	BlueCard PPO network providers

• In-Network Participating Pharmacy Providers	Select pharmacy network

Benefits	In-Network Providers	Out-of-Network Providers
General Provisions		
Deductible including Pharmacy • Individual • Family	 You pay $2,800 You pay $5,600	 You pay $4,000 You pay $8,000
Deductible - Embedded If you have other family members on the plan, each family member must meet their own deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.		

Benefits	In-Network Providers	Out-of-Network Providers
The amounts accumulated toward the deductible are applied to covered services provided by both network providers and out-of-network providers. Amounts accumulated toward the network deductible also accumulate toward the out-of-network deductible. When the network deductible is satisfied, covered services from network providers will be paid at the covered percentage. Amounts accumulated toward the out-of-network deductible also accumulate toward the network deductible. When the out-of-network deductible is satisfied, the claims administrator considers both the network and out-of-network deductibles satisfied and covered services from all providers will be paid at the covered percentage.		
Coinsurance	Generally, you pay 20% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year	Generally, you pay 50% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year
Out-of-Pocket Limits - eligible medical services including pharmacy • Individual • Family	 You pay $5,000 You pay $10,000	 You pay $8,000 You pay $16,000
Out-of-Pocket Limit - Embedded If you have other family members on the plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.		
The amounts accumulated toward the out-of-pocket limit are applied to covered services provided by both network providers and out-of-network providers. Amounts accumulated toward the network out-of-pocket limit also accumulate toward the out-of-network out-of-pocket limit. When the network out-of-pocket limit is satisfied, covered services from network providers will be paid at 100% of the allowed amount. Amounts accumulated toward the out-of-network out-of-pocket limit also accumulate toward the network out-of-pocket limit. When the out-of-network out-of-pocket limit is satisfied, the claims administrator considers both the network and out-of-network out-of-pocket limits satisfied and covered services from all providers will be paid at 100% of the allowed amount.		
Lifetime Maximum (per person) • Assisted fertilization ▪ all services combined (medical and prescription drugs) • Bariatric surgery • Travel expenses for transplants to a Blue Distinction Center only • Total benefits paid to all other providers combined	 $20,000 $20,000 $10,000 Not applicable	

Prescription Drug Benefits	In-Network Provider	Out-of-Network Provider
Prescription Drugs: • **Affordable Care Act (ACA) preventive covered prescription drugs**	**Retail Pharmacy:** You pay nothing **90dayRx Participating Retail Pharmacy:** You pay nothing **Mail Service Pharmacy:** You pay nothing	You pay nothing
• **Designated preventive prescription drugs other than Affordable Care Act (ACA) preventive prescription drugs**	**Retail Pharmacy:** You pay 30% coinsurance **90dayRx Participating Retail Pharmacy:** You pay 30% coinsurance **Mail Service Pharmacy:** You pay 30% coinsurance	You pay 30% coinsurance
• **FlexRx Preferred generic prescription drugs**	**Retail Pharmacy:** You pay $50.00 copay or 30% coinsurance after deductible, whichever is less per prescription **90dayRx Participating Retail Pharmacy:** You pay $125.00 copay or 30% coinsurance after deductible whichever is less per prescription **Mail Service Pharmacy:** You pay $125.00 copay or 30% coinsurance after deductible whichever is less per prescription	You pay $50.00 copay or 30% coinsurance after deductible whichever is less per prescription
• **FlexRx Preferred brand prescription drugs**	**Retail Pharmacy:** You pay $150.00 copay or 30% coinsurance after deductible, whichever is less per prescription **90dayRx Participating Retail Pharmacy:** You pay $375.00 copay or 30% coinsurance after deductible whichever is less per prescription **Mail Service Pharmacy:** You pay $375.00 copay or 30% coinsurance after deductible whichever is less per prescription	You pay $150.00 copay or 30% coinsurance after deductible whichever is less per prescription
• **Non-preferred generic prescription drugs**	**Retail Pharmacy:** You pay $50.00 copay or 30% coinsurance after deductible, whichever is less per prescription **90dayRx Participating Retail Pharmacy:** You pay $125.00 copay or 30% coinsurance after deductible whichever is less per prescription **Mail Service Pharmacy:**	You pay $50.00 copay or 30% coinsurance after deductible whichever is less per prescription

Prescription Drug Benefits	In-Network Provider	Out-of-Network Provider
	You pay $125.00 copay or 30% coinsurance after deductible whichever is less per prescription	
• **Non-preferred brand prescription drugs**	**Retail Pharmacy:** You pay $250.00 copay or 30% coinsurance after deductible, whichever is less per prescription **90dayRx Participating Retail Pharmacy:** You pay $625.00 copay or 30% coinsurance after deductible whichever is less per prescription **Mail Service Pharmacy:** You pay $625.00 copay or 30% coinsurance after deductible whichever is less per prescription	You pay $250.00 copay or 30% coinsurance after deductible whichever is less per prescription
• **Designated Preferred specialty prescription drugs purchased through a specialty pharmacy network supplier**	**Specialty pharmacy network supplier:** You pay 30% coinsurance after deductible up to a maximum of $375.00 per prescription for Preferred specialty drugs **90dayRx Participating Retail Pharmacy:** NO COVERAGE **Mail Service Participating Pharmacy:** NO COVERAGE	NO COVERAGE
• **Designated Nonpreferred specialty prescription drugs purchased through a specialty pharmacy network supplier**	**Specialty pharmacy network supplier:** You pay 30% coinsurance after deductible up to a maximum of $625.00 per prescription for Nonpreferred specialty drugs **90dayRx Participating Retail Pharmacy:** NO COVERAGE **Mail Service Participating Pharmacy:** NO COVERAGE	NO COVERAGE
• **Retail Pharmacy Vaccine program** ▪ certain eligible vaccines administered at a participating retail pharmacy	You pay nothing	NO COVERAGE

BENEFIT CHART

The health care plan provides coverage of benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copays amounts are described in "Benefit Overview." In-network care is generally covered at a higher level of benefits than out-of-network care.

Prior authorization, admission notification, or emergency admission notification are required for specific services. Please refer to "Health Care Management."

Please refer to "Not Covered" sections of the Benefit Chart and “General Exclusions” for additional information.

Benefit Descriptions

Please refer to the following pages for a more detailed description of benefits.

AMBULANCE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Emergency medically necessary and appropriate service from the place of departure to the nearest medical facility equipped to treat the condition	You pay 20% coinsurance after deductible	Same as in-network services
• Non-emergency medically necessary and appropriate service from the place of departure to nearest medical facility equipped to treat the condition	You pay 20% coinsurance after deductible	Same as in-network services

NOTES:

- Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility provider;
  - between hospitals; or
  - between a hospital and a skilled nursing facility provider;

  when such facility provider is the closest institution that can provide covered services appropriate for your condition. If there is no facility provider in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility provider outside the local area that can provide the necessary service.
- Transportation and related emergency service provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room for an injury or condition that is not considered emergency care will not be covered as emergency ambulance service. Please refer to "Terms You Should Know" for a definition of medical emergency.
- Benefits include non-emergency medically necessary and appropriate prearranged or scheduled ambulance service requested by an attending physician or nurse from the place of departure to the closest facility provider that can provide the necessary service.
- Eligible services you receive from out-of-network providers apply to the in-network deductible.
- Eligible services you receive from out-of-network providers apply to the in-network out-of-pocket limit.

NOT COVERED:

- ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility equipped to treat the condition (example: facility A is the closest medical facility equipped to treat the condition but you choose to be transported to facility B. The plan will cover eligible medically necessary and appropriate ambulance transportation costs that would otherwise apply to transportation to facility A. If you choose to be transported by ambulance to facility B, the cost of transportation service in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to facility A are not covered under the plan, and you will be responsible for those costs)
- travel, transportation, or living expenses, whether or not recommended by a physician, except as provided herein
- ambulance transportation services that are not medically necessary and appropriate for basic or advanced life support
- transportation services, including ambulance services that are mainly for your convenience

BEHAVIORAL HEALTH MENTAL HEALTH CARE

Your mental health is just as important as your physical health. That is why your health care plan provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance use disorder professional providers, so you can get the appropriate level of responsive, confidential care.

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit ▪ telemedicine services ▪ individual/family therapy (office/in-home mental health services)	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services in an office or clinic ▪ assessment and diagnostic services ▪ neuropsychological examination	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services ▪ neuropsychological examination	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Outpatient hospital/outpatient behavioral health treatment facility services including ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional health care services including: ▪ clinical based partial programs ▪ clinical based day treatment ▪ clinical based Intensive Outpatient Programs (IOP)	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Facility health services including: ▪ hospital based partial programs ▪ hospital based day treatment ▪ hospital based intensive outpatient programs (IOP)	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient health care professional services including: ▪ individual psychotherapy ▪ group psychotherapy ▪ psychological testing ▪ counseling with family members to assist in your diagnosis and treatment	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Inpatient hospital/residential behavioral health treatment facility services including: ▪ all eligible inpatient services ▪ emergency holds	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- For home health related services, please refer to "Home Health Care."
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, is deemed medically necessary and appropriate.
- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity and appropriateness. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and appropriate and otherwise covered under this health care plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
- Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
- Coverage is provided for inpatient care and outpatient care for the treatment of serious mental illness. A serious mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient care cost-sharing amounts. Serious mental illnesses include schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa and delusional disorder.
- Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as previously described, are also available when you are an outpatient.
- Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:
  - mental health and substance use disorder services are to be covered on the same basis as similar medical services;
  - cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
  - treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
- Coverage is provided for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments must be recommended by your physician and include, but are not limited to: antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

NOTES:

- Benefits are provided for autism treatment, including intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (EIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy. The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities. Treatment must be in accordance with an individualized treatment plan prescribed by the member's treating physician or mental health professional.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- services for mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- evaluations that are not performed for the purpose of diagnosing or treating mental health or substance use disorder conditions such as: custody evaluations; parenting assessments; education classes for DUI or DWI offences; competency evaluations; adoption home status; parental competency; and domestic violence programs
- services for or related to room and board for foster care, group homes, shelter care and lodging programs, halfway house services, and skills training
- services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or, marriage/couples retreats, encounters, or seminars
- services primarily educational in nature, except nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders not otherwise specified (NOS) and except as provided herein
- services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment for support for the foster child's improved functioning)
- services for the treatment of learning disabilities
- services for therapeutic day care and therapeutic camp services
- court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law
- services for or related to marriage/couples counseling

BEHAVIORAL HEALTH SUBSTANCE USE CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit ▪ telemedicine services ▪ individual and family therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services in an office or clinic ▪ assessment and diagnostic services ▪ opioid treatment	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services ▪ opioid treatment	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient health care professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient hospital/residential behavioral health treatment facility services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- Outpatient family therapy is covered if rendered by a health care professional, and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance use disorder including the following:
  - inpatient hospital or substance use disorder treatment facility provider services for detoxification
  - substance use disorder treatment facility provider services for non-hospital inpatient residential treatment and rehabilitation services
  - outpatient hospital/facility or substance use disorder treatment facility provider or outpatient substance use disorder treatment facility provider services for rehabilitation therapy
  - court-ordered treatment provided by the Department of Corrections is covered when included in a sentencing order and is based on a chemical assessment conducted by the Department of Corrections
  - admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold
  - coverage includes medication assisted treatment (MAT) for opioid use disorder
- For purposes of this benefit, a substance use disorder service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- For home health related services, please refer to "Home Health Care."
- For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:
  - mental health and substance use disorder services are to be covered on the same basis as similar medical services;

NOTES:

- cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
- treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.

- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- services for substance use disorder or addiction not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary and appropriate
- evaluations that are not performed for the purpose of diagnosing or treating substance use disorder or addictions including, but not limited to: custody evaluations; parenting assessments; education classes for driving under the influence (DUI)/driving while intoxicated (DWI) offenses; competency evaluations; adoption home status; and parental competency and domestic violence programs
- services for or related to room and board for foster care, group homes, shelter care, and lodging programs, halfway house services, and skills training
- substance use disorder interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person, with the intent of convincing the affected person to enter treatment for the condition
- services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit
- services for therapeutic day care and therapeutic camp services
- services for hippotherapy (equine movement therapy)
- court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law

CHIROPRACTIC CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Spinal manipulations - includes office visit	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Other chiropractic services including therapies	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Benefits include coverage for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visits and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem and chiropractor time.
- Eligible acupuncture services are limited to 20 visits per person per calendar year.
- Spinal manipulations and other chiropractic services including therapies are limited to 20 visits per person per calendar year.

NOT COVERED:

- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider
- services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; etc.; and all related material and products for these programs
- services for or related to therapeutic massage
- maintenance services
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and appropriate and part of specialized maintenance therapy to treat the member's condition
- custodial care

DENTAL CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
This is not a dental plan. The following limited dental-related coverage is provided: • Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy natural teeth (see NOTES) • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder including: ▪ orthognathic surgery ▪ related orthodontia	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- For medical services, please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc.
- Mandibular staple implant is covered, provided the procedure is not done to prepare the mouth for dentures.
- Bone grafts for the purpose of reconstruction of the jaw is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.
- A sound and healthy natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one (1) year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one (1) year. A dental implant is not a sound and healthy natural tooth.
- Accident-related dental services, treatment and/or restoration of a sound and healthy natural tooth must begin within 12 months of the date of injury or within 12 months of your effective date of coverage under this plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date of treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy natural teeth, crowns, fillings and bridges.
- The health care plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. For hospital/facility charges please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." Dental services are not covered unless otherwise noted.
- Services for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder, including orthognathic surgery and related orthodontia, must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.

NOT COVERED:

- services for or related to orthodontia, except as provided herein
- oral surgery procedures, except as provided herein
- dental services to treat an injury from biting or chewing
- dentures, regardless of the cause or the condition, and any associated services including bone grafts
- dental implants, and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19
- removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as provided herein
- services for or related to replacement of a damaged dental bridge from an accident-related injury
- osteotomies and other procedures associated with the fitting of dentures or dental implants, except as provided herein
- services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia, or facility charges, except as provided herein
- services, including dental splints, to treat bruxism
- charges for routine dental care, except as provided herein

EMERGENCY CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services to treat an emergency medical condition as defined in Minnesota law	You pay 20% coinsurance after deductible	Same as in-network services
• Outpatient hospital/facility services to treat an emergency medical condition as defined in Minnesota law	You pay 20% coinsurance after deductible	Same as in-network services

NOTES:

- In emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number. When determining if a situation is a medical emergency the claims administrator will take into consideration presenting symptoms including, but not limited to, severe pain and a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day. Once the crisis has passed, call your physician to receive appropriate follow-up care.
- Please refer to "Terms You Should Know" for a definition of medical emergency.
- For inpatient services, please refer to "Hospital Inpatient Care" and "Office Visit and Professional Services."
- For urgent care visits, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services."
- Eligible services you receive from out-of-network providers apply to the in-network deductible.
- Eligible services you receive from out-of-network providers apply to the in-network out-of-pocket limit.

GENDER CONFIRMATION CARE

The services outlined on this page are for the treatment of gender dysphoria. Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. The therapeutic approach to gender dysphoria, as outlined by the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, from the World Professional Association for Transgender Health (WPATH), may consist of several interventions with the type and sequence of interventions differing from person to person.

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional services for gender affirming procedures for the treatment of gender dysphoria	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Services include related preparation and follow-up treatment care.
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- For outpatient counseling services, please refer to "Behavioral Health Mental Health Care."
- For prescription drugs for the management of gender dysphoria, please refer to "Prescription Drugs."
- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- For therapeutic injections, please refer to "Hospital Outpatient Care" or "Office Visit and Professional Services."
- For more information contact customer service at the telephone number on the back of your member ID card or visit www.bluecrossmnonline.com.
- Coverage includes cosmetic surgery related to sex transformation surgery only.

NOT COVERED:

- treatment, services or supplies that are not medically necessary and appropriate

HOME HEALTH CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Home health care agency or hospital program for home health care including, but not limited to: ▪ intermittent skilled nursing care in your home by a: • licensed registered nurse • licensed practical nurse ▪ physical therapy and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services provided by a medical technologist ▪ services provided by a licensed registered dietician ▪ services provided by a respiratory therapist ▪ services of a home health aide or master's level social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees ▪ use of appliances that are owned or rented by the home health agency ▪ home health care following early maternity discharge ▪ palliative care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services.
- Benefits for home/suite infusion therapy and related home health care are listed under "Infusion Therapy."
- For supplies and durable medical equipment billed by a home health agency, please refer to "Medical Equipment and Supplies."
- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and her newborn child.

NOT COVERED:

- homemaker services
- maintenance services
- services for dialysis treatment you receive from a home health care agency
- services for custodial care you receive from a home health care agency

NOT COVERED:

- services for food or home-delivered meals you receive from a home health care agency
- services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury (please refer to "Custodial Care" and "Skilled Care" in the "Terms You Should Know")
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care

HOSPICE CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Hospice care for terminal condition	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- Benefits are limited to members with a terminal condition (i.e., life expectancy of six (6) months or less). The member’s primary physician must certify, in writing, a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program.
- Inpatient respite care is for the relief of the member’s primary caregiver and is limited to a maximum of five (5) consecutive days at a time.
- Home respite care is for the relief of the member's primary caregiver and is limited to a maximum of five (5) consecutive days per admission to the hospice program.
- Hospice program general inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Benefits include family counseling related to the member's terminal condition.
- Medical care services unrelated to the terminal condition under the hospice program are covered, but are separate from the hospice benefit.

NOT COVERED:

- services for respite care, except as provided herein
- room and board expenses in a residential hospice facility
- services for dialysis treatment you receive from hospice or a hospital program for hospice care
- services for custodial care you receive from hospice or a hospital program for hospice care
- services for food or home-delivered meals you receive from hospice or a hospital program for hospice care

HOSPITAL INPATIENT CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Hospital room and board, and general nursing services • Special care unit which is a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients • Use of operating, delivery, and treatment rooms and equipment • Anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery • Medical and surgical dressings, supplies, casts, and splints • Prescription drugs and medicines provided to you while you are inpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • Diagnostic services • Communication services of a private-duty nurse or a personal care assistant up to 120 hours per hospital admission for ventilator dependent persons • Therapy and rehabilitation services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- The health care plan covers inpatient services from a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the member's condition.
- The plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major organ transplant or other kinds of transplants, please refer to "Transplant."
- The plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the plan:
  - potential donor testing;
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement.
- Diagnostic services include the following when ordered by a health care provider:
  - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
  - diagnostic pathology consisting of laboratory and pathology tests;
  - diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the claims administrator; and
  - allergy testing consisting of percutaneous, intracutaneous, and patch tests.

NOTES:

- The health care plan covers anesthesia and inpatient hospital services when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or, has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- charges for inpatient admissions which are primarily for diagnostic studies
- personal comfort items such as telephone, television
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this plan
- communication services provided on an outpatient basis or in the home
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care

HOSPITAL OUTPATIENT CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient hospital/facility services, except as noted below • Surgeon or assistant at surgery • Use of operating, delivery, and treatment rooms and equipment • Medical and surgical dressings, supplies, casts and splints • Radiation and chemotherapy • Dialysis treatment • Respiratory therapy • Cardiac rehabilitation • Physical, occupational, and speech therapy • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • Prescription drugs and medicines provided to you while you are outpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Laboratory services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Facility billed freestanding ambulatory surgical center services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Urgent care center visits		
▪ facility billed services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ facility laboratory services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ facility diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Pre-admission testing is covered for tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.
- Coverage is provided for hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.
- Coverage is provided for anesthesia, anesthesia supplies and devices rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery.

NOTES:

- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The health care plan covers anesthesia and outpatient hospital services when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- Assisted fertilization services are subject to a lifetime maximum limit of $20,000 per person for medical services and prescription drugs combined.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

INFUSION THERAPY

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Home infusion and suite infusion therapy services • Intravenous solutions and pharmaceutical additives, pharmacy compounding and dispensing services • Medical/surgical supplies • Nursing services associated with infusion therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or home setting.
- Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy.

NOT COVERED:

- infusion services or supplies not specifically listed as covered services
- nursing services to administer infusion therapy when the patient or caregiver can be successfully trained to administer therapy

MATERNITY CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Prenatal hospital/facility provider services	You pay nothing	You pay 50% coinsurance after deductible
• Prenatal professional services	You pay nothing	You pay 50% coinsurance after deductible
• Health care professional services for: ▪ delivery in a hospital/facility ▪ examination of the newborn infant while the mother is an inpatient	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ postpartum care • office visit	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• all other eligible services - office/clinic	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• all other eligible services – outpatient hospital/facility	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient hospital/facility services for: ▪ delivery in a hospital/facility ▪ postpartum care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and her newborn child.
- If you think you are pregnant, you may contact your physician or go to an in-network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital.
- Normal pregnancy – normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.
- Hospital, medical and surgical services rendered by a facility provider or professional provider for:
  - Complications of pregnancy - physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.
  - Prenatal care - the comprehensive package of medical and psychosocial support provided throughout the pregnancy, includes risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.
- Under federal law, group health plans such as this plan are required to provide benefits for any hospital length of stay in connection with childbirth as follows:
  - inpatient hospital coverage for the mother (to the extent the mother is covered under this health care plan) is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this health care plan. Please refer to "Home Health Care."

NOTES:

- inpatient hospital coverage for the newborn (to the extent the newborn is covered under this health care plan) is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this plan. Please refer to "Home Health Care."

- Under federal law, the health care plan may require that a provider obtain authorization from the health care plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.
- Eligible acupuncture services are limited to 20 visits per person per calendar year.

NOT COVERED:

- health care professional services for childbirth deliveries in the home
- services for or related adoption fees
- services for or related to surrogate pregnancy including: diagnostic screening, physician services, assisted fertilization, and prenatal/delivery/postnatal services when the surrogate is not a covered member under this plan
- services for childbirth classes
- services for or related to preservation, storage, and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue
- services for donor ova or sperm
- services for or related to elective cesarean (C)-section for the purpose of convenience
- services and prescription drugs for or related to the selection of gender in embryos

MEDICAL EQUIPMENT AND SUPPLIES

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Durable medical equipment (DME), except as noted below • Amino acid-based elemental formula • Corrective lenses, frames and contact lenses after cataract surgery (purchased within 24 months of cataract surgery) • Scalp hair prostheses (wigs) for hair loss due to alopecia areata or cancer only • Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Insulin infusion devices	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Blood glucose monitors	You pay nothing	You pay 50% coinsurance after deductible
• Orthotics	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Cochlear implants	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Non-investigative bone conductive hearing devices	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Coverage includes the purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.
- Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a health care provider legally authorized to prescribe such items under the law:
  - equipment and supplies: all physician prescribed medically necessary and appropriate equipment and supplies, including but not limited to, blood glucose monitors, monitor supplies, and insulin infusion devices.
- The rental or, upon approval by the claims administrator, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a health care provider within the scope of his/her license. Rental costs cannot exceed the total cost of purchase.
- Amino acid-based elemental formula is a type of exempt formula which is regulated by the U.S. Food and Drug Administration (FDA) and is prescribed for infants or children with specific medical or dietary problems. An amino acid-based formula contains proteins which are broken down into their simplest and purest form making it easier for the body to process and digest. An infant or child may be placed on an amino acid-based formula if he/she is unable to digest or tolerate whole proteins found in other formulas, due to certain allergies or gastrointestinal conditions. Examples of amino acid-based elemental formulas are Neocate®, EleCare®, PurAmino™ (formerly Nutramigen® AA™ LIPIL), Vivonex®, Tolerex®, Alfamino, and E028 Neocate Splash.

NOTES:

- Coverage for eligible orthotic devices includes purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.
- Scalp hair prostheses (wigs) for hair loss due to alopecia areata or cancer only. Maximum of $350 per person per calendar year.
- Corrective lenses, frames and contact lenses must be purchased within 24 months of cataract surgery.
- Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years.
- You are required to obtain prior authorization for durable medical equipment when you use nonparticipating providers in Minnesota or any provider outside of Minnesota. Please refer to www.bluecrossmnonline.com (click on "For Providers" at the bottom of the page, then "Medical Policy" under "Tools and Resources") or contact customer service at the telephone number on the back of your member ID card.

NOT COVERED:

- foot orthoses, except as provided herein
- services for or related to hearing aids or devices, except as provided herein
- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the "Benefit Chart"
- personal and convenience items or items provided at levels which exceed our determination of medically necessary and appropriate for durable medical equipment, supplies, and prosthetics
- services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; and incontinence pads or pants
- modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- replacement of properly functioning durable medical equipment
- duplicate equipment, prosthetics, or supplies
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- charges for devices for maintenance services
- scalp hair prostheses (wigs), except as provided herein
- charges for the rental of a manual breast pump
- charges for an electric breast pump
- services for eyeglasses or contact lenses for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury)

OFFICE VISIT AND PROFESSIONAL SERVICES

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• General physician office visits	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Specialty physician office visits	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• E-visits • Telephone consultations	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Urgent care center visits for illness/injury ▪ office visit for urgent care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ professional laboratory services for urgent care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ professional diagnostic imaging services for urgent care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services for urgent care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Retail health clinic ▪ retail health clinic office visit	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ laboratory services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional office and outpatient laboratory services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional office and outpatient diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional billed services received at a freestanding ambulatory surgical center	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Omada program for members age 18 or older for: ▪ pre-diabetes/pre-cardiac	You pay nothing	NO COVERAGE
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Assisted fertilization	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• All other professional services – office/clinic	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• All other professional services – outpatient hospital/facility	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- For members diagnosed with End Stage Renal Disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the claims administrator. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.
- Medical care rendered concurrently with surgery during one inpatient stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Medical care by two or more professional providers rendered concurrently during one inpatient stay when the nature or severity of your condition requires the skills of separate physicians.
- Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a health care provider legally authorized to prescribe such items under the law:
  - Diabetes Education Program*: When your health care provider certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
    - visits medically necessary and appropriate upon the diagnosis of diabetes
    - subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

  *Diabetes Education Program – an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care provider working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association with expertise in diabetes.
- If more than one (1) surgical procedure is performed during the same operative session, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- Physician services include services of an optometrist and an advanced practice nurse when performed within the scope of their licensure.
- The plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; and psychotherapy.
- A retail health clinic, located in a retail establishment or worksite, provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital/facility provider. Retail health clinics are staffed by eligible nurse practitioners or other eligible health care providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
- The plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major organ transplant, please refer to "Transplant."
- The plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the plan:
  - potential donor testing;
  - donor evaluation and workup; and
  - hospital and professional services related to organ procurement.
- The plan covers certain routine patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.

NOTES:

- Diagnostic services include the following when ordered by a health care provider:
  - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine
  - diagnostic pathology consisting of laboratory and pathology tests
  - diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the claims administrator; and
  - allergy testing consisting of percutaneous, intracutaneous, and patch tests
- Eligible therapeutic injections, including specialty drugs, administered by a health care provider required in the diagnosis, prevention and treatment of an injury or illness, provided that the drugs are not "usually self-administered" by a member and when the administration of the drug and the medication are billed by the health care provider and eligible under the "Office Visit and Professional Services" benefit. For injectable medications billed by a pharmacy or specialty drugs billed by the participating specialty pharmacy network provider, please refer to "Prescription Drugs." For specialty drugs that are administered in a clinic or an outpatient hospital, your health care provider may be required to obtain the specialty drugs from a designated vendor.
- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The plan covers services for or related to growth hormone replacement therapy if it is determined to be medically necessary and appropriate and otherwise covered under this health care plan.
- Please refer to “Preventive Care” for female sterilization.
- Omada delivers the largest CDC recognized prevention program for high-risk (pre-diabetes/pre-cardiac) conditions. Eligible members age 18 and older may participate in the digital care program, personalized to meet each eligible participant’s unique needs, as they evolve. The Omada for prevention program helps participants lose weight (and keep it off), build strategies for healthy eating, activity, sleep, and stress management, and reduce the risk of developing diabetes and cardiovascular disease-one step at a time. Each participant is given a professional health coach, connected devices, including a digital scale, online peer community, weekly interactive lessons and insight driven health goals.
- You are entitled to receive care at the in-network level from out-of-network providers if these services are covered under your plan:
  - the voluntary planning of the conception and bearing of children;
  - the diagnosis of infertility;
  - the testing and treatment of a sexually transmitted disease; or,
  - the testing of AIDS or other HIV-related conditions.
- E-visit is a patient-initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services. These services provide real-time interaction between a distant site physician/medical practitioner and the member who is present and participating in the televideo visit at a remote facility.
- Therapeutic injections include coverage for off-label prescription drugs used for cancer treatment as specified by law. An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard compendia or in one article in the medical literature as specified by law.
- For self-administered prescription medications/drugs, please refer to “Prescription Drugs.”

NOTES:

- If you are prescribed a medication subject to step therapy, another eligible medication that is safe, more clinically effective, and in some cases more cost effective must have been prescribed and tried before the medication subject to step therapy will be paid under the medical benefit. Medical policy guidelines are available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. At your written request, we will provide you the criteria that we use to determine the medical necessity and appropriateness of a prescription drug that is subject to step therapy. If you or your prescribing health care provider believe that you need coverage for a prescription drug that is subject to the step therapy provision, an override from step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. If the step therapy override request meets one of the legally required conditions, we will grant the request, override the step therapy requirement, and cover the drug if it is a covered prescription drug under your plan.
- Assisted fertilization services are subject to a lifetime maximum limit of $20,000 per person for medical services and prescription drugs combined.
- The plan covers hearing aid examinations/fitting/adjustments for children age 18 and younger.
- Eligible acupuncture services are limited to 20 visits per person per calendar year.

NOT COVERED:

- out-of-network provider-initiated communications
- charges for giving injections that can be self-administered
- self-administered drugs that are available for coverage under the pharmacy/prescription drug benefit
- services for autopsies
- services for or related to cosmetic health services or surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as provided herein
- separate services for pre-operative and post-operative care for surgery billed by an out-of-network provider
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered under this plan
- services for or related to the LINX™ Reflux Management System (considered investigative) for the treatment of gastroesophageal reflux disease (GERD)
- services and supplies for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, except as provided herein
- services for routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein
- services for educational classes or programs, except as required by law
- services for or related to vision correction surgery such as the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, laser-assisted in situ keratomileusis (LASIK) and all related services
- services for or related to vocational rehabilitation (defined as service provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider

NOT COVERED:

- services provided during an e-visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit
- services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit
- services for or related to reversal of sterilization

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Habilitative and rehabilitative office visits from a physical therapist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative therapies from a physical therapist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative office visits from an occupational therapist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative therapies from an occupational therapist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative office visits from a speech or language pathologist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative therapies from a speech or language pathologist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Coverage includes benefits for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
- For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- Office visits may include an evaluation or re-evaluation of the following therapies:
  - physical
  - occupational
  - speech
  - swallowing
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a hospital/facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Habilitation and rehabilitation therapy benefits for physical, occupational, and speech therapy are limited to a combined maximum of 90 visits per person per calendar year.

NOT COVERED:

- services for or related to vocational rehabilitation (defined as service provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider
- services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate

PRESCRIPTION DRUGS

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips, needles and syringes, lancets • Prescription injectable drugs that are self-administered and do not require the services of a health care professional, except for designated specialty drugs (see NOTES) • Insulin • Affordable Care Act (ACA) preventive covered prescription drugs • FDA-approved tobacco cessation drugs and products, subject to limitations below • Designated specialty drugs purchased through a participating specialty pharmacy network supplier • Retail pharmacy vaccine program ▪ certain eligible vaccines administered at a participating retail pharmacy (see NOTES)	Please refer to "Prescription Drug Benefits" in "Benefit Overview."	Please refer to "Prescription Drug Benefits" in "Benefit Overview."

NOTES:

- Covered prescription drugs include drugs listed in your health care plan's covered drug list; including compounded medications, consisting of the mixture of at least two (2) or more FDA-approved prescription drugs/medications. (Please refer to “Terms You Should Know”).
- The claims administrator covered drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the Blue Cross Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. This list can change throughout the year.
- Eligible prescription drugs are covered when you purchase them through the pharmacy network applicable to your health care plan, except as provided herein. For convenience and choice, in-network pharmacies include both major chains and independent stores. Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day.
- The claims administrator chooses which drugs are on its drug lists, or excluded from its drug lists, based on numerous factors including their quality, safety and effectiveness, and overall cost. The overall cost of a drug can be impacted by volume discounts or reimbursements paid by drug manufacturers. At times, this may result in a brand name drug being included on a drug list while the generic of the same drug is excluded from a drug list.
- To receive a copy of your covered drug list visit www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card.
- The drug list is subject to periodic review and modification by the claims administrator or a designated committee of physicians and pharmacists.
- A retail pharmacy is a licensed pharmacy that you can physically enter to obtain a prescription drug. Eligible prescription drugs and diabetic supplies are generally covered up to a 31-day supply.
- 90dayRx includes the following: a retail pharmacy participating in the 90dayRx network and a participating mail service pharmacy that dispenses prescription drugs through the U.S. Mail. Eligible prescription drugs are dispensed up to a 90-day authorized supply of ongoing, long-term prescription drugs.

NOTES:

- The health care plan will cover off-label prescription drugs used for cancer treatment as specified by law. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard compendia or in one article in the medical literature as specified by law.
- Amino acid-based elemental formula is considered a supply item. Please refer to “Medical Equipment and Supplies.”
- Biosimilar drugs are not considered generic drugs. Please refer to your covered drug list.
- There may be circumstances where early or extended prescription drug refills are available. Please contact customer service at the telephone number listed on the back of your member ID card for further information. Restrictions apply.
- The claims administrator may receive pharmaceutical manufacturer volume discounts or reimbursements in connection with the purchase of certain prescription drugs covered under the health care plan. Such discounts are the sole property of the claims administrator and/or the health care plan and will not be considered in calculating any coinsurance, copay, deductible, or benefit maximums, except as required by law.
- Benefits are provided for a range of FDA-approved preventive contraceptive methods and for patient education/counseling, for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
- Benefits are provided for designated ACA preventive drugs with a prescription which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
- For more information regarding contraceptive or ACA preventive prescription drug coverage, please visit www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card.
- The claims administrator applies medical management in determining which contraceptives are included on your covered drug list, as well as a subset of contraceptive medications where a $0 member cost-sharing applies. To view a current list of contraceptive medications that are eligible for coverage without member cost-sharing under your plan visit www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. If your prescribing health care professional determines that none of the $0 member cost-sharing options available under your plan are clinically appropriate for you, he or she may request an exception through www.bluecrossmnonline.com (select "Forms” then “Coverage Exception Form”).
- Covered prescription drugs also include selected specialty prescription drugs within, but not limited to, the following prescription drugs classifications only when such prescription drugs are covered medications and are dispensed through exclusive specialty pharmacy network supplier. Specialty prescription drugs are designated complex injectable and oral drugs generally covered up to a 31-day supply that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Specialty prescription drugs are prescription drugs including, but not limited to prescription drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia. A current list of designated specialty prescription drugs and suppliers is available at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. Specialty prescription drugs are not available through 90dayRx.
- Specialty prescription drugs may be ordered by a health care provider on your behalf or you may submit the prescription order directly to the specialty pharmacy network supplier. In either situation, the specialty pharmacy network supplier will deliver the prescription to you.
- The retail pharmacy vaccine program allows you the opportunity to receive certain otherwise eligible vaccines at designated participating retail pharmacies subject to your prescription drug cost-sharing. This program is in addition to your current vaccine benefit administered through your clinic/physician's office. A list of eligible vaccines under this program and designated participating pharmacies is available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card.

NOTES:

- If you are prescribed a medication subject to step therapy, another eligible medication that is safe, more clinically effective, and in some cases more cost effective must have been prescribed and tried before the medication subject to step therapy will be paid under the prescription drug benefit. Step therapy prescription drug categories are available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. At your written request, we will provide you the criteria that we use to determine the medically necessity and appropriateness of a prescription drug that is subject to step therapy. If you or your prescribing health care provider believes that you need coverage for a prescription drug that is subject to the step therapy provision, an override from step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. If the step therapy override request meets one of the legally required conditions, we will grant the request, override the step therapy requirement, and cover the prescription drug if it is a covered prescription drug under your plan.
- If you are prescribed a brand drug when there is an equivalent generic drug, you will also pay the difference in cost between the brand drug and the generic drug, in addition to the applicable member cost-sharing. When you have reached your out-of-pocket limit, you still pay the difference in cost between the brand drug and the generic drug, even though you are no longer responsible for the applicable prescription drug member cost-sharing. You are also responsible for the payment differential when a generic drug is authorized by the physician and the member purchases a brand drug. Your payment is the price difference between the brand drug and generic drug in addition to the brand drug cost-sharing amounts that apply.
- Self-administered injectable and oral prescription drugs for assisted fertilization must be obtained through a specialty pharmacy network supplier and are subject to the lifetime maximum limit of $20,000 per member for all assisted fertilization for all charges and networks combined.

NOT COVERED:

- any charges by any pharmacy provider or pharmacist, except as provided herein
- any prescription for more than the retail days supply or 90dayRx days supply as outlined in “Benefit Overview,” except as provided herein
- charges for any drug purchased through mail order but not dispensed by a designated mail order pharmacy provider
- blenderized food, baby food, or regular shelf food when used with an enteral system, banked breast milk
- milk or soy-based infant formula with intact proteins
- any formula (standard and specialized), when used for the convenience of you or your family members
- solid or liquid food, standard or specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except if administered by tube feeding and as provided in the "Benefit Chart"
- investigative or non-FDA approved drugs, except as provided by law
- vitamin or dietary supplements, except as provided herein
- services for or related to tobacco cessation drugs and program fees and/or supplies, except as provided herein
- semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally
- normal food products used in the dietary management of rare hereditary genetic metabolic disorders
- medical devices approved by the FDA under the prescription drug benefit unless the devices are on your covered drug list. Covered medical devices are generally submitted and reimbursed under your medical benefits, please refer to “Medical Equipment and Supplies”
- specialty drugs not purchased through a specialty pharmacy network supplier
- drugs removed from the covered drug list due to safety reasons may not be covered
- over-the-counter drugs, except as provided herein

NOT COVERED:

- tobacco cessation drugs and products without a prescription
- prescription drugs for cosmetic alteration
- prescription drugs for weight loss

PREVENTIVE CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
Preventive care services from health care professionals, outpatient hospitals/facilities, and medical equipment suppliers in accordance with a predefined schedule based on age, sex and certain risk factors which are the recommendations of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, Health Resources and Services Administration (HRSA), and the Internal Revenue Service (IRS) for:		
• Adults and children age 6 and older ▪ routine physical examinations	You pay nothing	You pay 50% coinsurance after deductible
▪ vision examination (glaucoma, acuity, refraction)	You pay nothing	You pay 50% coinsurance after deductible
▪ hearing screening	You pay nothing	You pay 50% coinsurance after deductible
▪ adult immunizations that require administration by a health care provider, including the immunizing agent, when required for the prevention of disease	You pay nothing	You pay 50% coinsurance after deductible
▪ diagnostic services and procedures ▪ surveillance tests for ovarian cancer - (CA125 tumor marker, trans-vaginal ultrasound, pelvic examination)	You pay nothing	You pay 50% coinsurance after deductible
▪ routine gynecological examinations, including a Papanicolaou (PAP) test	You pay nothing	You pay 50% coinsurance after deductible
▪ mammograms, 2 dimensional (2D) or 3 dimensional (3D), annual routine and medically necessary and appropriate	You pay nothing	You pay 50% coinsurance after deductible
▪ colorectal cancer screening ▪ prostate specific antigen (PSA) tests and digital rectal examinations for men of all ages	You pay nothing	You pay 50% coinsurance after deductible
• Infants and children ▪ routine physical examinations from birth to age 6 ▪ developmental assessments from birth to age 6	You pay nothing	You pay 50% coinsurance after deductible
▪ pediatric immunizations from birth to age 18	You pay nothing	You pay 50% coinsurance after deductible

NOTES:

- Preventive care services are consistent with state and federal statutes, regulations, and related guidance.
- Benefits for services identified as preventive care are determined based on recommendations and criteria established by professional associations and experts in the field of preventive care (e.g., Institute for Clinical Systems Improvement (ICSI), United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), etc.). For all other eligible services, please refer to “Hospital Inpatient Care,” "Hospital Outpatient Care," "Office Visit and Professional Services," etc. for appropriate benefit levels.

NOTES:

- Routine physical examinations including a complete medical history for adults, and other items and services.
- For more information regarding preventive care services, please visit www.bluecrossmnonline.com (choose "Live Healthy" then "Preventive Care") or contact customer service at the telephone number listed on the back of your member ID card.
- Preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors which are the recommendations of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and Health Resources and Services Administration (HRSA). The claims administrator periodically reviews the schedule of covered services based on the requirements of the Patient Protection and Affordable Care Act of 2010, and recommendations from USPSTF, ACIP and HRSA. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto the member website at, www.bluecrossmnonline.com or call customer service at the telephone number listed on the back of your member ID card.
- Benefits are provided for surgical implants and tubal ligation for elective sterilization for females which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage please visit www.bluecrossmnonline.com ("Member Sign In" then "Plan Details"/"Preventive care benefit information"/"learn more") or contact customer service.
- Benefits are provided for a full range of FDA-approved preventive contraceptive methods and for patient education/counseling, for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. Please refer to "Prescription Drug Benefits" in the "Benefit Overview" section for outpatient drug coverage.
- Services for complications related to female contraceptive drugs, devices, and services for women of reproductive capacity may be covered under other plan benefits. Please refer to "Hospital Inpatient Care, "Hospital Outpatient Care, "Office Visit and Professional Services," etc. for appropriate benefit levels.
- Benefits are provided for “child health supervision services,” which means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age 6, and appropriate immunizations from ages six (6) to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. We will reimburse five (5) child health supervision visits from birth to 12 months, three (3) child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.
- Well-woman benefits are provided for female members for items and services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling and breastfeeding support and counseling.
- You are entitled to receive care at the in-network level for screening for sexually transmitted disease or HIV.
- Benefits are provided for the purchase of a manual breast pump.
- Adult preventive care services are limited to those on the health care plan’s preventive schedule and the women's health preventive schedule. Gender, age and frequency limits may apply.
- Pediatric preventive care services are limited to those on the health care plan’s preventive schedule. Gender, age and frequency limits may apply.
- Services to treat an illness/injury diagnosed as a result of preventive care services or preventive care services in excess of USPSTF, ACIP of the Centers for Disease Control, HRSA, or the IRS recommendations and criteria may be covered under other plan benefits. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. for appropriate benefit levels.
- All female members, regardless of age, are covered for routine gynecological examinations, including a pelvic and clinical breast examination.
- Benefits are provided to eligible dependent children for pediatric immunizations.

NOTES:

- Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:
  - diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
  - diagnostic imaging screening services such as barium enema
  - surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
  - such other diagnostic pathology and laboratory, diagnostic imaging, surgical screening tests and diagnostic screening services consistent with approved medical standards and practices for the detection of colon cancer
- If you are determined to be at high or increased risk, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician. Colorectal cancer screening services which are otherwise not described herein and are prescribed by a physician for a symptomatic member are not considered preventive care services. The payment for these services will be consistent with similar medically necessary and appropriate covered services.

NOT COVERED:

- services for routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein

RECONSTRUCTIVE SURGERY

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved body part • Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending health care provider. • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Elimination or maximum feasible treatment of port wine stains	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- If more than one (1) surgical procedure is performed during the same operative session, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- Congenital means present at birth.
- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."

NOT COVERED:

- repairs of scars and blemishes on skin surfaces
- dentures, regardless of the cause or condition, and any associated services including bone grafts
- dental implants, and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19

SKILLED NURSING FACILITY CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Skilled care ordered by a physician • Room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Coverage is limited to a maximum benefit of 60 days per person per calendar year.

NOT COVERED:

- custodial care, nonskilled care, adult daycare or personal care attendants
- services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care
- services when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience
- treatment, services or supplies that are not medically necessary and appropriate
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care

TRANSPLANT

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Benefits may be provided for covered services furnished by a hospital which are directly and specifically related to the transplantation of the following: medically necessary and appropriate human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures: ▪ allogeneic and syngeneic bone marrow transplant and peripheral stem cell and umbilical cord blood transplant procedures ▪ autologous bone marrow transplant and peripheral blood stem cell transplant procedures ▪ heart ▪ heart-lung ▪ kidney-pancreas transplant performed simultaneously (SPK) ▪ liver - deceased donor and living donor ▪ liver-kidney ▪ lung - single or double ▪ pancreas transplant - deceased donor and living donor segmental • Pancreas Transplant Alone (PTA) • Simultaneous Pancreas-Kidney (SPK) transplant • Pancreas After Kidney (PAK) transplant ▪ small-bowel and small-bowel/liver	You pay nothing of the transplant payment allowance after deductible for the transplant admission when you use a Blue Distinction Centers for Transplant (BDCT) provider	You pay 20% coinsurance of the transplant payment allowance after deductible when you use a participating transplant provider NO COVERAGE when you use a nonparticipating provider

NOTES:

- For members diagnosed with End Stage Renal Disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the claims administrator. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.
- Kidney transplants when not done in conjunction with an eligible major organ transplant noted above, and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to "Hospital Inpatient Care," "Office Visit and Professional Services," etc.
- If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:
  - when both the recipient and the donor are members, each is entitled to the benefits of their health care plan;
  - when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this health care plan subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this health care plan to the extent that benefits remain and are available under this health care plan after benefits for the recipient's own expenses have been paid;
  - when only the donor is a member, the donor is entitled to the benefits of this health care plan, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this health care plan; and 2) no benefits will be provided to the non-member transplant recipient; and

NOTES:

- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's health care plan limit.

- For services not included in the transplant payment allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.
- Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures, and should be submitted in writing or faxed to 651-662-1624.
- Eligible transplant services provided by participating transplant providers will be paid at the Blue Distinction Centers for Transplant (BDCT) providers level of benefits when the transplant services are not available at a BDCT provider.
- If you live more than 50 miles from a BDCT provider, there may be a travel benefit available for expenses directly related to a preauthorized transplant.

NOT COVERED:

- services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow and peripheral stem cell transplant procedures that are considered investigative or not medically necessary and appropriate
- living donor organ and/or tissue transplants, except as provided herein
- benefits for travel expenses when you are using a Non-BDCT provider
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this plan
- transplant services you receive from a nonparticipating provider

GENERAL EXCLUSIONS

Except as specifically provided in this health care plan or as the claims administrator is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges noted under "NOT COVERED" in the Benefit Chart and as noted below.

No benefits will be provided for the following:

1. Court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law.
2. Custodial care, nonskilled care, adult daycare or personal care attendants.
3. Services rendered prior to your effective date of coverage.
4. Services which are experimental/investigative in nature, except for certain routine care for approved clinical trials.
5. Treatments, services or supplies which are not medically necessary and appropriate based on the definition of “Medically Necessary and Appropriate” in “Terms You Should Know.”
6. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as provided herein.
7. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as provided herein.
8. Services for palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
9. Services for or related to hearing aid devices and tinnitus maskers for adults age 19 and older.
10. Physical, occupational, and speech therapy services for or related to the treatment of learning disabilities and disorders, except when medically necessary and appropriate and provided by an eligible health care provider.
11. New to market FDA-approved drugs, devices, diagnostics, therapies, and medical treatments until they have been reviewed and approved by the claims administrator and deemed eligible for coverage.
12. To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this health care plan and you elect this coverage as primary.
13. To the extent benefits are provided to members of the armed forces while on active duty or to members in Veteran's Administration facilities for service-connected illness or injury, unless you have a legal obligation to pay.
14. Charges for the covered patient’s failure to keep a scheduled visit.
15. Charges billed by your provider for the completion of a claim form.
16. Any other medical or dental service or treatment or prescription drug, except as provided herein.
17. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle, including a motor vehicle accident, if such treatment or service is eligible, paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable. Charges that are eligible, paid, or payable under any medical payment, automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
18. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
19. Services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury.
20. Services which are not prescribed by or performed by or upon the direction of a professional provider.

21. Services rendered by other than ancillary providers, facility providers or professional providers.
22. Services which are submitted by another professional provider of the same specialty for the same services performed on the same date for the same member.
23. Services that are primarily for the convenience of the member, physician, or health care provider or are more costly than alternative services or sequence of services that are clinically appropriate and are likely to produce equivalent therapeutic or diagnostic results to treat the member's illness, injury, or disease.
24. Services rendered by a provider who is a member of your immediate family.
25. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
26. Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care.
27. Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
28. Tobacco cessation drugs and products without a prescription.
29. Services incurred after the date of termination of your coverage, except as provided herein.
30. Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
31. Services for or related to any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.
32. Services that are provided without charge, including services of the clergy.
33. Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that he or she will not owe the required cost-sharing amount (including, for example, deductibles, copays, and coinsurance) described in this plan.
34. Services for or related to acupuncture, except for medically necessary and appropriate acupuncture services for the treatment of chronic pain (defined as a duration of six (6) months); and for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy.
35. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; etc., and all related material and products for these programs.
36. Services for dependents if you have employee-only coverage.
37. Services that are not within the scope of licensure or certification of a provider.
38. Services that are prohibited by law or regulation.
39. Services for furnishing medical records or reports and associated delivery services.
40. Services for transportation, other than local ambulance service, to the nearest medical facility provider that can provide the necessary services/is equipped to treat the condition, except as provided herein.
41. Ambulance transportation costs that exceed the allowable cost from the place of departure to the nearest medical facility that can provide the necessary service/is equipped to treat the condition.
42. Services for or related to therapeutic massage.
43. Services for or related to experimental infertility treatment procedures, surrogacy services, or cryopreservation of eggs or sperm.
44. Charges for donor ova or sperm.
45. Services for or related to preservation, storage, and thawing of human tissue, including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue.

46. Services provided during an e-visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
47. Services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
48. Services and fees for or related to health clubs and spas.
49. Services for or related to the repair of scars and blemishes on skin surfaces.
50. Services for hippotherapy (equine movement therapy).
51. Maintenance services.
52. Services that do not involve direct patient contact such as delivery services and recordkeeping billed by an out-of-network provider.
53. Services for educational classes or programs, except as required by law.
54. Services for or related to functional capacity evaluations for vocational purposes or the determination of disability or pension benefits.
55. Services for or related to gene therapy (for those considered experimental) as a treatment for inherited or acquired disorders.
56. Services for or related to any treatment, equipment, drug, and/or device that does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment; services for or related to homeopathy, or chelation therapy that is not medically necessary and appropriate.
57. Charges for growth hormone replacement therapy, except for services that meet medical necessity and appropriateness criteria.
58. Services for or related to fetal tissue transplantation.

In addition, under your prescription drug benefits, except as specifically provided in this health care plan or as the claims administrator is mandated or required to provide based on state or federal law, no benefits will be provided for:

59. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
60. Charges for over-the-counter drugs, except those set forth in the predefined preventive schedule. Please refer to "Prescription Drugs" for more information.
61. Charges for food supplements.
62. Charges for any drugs prescribed for cosmetic purposes only.
63. Charges for any drugs which are investigative.
64. Prescription drugs, including but not limited to biological products, biosimilars, and gene or cell therapies, that have an alternative drug available similar in safety and effectiveness and is more cost-effective.
65. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
66. Charges for selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
67. Over-the-counter drugs, except as provided herein.

Medical and Behavioral Health Care Management

The claims administrator reviews services to verify that they are medically necessary and appropriate and that the treatment provided is the proper level of care. All applicable terms and conditions of your plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization or admission notification, or emergency admission notification.

Prior authorization and admission notification are required.

If you are admitted to the hospital due to an emergency, admission notification is required as soon as reasonably possible, no later than two (2) business days, following the admission.

Prior Authorization

Prior authorization is a process that involves a benefits review and determination of medical necessity and appropriateness before a service is rendered. The claims administrator's prior authorization list describes the services for which prior authorization is required. The prior authorization list is subject to change due to changes in the claims administrator's medical policy. The claims administrator reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on the claims administrator's website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. They will direct your call.

Participating Providers in Minnesota and Bordering Counties

For services that require prior authorization participating providers in Minnesota and bordering counties are required to obtain prior authorization for you. Participating providers in Minnesota and bordering counties who do not obtain required prior authorization are responsible for the charges (except where other benefit exclusions apply).

Nonparticipating Providers and Participating Providers Located Outside of Minnesota and Bordering Counties

You are required to obtain prior authorization when you use nonparticipating providers and any provider outside of Minnesota/bordering counties. Some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you or not. If prior authorization is not completed and at the point the claim is processed it is found that services received from a nonparticipating provider or any provider outside of Minnesota/bordering counties were not medically necessary and appropriate, you are liable for all of the charges.

The claims administrator prefers that all requests for prior authorization be submitted in writing to ensure accuracy. **Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.**

Standard review process

The claims administrator requires that you or the provider contact them at least 10 working days prior to the provider scheduling the care/services to determine if the services are eligible. The claims administrator will notify you of their decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

Expedited review process

The claims administrator will use an expedited review process when the application of a standard review could seriously jeopardize your life or health or if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, the claims administrator will notify you as expeditiously as the medical condition requires, but no later than 72 hours from the initial request, unless more information is needed to determine whether the requested benefits are covered. If the expedited determination is to not authorize services, you may submit an expedited appeal. Please refer to "Appeals of Adverse Benefit Determinations" for more information about submitting an expedited appeal.

The claims administrator prefers that all requests for prior authorization be submitted to them in writing to ensure accuracy. Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.

Admission Notifications

- **Admission notification** is a process whereby the provider, or you, inform the claims administrator that you will be admitted for inpatient hospitalization or post-acute care services (e.g., long-term acute care, acute rehabilitation, skilled nursing facility, residential treatment or half-way house). The claims administrator requires that you, or your provider, as determined below, call us prior to being admitted, or as soon as reasonably possible, no later than two (2) business days, following the admission.
- **Emergency admission notification** is a process whereby the provider, or you, inform the claims administrator of an unplanned or emergency admission, no later than two (2) business days, following the admission.

Upon receipt of an admission notification, when required, the claims administrator will provide a review of medical necessity and appropriateness related to a specific request for care or services. As needed during an admission, the claims administrator will review the continued stay to determine medical necessity and appropriateness and to help you when you are discharged

You, or your provider, may also be required to obtain prior authorization for the services or procedures done during a hospital stay; for example, an elective surgery that requires you to be admitted to the hospital. Please refer to "Prior Authorization" in this section to determine if you, or your provider, is responsible for obtaining any required prior authorization(s).

Participating Providers

Participating providers in Minnesota and participating providers outside of Minnesota are required to provide admission notification and emergency admission notification for you. You will not be held responsible if notification is not completed when using participating providers.

Nonparticipating Providers

You are required to provide admission notification to the claims administrator if you are going to receive care from any nonparticipating providers. Some of these providers may provide admission notification for you. Verify with your provider if this is a service they will perform for you or not.

To provide admission notification, contact customer service at the telephone number listed on the back of your member ID card. They will direct your call.

Note: If, at the point the claim is processed, it is found that any services received from a nonparticipating provider were not medically necessary and appropriate, you are liable for all the charges.

Medical and Behavioral Health Care Management Overview

The following chart is an overview of the information outlined in the previous section. For more detail, refer to the previous section.

Services received from:	Prior Authorization	Admission Notification	Emergency Admission Notification
Participating Provider Minnesota/Bordering Counties	Provider is responsible to request this for you and the provider must send the request in writing at least 10 working days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission, or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.

Participating Provider Outside of Minnesota/ Bordering Counties	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 working days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.
Nonparticipating Provider Nationwide	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 working days prior to services.	You are responsible for completing the notification and you must call at least 72 hours prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	You are responsible for completing the notification and you must call as soon as reasonably possible, no later than two (2) business days, following the admission.

HOW YOUR PROGRAM WORKS

Your health care plan lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two (2) levels of health care services: **in-network** or **out-of-network.**

In-Network Care

In-network care is care you receive from providers in the health care plan's in-network.

When you receive health care within the in-network, you enjoy maximum coverage and maximum convenience. You present your member ID card to the provider who submits your claim.

Out-of-Network Care

Out-of-network care is care you receive from providers who are not in the in-network.

Even when you go outside the in-network, you will still be covered for eligible services. However, your benefits generally will be paid at the lower, out-of-network level. Additionally, prior authorization may be required from the claims administrator before services are received. For specific details, please refer to "Health Care Management."

Please note that you may incur significantly higher financial liability when you use nonparticipating providers compared to the cost of receiving care from in-network providers. If you receive services from a nonparticipating provider, you will be responsible for any deductibles or coinsurance plus the difference between what the claims administrator would reimburse for the nonparticipating provider and the actual charges the nonparticipating provider bills. This difference does not apply to your out-of-pocket limit. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on the claims administrator’s allowed amount, which is typically lower than the amount billed by the provider. In addition, participating facilities may have nonparticipating professionals practicing at the facility and you may be responsible for significantly higher out-of-pocket expenses for the nonparticipating professional services.

Out-of-Area Care

Your health care plan also provides coverage for you and your eligible dependents who are temporarily away from home, or those dependents who permanently reside away from home.

Services received from providers across the country who are part of the local Blue Cross and Blue Shield BlueCard PPO network will be covered at the higher level of benefits. If you receive covered services from a provider who is not part of the local Blue Cross and Blue Shield BlueCard PPO network, these services will be covered at the lower, out-of-network level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic:

- If the illness or injury is a true emergency, it will be covered at the higher benefit level, regardless of whether the provider is in the local Blue Cross and Blue Shield BlueCard PPO network. If the treatment results in an admission, the local Blue Cross and Blue Shield BlueCard PPO network provider must obtain admission notification from the claims administrator. However, it is important that you confirm the claims administrator’s determination of medical necessity and appropriateness. If the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, please refer to "Health Care Management."
- If the illness or injury is not an emergency, you are required to use providers in the local Blue Cross and Blue Shield BlueCard PPO network in order to be covered at the higher benefit level. If you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level of benefits.

General Provider Payment Methods

Participating Providers

Several industry-standard methods are used to pay health care providers. If the provider is "participating" they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

Depending upon your health care plan, a participating provider may be an in-network provider or may be an out-of-network provider. Payment will be based upon which network the participating provider is in for your health care plan.

Please refer to "How Your Program Works" for additional detail on covered services received in the in-network and out-of-network.

- Non-Institutional or Professional (i.e., doctor visits, office visits) Participating Provider Payments
  - **Fee-for-Service -** Providers are paid for each service or bundle of services. Payment is based on the amount of the provider's billed charges.
  - **Discounted Fee-for-Service -** Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.
  - **Discounted Fee-for-Service, Withhold and Bonus Payments -** Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5-20%) of the provider's payment is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider's care. In order to determine cost-effectiveness, a per person per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

  In addition, as an incentive to promote high quality care and as a way to recognize those providers that participate in certain quality improvement projects, providers may be paid a bonus based on the quality of the provider's care to its members. In order to determine quality of care, certain factors are measured, such as member/patient satisfaction feedback on the provider, compliance with clinical guidelines for preventive services or specific disease management processes, immunization administration and tracking, and tobacco cessation counseling.

  Payment for high cost cases and selected preventive and other services may be excluded from the discounted fee-for-service and withhold payment. When payment for these services is excluded, the provider is paid on a discounted fee-for-service basis, but no portion of the provider's payment is withheld.
- Institutional (i.e., Hospital and other Facility provider) Participating Provider Payments
  - Inpatient care
    - **Payments for each Case (case rate) -** Providers are paid a fixed amount based upon the member's diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis ("outlier payment"). This method is similar to the payment methodology used by the federal government to pay providers for Medicare services.
    - **Payments for each Day (per diem) -** Providers are paid a fixed amount for each day the member spends in the hospital or facility provider.
    - **Percentage of Billed Charges** - Providers are paid a percentage of the hospital's or facility provider's billed charges for inpatient or outpatient services, including home services.
  - Outpatient care
    - **Payments for each Category of Services** - Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
    - **Payments for each visit** - Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.
    - **Payments for each Patient** - Providers are paid a fixed amount per person per calendar year for certain categories of outpatient services.

Special Incentive Payments

As an incentive to promote high quality, cost-effective care and as a way to recognize that those providers participate in certain quality improvement projects, providers may be paid extra amounts following the initial adjudication of a claim based on the quality of the provider's care to their members and further based on claims savings that the provider may generate in the course of rendering cost-effective care to its member. Certain providers also may be paid in advance of a claim adjudication in recognition of their efficiency in managing the total cost of providing high quality care to members and for implementing quality improvement programs. In order to determine quality of care, certain factors are measured to determine a provider's compliance with recognized quality criteria and quality improvement.

Areas of focus for quality may include, but are not limited to: services for diabetes care; tobacco cessation; colorectal cancer screening; and breast cancer screening, among others. Cost of care is measured using quantifiable criteria to demonstrate that a provider is meeting specific targets to manage claims costs. These quality and cost of care payments to providers are determined on a quarterly or annual basis and will not directly be reflected in a claims payment for services rendered to an individual member. Payments to providers for meeting quality improvement and cost of care goals and for recognizing efficiency are considered claims payment.

Pharmacy Payment

Four (4) kinds of pricing are compared and the lowest amount of the four (4) is paid:

- the average wholesale price of the prescription drug, less a discount, plus a dispensing fee;
- the pharmacy's retail price;
- the maximum allowable cost the claims administrator determines by comparing market prices (for generic drugs only); or,
- the amount of the pharmacy's billed charge.

Nonparticipating Providers

Nonparticipating providers are not network providers. Payment for covered services provided by a nonparticipating provider will be at the out-of-network level. Please refer to "How Your Program Works" for additional detail on covered services received in the in-network and out-of-network.

When you use a nonparticipating provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A nonparticipating provider does not have any agreement with Blue Cross or another Blue Cross and/or Blue Shield plan. For services received from a nonparticipating provider (other than those described under "Special Circumstances" below), the allowed amount will be based upon one of the following payment options to be determined at the claims administrators' discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar service; (2) a percentage, not less than 100%, of the Medicare Advantage Allowed Charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield plan; or, (5) pricing based on: provider reimbursement databases, median costs from a benchmark of claims, or fee negotiations. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than calculated by another payment option. When the Medicare Allowed Charge or Medicare Advantage Allowed Charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator. The allowed amount for a nonparticipating provider is usually less than the allowed amount for a participating provider for the same service and can be significantly less than the nonparticipating provider's billed charges. You will be paid the benefit under the health care plan and you are responsible for paying the nonparticipating provider. The only exception to this is stated in "Claims Procedures," "Claims Payment." The amount you pay does not apply toward any out-of-pocket limit contained in the plan.

In determining the allowed amount for nonparticipating providers, the claims administrator makes no representations that the allowed amount is a usual, customary or reasonable charge from a provider. Please refer to "Allowed Amount" under "Terms You Should Know" for a more complete description of how payments will be calculated for services provided by nonparticipating providers.

Example

The following table illustrates the different out-of-pocket costs you may incur using nonparticipating versus participating providers. The example presumes that your deductible has been satisfied and that the health care plan covers 80% for participating providers and 60% for nonparticipating providers. It also presumes that the allowed amount for a nonparticipating provider will be less than for a participating provider. The difference in the allowed amount between a Participating and nonparticipating provider could be more or less than the 20% difference in the example below.

	Participating Provider	Nonparticipating Provider
Provider charge:	$150	$150
Allowed amount:	$100	$80
Claims administrator pays:	80% ($80)	60% ($48)
Coinsurance you owe:	20% ($20)	40% ($32)
Difference up to billed charge you owe:	None	$70 ($150 minus $80)
You pay:	$20	$102

Special Circumstances

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care. For example, some hospital-based providers (e.g., anesthesiologists) or independent laboratory providers may not be participating providers. Typically, when you receive care from nonparticipating providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care such as in a participating hospital and were not able to choose the provider who rendered such care (nonparticipating providers in a participating hospital or your physician sending laboratory samples to a nonparticipating lab), Minnesota law provides that you may not be responsible for any amounts above what would have been required to pay (such as cost-sharing and deductibles) had you used a participating provider, unless you gave advance written consent to the nonparticipating provider. If you receive a bill from a nonparticipating provider while using a participating hospital or facility, and you did not provide written consent to receive the nonparticipating provider's services, you should submit the bill to the claims administrator for processing. If you have questions, please contact customer service at the telephone number listed on the back of your member ID card. The extent of reimbursement in certain medical emergency circumstances may also be subject to state and federal law – please refer to "Emergency Care" for coverage of benefits.

The above is a general summary of our provider payment methodologies only. Further, while efforts are made to keep this form as up-to-date as possible, provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary.

Please note that some of these payment methodologies may not apply to your particular plan.

Women's Health and Cancer Rights Act

Under the federal Women's Health and Cancer Rights Act of 1998 and Minnesota law, you are entitled to the following services:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prosthesis and physical complications at all stages of mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and patient.

Coverage may be subject to annual deductible, copay, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

Coverage of Health Care Services on the Basis of Gender

Federal law prohibits denying or limiting health services, that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Eligible, covered services must be medically necessary and appropriate, and remain subject to any requirements outlined in the claims administrator's medical policy and/or federal law.

Inter-Plan Arrangements

Out-of-Area Services

Overview

The claims administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These inter-plan arrangements work based on rules and

procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area the claims administrator serves, the claim for those services may be processed through one of these inter-plan arrangements. The inter-plan arrangements are described below.

When you receive care outside of the claims administrator's service area, you will receive it from one of two (2) kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. The claims administrator explains below how the claims administrator pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through inter-plan arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the plan administrator to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive covered health care services within the geographic area served by a Host Blue, the claims administrator will remain responsible for doing what the claims administrator agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Whenever you receive covered health care services outside the claims administrator's service area and the claim is processed through the BlueCard program, the amount you pay for covered health care services is calculated based on the lower of:

- the billed charges for covered services; or,
- the negotiated price that the Host Blue makes available to the claims administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the claims administrator has used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered health care services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to the claims administrator through average pricing or fee schedule adjustments. Additional information is available upon request.

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

If the claims administrator has entered into a Negotiated Arrangement with a Host Blue to provide value-based programs to employer on your behalf, the claims administrator will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard program.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the claims administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside the Claims Administrator's Service Area

Member Liability Calculation

When covered health care services are provided outside of the claims administrator's service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating

provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment the claims administrator will make for the covered health care services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health care services. Blue Cross Blue Shield Global Core is unlike the BlueCard program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered health care services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the claims administrator, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week.

Out-of-Country Benefits

Eligible services coordinated through the Blue Cross Blue Shield Global Core program (please refer to "Inter-Plan Arrangements," "Blue Cross Blue Shield Global Core") will process at the network level of coverage.

Call the Blue Cross Blue Shield Global Core service center within 24 hours of a medical emergency at 1-804-673-1177. You will be advised by the service center if services are not eligible under this program.

If you do not call the Blue Cross Blue Shield Global Core service center or services are not eligible under this program, eligible services will process at the out-of-network level of benefits.

Services not covered under the plan will not be considered for benefits.

Your Provider Network

Your provider network is your key to receiving the higher level of benefits. The network includes: thousands of physicians; a wide range of specialists; a wide variety of mental health and substance use disorder providers; community and specialty hospitals; and laboratories in the health care plan service area.

To determine if your physician is in-network, call the customer service toll-free telephone number listed on the back of your member ID card.

Getting your care "through the network" also assures you get quality care. All physicians are carefully evaluated before they are accepted into the network. The claims administrator considers educational background, office procedures and

performance history to determine eligibility. Then the claims administrator monitors care on an ongoing basis through office record reviews and member satisfaction surveys.

Please note that while you or a family member can use the services of any in-network physician or specialist without a referral and receive the maximum coverage under your health care plan, you are encouraged to select a personal physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Remember:
If you want to enjoy the higher level of benefits, it is *your* responsibility to ensure that you receive in-network care. You may want to double-check any provider recommendations to make sure the doctor or facility provider is in-network. Your provider directory lists in-network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is an in-network provider for your particular plan. Not every provider is an in-network provider for every plan. For a list of providers in the directory, visit www.bluecrossmnonline.com ("Member Log in" then "Find a Doctor") or call the customer service toll-free telephone number listed on the back of your member ID card. For benefit information, please refer to "Benefit Overview."

How to Get Your Physicians' Professional Qualifications

To view Board Certification information, hospital affiliation or other professional qualifications of your provider, visit your member website at www.bluecrossmnonline.com, or contact customer service at the telephone number listed on the back of your member ID card.

In-Network Pharmacies

- **Retail Pharmacy:** Participating retail pharmacies have an arrangement with the claims administrator to provide prescription drugs to you at an agreed upon price. When you purchase covered prescription drugs from an in-network pharmacy applicable to your health care plan, present your prescription and ID card to the pharmacist. (Prescriptions that the pharmacy receives by telephone from your physician or dentist may also be covered.) You should request and retain a receipt for any amounts you have paid if needed for income tax or any other purpose.

  If you travel within the United States and need to refill a prescription, contact customer service at the telephone number listed on the back of your member ID card for help. They can help you find an in-network pharmacy near the area you are visiting. You also can use the member website to find a pharmacy. Once you have the name and address of the in-network pharmacy, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill process. **Note: Save the new medicine container. This will make it easier to transfer the prescription back to your pharmacy at home.**

- **90dayRx:** 90dayRx Pharmacy includes 90dayRx participating retail pharmacy and Mail Order Pharmacy. This option offers savings and convenience for prescriptions you may take on an ongoing, long-term basis.
  - To utilize a 90dayRx participating retail pharmacy, verify that your pharmacy participates in the network and present your prescription for a 90-day fill of the eligible prescription medication.
  - To start using mail order pharmacy:
    - Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year, if appropriate.
      - Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling customer service or from your member website. After logging in, click on "Fill Rx" at the top of the home page. Then click on "Health & Benefits Information" and select the "Print Forms" link.

    Send the completed forms and your payment to the address listed on the mail order form. It usually takes about five (5) days to get your prescription after it has been processed. Your mail order will include directions for ordering refills.

- **Specialty Pharmacy Network Supplier:** The specialty pharmacy network supplier has an agreement, with the claims administrator pertaining to the payment and exclusive dispensing of selected specialty prescription drugs provided to you. Please refer to "Specialty Drugs" in "Terms You Should Know" for a list of the selected specialty prescription drug categories.

Continuity of Care

Continuity of Care for New Members

If you are a member of a group that is new to the claims administrator, this section applies to you. If you are currently receiving care from an out-of-network physician or specialist, you may request to continue to receive care from this physician for a special medical need or condition for a reasonable period of time before transferring to an in-network physician as required under the terms of your coverage under the health care plan. The claims administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician, advanced practice nurse, or physician assistant certifies that your life expectancy is 180 days or less. The claims administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:
1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or,
6. are receiving services from a provider that speaks a language other than English.

Continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

Transition to In-network Providers

The claims administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the claims administrator's prior authorization requirements and 2) provide the claims administrator with necessary medical information related to your care.

Continuity of Care does not apply to services that are not covered under the health care plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one plan to another.

Provider Termination for Cause

If it is known that the claims administrator has terminated its relationship with your provider for cause, the claims administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

Continuity of Care for Current Members

If you are a current member or dependent, this section applies to you. If the relationship between your in-network clinic or physician and the claims administrator ends, rendering your clinic or provider out-of-network, and the termination was by the claims administrator and was not for cause, you may request to continue to receive care for a special medical need or condition for a reasonable period of time before transferring to an participating provider as required under the terms of your coverage under the health care plan. The claims administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician, advanced practice nurse, or physician assistant certifies that your life expectancy is 180 days or less. The claims administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:
1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or,

6. are receiving services from a provider that speaks a language other than English.

Continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

Transition to In-network Providers

The claims administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the claims administrator's prior authorization requirements and 2) provide the claims administrator with necessary medical information related to your care.

Continuity of Care does not apply to services that are not covered under the health care plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one plan to another.

Provider Termination for Cause

If it is known that the claims administrator has terminated its relationship with your provider for cause, the claims administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

Plan Administration

Plan Administrator

The general administration of the health care plan and the duty to carry out its provisions is vested in the employer. The board of directors will perform such duties on behalf of the employer, provided it may delegate such duty or any portion thereof to a named person, including employees and agents of the employer, and may from time to time revoke such authority and delegate it to another person. Any delegation of responsibility must be in writing and accepted by the designated person. Notwithstanding any designation or delegation of final authority with respect to claims, the plan administrator generally has final authority to administer the health care plan.

Powers and Duties of the Plan Administrator

The plan administrator will have the authority to control and manage the operation and administration of the health care plan. This will include all rights and powers necessary or convenient to carry out its functions as plan administrator. Without limiting that general authority, the plan administrator will have the express authority to:

1. construe and interpret the provisions of the health care plan and decide all questions of eligibility;
2. prescribe forms, procedures, policies, and rules to be followed by you and other persons claiming benefits under the health care plan;
3. prepare and distribute information to you explaining the health care plan;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the health care plan;
5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the health care plan; and
6. retain such actuaries, accountants, consultants, third party administration service providers, legal counsel, or other specialists, as it may deem appropriate or necessary for the effective administration of the health care plan.

Actions of the Plan Administrator

The plan administrator may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the plan administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the health care plan, except with respect to claim determinations where final authority has been delegated to the claims administrator. All rules and decisions of the plan administrator will be uniformly and consistently applied so that all individuals who are similarly situated will receive substantially the same treatment.

The plan administrator or the employer may contract with one (1) or more service agents, including the claims administrator, to assist in the handling of claims under the health care plan and/or to provide advice and assistance in the general administration of the health care plan. Such service agent(s) may also be given the authority to make payments of benefits under the health care plan on behalf of and subject to the authority of the plan administrator. Such service agent(s) may also be given the authority to determine claims in accordance with procedures, policies, interpretations, rules, or practices made, adopted, or approved by the plan administrator.

Nondiscrimination

The health care plan shall not discriminate in favor of "highly compensated employees" as defined in Section 105(h) of the Internal Revenue Code, as to eligibility to participate or as to benefits.

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:00 a.m. United States Central Time and ends at 12:00 a.m. United States Central Time the following day.

Termination or Changes to the Plan

No agent can legally change the health care plan or waive any of its terms.

The employer reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to terminate, modify or amend, in whole or in part, any or all provisions of the health care plan, provided, however that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the health care plan. Any amendment to this health care plan may be effected by a written resolution adopted by the plan administrator. The plan administrator will communicate any adopted changes to the employees.

Funding

This plan is a self-insured medical plan funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the claims administrator. Your contributions toward the cost of coverage under the health care plan will be determined by the employer each year. The claims administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The claims administrator's payment of claims is contingent upon the plan administrator continuing to provide sufficient funds for benefits.

Controlling Law

Except as they may be subject to federal law, including ERISA, any questions, claims, disputes, or litigation concerning or arising from the health care plan will be governed by the laws of the State of Minnesota.

Fraudulent Practices

Coverage for you or your dependent will be terminated if you or your dependent engage in fraud of any type, including, but not limited to, submitting fraudulent misstatements about your medical history or eligibility status on the application for coverage; submitting fraudulent, altered, or duplicate billings for personal gain; and/or allowing another party not eligible for coverage under the health care plan to use your or your dependent's coverage.

Payments Made in Error

Payments made in error or overpayments may be recovered by the claims administrator as provided by law or equity. This includes the right to recoup from any future benefits to be paid to or on behalf of you or your eligible dependents. Payment made for a specific service or erroneous payment shall not make the claims administrator or the plan administrator liable for further payment for the same service.

Your claims may be reprocessed due to errors in the allowed amount paid to network providers, out-of-network participating providers, or nonparticipating providers. Claim reprocessing may result in changes to the amount you paid at the time your claim was originally processed.

Liability for Health Care Expenses

Charges That Are Your Responsibility

In-Network Providers

When you use in-network providers for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

1. deductibles and coinsurance;
2. copays;
3. charges that exceed the benefit maximum; and
4. charges for services that are not covered.

Out-of-Network Providers

Out-of-Network Participating Providers

When you use out-of-network participating providers for covered services, payment is based on the allowed amount. You may not be required to pay for charges that exceed the allowed amount. All out-of-network participating providers in Minnesota accept the claims administrator's payment based on the allowed amount. Most out-of-network participating providers outside Minnesota accept the claims administrator's payment based on the allowed amount. However, contact your out-of-network participating provider outside Minnesota to verify if they accept the claims administrator's payment based on the allowed amount (to determine if you will have additional financial liability). You are required to pay the following amounts:

1. charges that exceed the allowed amount if the out-of-network participating provider outside Minnesota does not accept the claims administrator's payment based on the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum; and
5. charges for services that are not covered.

Nonparticipating Providers

When you use nonparticipating providers for covered services, payment is still based on the allowed amount. However, because a nonparticipating provider has not entered into a network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan, the nonparticipating provider is not obligated to accept the allowed amount as payment in full. This means that you may have substantial out-of-pocket expense when you use a nonparticipating provider. You are required to pay the following amounts:

1. charges that exceed the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum;
5. charges for services that are not covered including services that the claims administrator determined are not covered based on claims coding guidelines; and
6. charges for services that are investigative or not medically necessary and appropriate.

Medical Policy Committee and Medical Policies

The claims administrator applies medical policies in order to determine benefits consistently for members. Internally developed policies are subject to approval by the claims administrator's Medical Policy Committee, which consists of independent community physicians who represent a variety of medical specialties as well as a clinical psychologist and pharmacist. The remaining policies are approved by other external specialists. For all policies, the claims administrator's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. From time-to-time, new medical policies may be created or existing medical policies may change. Covered benefits will be determined in accordance with the claims administrator's policies in effect at the time treatment is rendered or, if applicable, prior authorization may also be required. Internally developed medical policies can be found at the member website. All medical policies are available upon request.

Who is Eligible

Please refer to the plan administrator for employee/dependent eligibility criteria.

Special Enrollment Periods

Special enrollment periods are periods when an eligible employee or dependent may enroll in the health plan under certain circumstances **after they were first eligible for coverage**. In order to enroll the eligible employee or dependent **must notify the claims administrator within 30 days** of the triggering event, unless otherwise noted below. If you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order you must request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Coverage will be made effective in accordance with applicable regulatory requirements. The eligible circumstances are:

Special Enrollment Triggering Event
Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or rescission): • loss of eligibility for employer-sponsored coverage • plan no longer offers benefits • termination of all employer contributions • termination of employment or reduction in hours • legal separation or divorce • loss of dependent child status • death of employee • move outside HMO or ACO service area • exceeding the plan's lifetime maximum • employer bankruptcy • COBRA exhaustion • employee becomes entitled to Medicare
Minimum Essential Coverage includes coverage under specified government sponsored plans (including Medicare and Medicaid), employer-sponsored coverage, individual market policies, grandfathered coverage, and other coverage recognized by the secretary of the U.S. Department of Health and Human Services.
Gaining or becoming a dependent due to marriage.

Special Enrollment Triggering Event
Gaining a dependent due to birth, adoption, placement for adoption, or placement for foster care.
An individual who loses or gains eligibility for medical assistance (Medicaid) or Children's Health Insurance Program (CHIP) must notify the claims administrator within 60 days.
Child support order or other court order to provide coverage.

Changes in Membership Status

For the health care plan to administer consistent coverage for you and your dependents, you must keep your Employee Benefit Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Leave of Absence or Layoff

Upon your return to work following a leave of absence or layoff that continued beyond the period of your coverage, your employer may, in some cases, allow you to resume your coverage. You should consult with your plan administrator/employer to determine whether your group health care plan has adopted such a policy.

Termination of Your Coverage

Coverage ends on the earliest of the following dates:

1. For you and your dependents, the date on which the health care plan terminates.
2. For you and your dependents, the On the day following the last day the Member is an Employee of the Group:
    a. required charges for coverage were paid, if payment is not received when due. Your payment of charges to the employer does not guarantee coverage unless the claims administrator receives full payment when due. If the claims administrator terminates coverage for all employees in the health care plan for nonpayment of the charges, the claims administrator will give all employees a 30 day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months.
    b. you are no longer eligible.
    c. you enter military service for duty lasting more than 31 days.
    d. you request that coverage be terminated.
    e. you retire.

Extension of Benefits

If you or your dependent is confined as an inpatient on the date coverage ends due to the replacement of the claims administrator, the health care plan will automatically extend coverage until the date you or your dependent is discharged from the facility or the date plan maximums are reached, whichever is earlier. Coverage is extended only for the person who is confined as an inpatient, and only for inpatient charges incurred during the admission. For purposes of this provision, "replacement" means that the administrative service agreement with the claims administrator has been terminated and your employer maintains continuous group coverage with a new claims administrator or insurer.

Continuation of Coverage

You or your covered dependents may continue this coverage if coverage ends due to one of the qualifying events listed below. You and your eligible dependents must be covered on the day before the qualifying event in order to continue coverage.

Qualifying Events

If you are the ***employee*** and are covered, you have the right to elect continuation coverage if you lose coverage because of any one (1) of the following qualifying events:

- Voluntary or involuntary termination of your employment (for reasons other than gross misconduct).
- Reduction in the hours of your employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment).

If you are the ***spouse/ex-spouse*** of a covered ***employee***, you have the right to elect continuation coverage if you lose coverage because of any of the following qualifying events:

- The death of the ***employee***.
- A termination of the ***employee's*** employment (as described above) or reduction in the ***employee's*** hours of employment.
- Entering of decree or judgment of divorce or legal separation from the ***employee***. (This includes if the ***employee*** terminates your coverage in anticipation of the divorce or legal separation. A later divorce or legal separation is considered a qualifying event even though you lost coverage earlier. You must notify the plan administrator within 60 days after the later divorce or legal separation and establish that your coverage was terminated in anticipation of the divorce or legal separation. Continuation coverage may be available for the period after the divorce or legal separation.)
- The ***employee*** becomes enrolled in Medicare.

A ***dependent child*** of a covered ***employee*** has the right to elect continuation coverage if he or she loses coverage because of any of the following qualifying events:

- The death of the ***employee***.
- The termination of the ***employee's*** employment (as described above) or reduction in the ***employee's*** hours of employment with the employer.
- Parents' divorce or legal separation.
- The ***employee*** becomes enrolled in Medicare.
- The dependent ceases to be a "dependent child" under this plan.

Your Notice Obligations

You and your dependents must notify the employer of any of the following events within 60 days of the occurrence of the event:

- divorce or legal separation; or,
- a dependent child no longer meets the health care plan's eligibility requirements.

If you or your dependents do not provide this required notice, any dependent who loses coverage is NOT eligible to elect continuation coverage. Furthermore, if you or your dependents do not provide this required notice, you or your dependent must reimburse any claims mistakenly paid for expenses incurred after the date coverage actually terminates.

Note: Disability Extensions also require specific notice. See below for these notification requirements.

When you notify the employer of a divorce, legal separation, or a loss of dependent status, the employer will notify the affected family member(s) of the right to elect continuation coverage. If you notify the employer of a qualifying event or disability determination and the employer determines that there is no extension available, the employer will provide an explanation as to why you or your dependents are not entitled to elect continuation coverage.

Employer's and Plan Administrator's Notice Obligations

The employer has 30 days to notify the plan administrator of events they know have occurred, such as termination of employment or death of the ***employee***. This notice to the plan administrator does not occur when the plan administrator is the ***employer.*** After plan administrators are notified of the qualifying event, they have 14 days to send the qualifying event notice. Qualified beneficiaries have 60 days to elect continuation coverage. The 60-day time frame begins on the date coverage ends due to the qualifying event or the date of the qualifying event notice, whichever is later.

The employer will also notify you and your dependents of the right to elect continuation coverage after receiving notice that one of the following events occurred and resulted in a loss of coverage: the ***employee's*** termination of employment (other than for gross misconduct), reduction in hours, death, or the ***employee's*** becoming enrolled in Medicare.

Election Procedures

You and your dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after the plan administrator provides you or your family member with notice of the right to elect continuation coverage. If you or your dependents do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.

You or your dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, a spouse/ex-spouse may not decline coverage for the other spouse/ex-spouse and a parent cannot decline coverage for a non-minor

dependent child who is eligible to continue coverage. In addition, a dependent may elect continuation coverage even if the covered ***employee*** does not elect continuation coverage.

You and your dependents may elect continuation coverage even if covered under another employer-sponsored group health plan or enrolled in Medicare.

How to Elect

Contact the employer to determine how to elect continuation coverage.

Type of Coverage

Generally, continuation coverage is the same coverage that you or your dependent had on the day before the qualifying event. Anyone who is not covered under the health care plan on the day before the qualifying event is generally not entitled to continuation coverage. Exceptions include: 1) when coverage was eliminated in anticipation of a divorce or legal separation, the later divorce or legal separation is considered a qualifying event even though the ex-spouse/spouse lost coverage earlier; and 2) a child born to or placed for adoption with the covered ***employee*** during the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary's maximum continuation period.

Qualified beneficiaries are provided the same rights and benefits as similarly-situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly-situated active employees or their dependents, then continuation coverage will be modified in the same way. Examples include: 1) If the employer offers an open enrollment period that allows active employees to switch between plans without being considered late entrants, all qualified beneficiaries on continuation are allowed to switch plans as well; and 2) If active employees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage, qualified beneficiaries who get married while on continuation are afforded this same right.

Maximum Coverage Periods

Continuation coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of Continuation Coverage Before the End of the Maximum Coverage Period." In other instances, the maximum coverage period can be extended as described under the heading "Extension of Maximum Coverage Periods."

18 Months. If you or your dependent loses coverage due to the ***employee's*** termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the first of the month following termination or reduction in hours.

36 Months. If a dependent loses coverage because of the ***employee's*** death, divorce, legal separation, the ***employee*** became enrolled in Medicare or because of a loss of dependent status under the health care plan, then the maximum coverage period (for spouse and dependent child) is three (3) years from the date of the qualifying event.

Continuation Premiums

Premiums for continuation can be up to the group rate plus a two (2) percent administration fee. In the event of a dependent's disability, the premiums for continuation for the employee and dependents can be up to 150 percent of the group rate for months 19-29 if the disabled dependent is covered. All premiums are paid directly to the employer.

Extension of Maximum Coverage Periods

Maximum coverage periods of 18 or 36 months can be extended in certain circumstances.

- ***Disability Extension***: This extension is applicable when the qualifying event is the ***employee's*** termination of employment or reduction of hours, and the extension applies to all qualified beneficiaries. If you or your dependent who is a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of continuation, then the continuation period for all qualified beneficiaries is extended to 29 months from the date coverage terminated.

  Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the plan administrator of the SSA disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the ***employee's*** termination of employment or reduction of hours; 3) the date on which the qualified beneficiary loses (or would lose) coverage under the health care plan as a result of the qualifying event; and 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the administrator. **Notice Obligation:** The qualified beneficiary must notify the plan administrator of the Social Security disability determination before the end of the 18-month

period following the qualifying event (the ***employee's*** termination of employment or reduction of hours).

Notice Obligation: If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the plan administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of: 1) the first day of the month following 30 days after a final determination by the SSA that the formerly disabled qualified beneficiary is no longer disabled; or, 2) the end of the coverage period that applies without regard to the disability extension.

- ***Multiple Qualifying Events***: This extension is applicable when the initial qualifying event is the ***employee's*** termination of employment or reduction of hours and is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month maximum coverage period (i.e., death of the ***employee,*** divorce, legal separation, the ***employee*** becoming enrolled in Medicare or a dependent child losing dependent status). The extension applies to the ***employee's*** dependents who are qualified beneficiaries.

  When a second qualifying event occurs that gives rise to a 36-month maximum coverage period for the dependent, the maximum coverage period (for the dependent) becomes three (3) years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the plan administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension will occur.

- ***Pre-Termination or Pre-Reduction Medicare Enrollment:*** This extension applies when the qualifying event is the reduction of hours or termination of employment that occurs within 18 months after the date of the ***employee's*** Medicare enrollment. The extension applies to the ***employee's*** dependents who are qualified beneficiaries.

  If the qualifying event occurs within 18 months after the ***employee*** becomes enrolled in Medicare, regardless of whether the ***employee's*** Medicare enrollment is a qualifying event (causing a loss of coverage under the health care plan), the maximum period of continuation for the ***employee's*** dependents who are qualified beneficiaries is three (3) years from the date the ***employee*** became enrolled in Medicare. Example: ***employee*** becomes enrolled in Medicare on January 1. ***Employee's*** termination of employment is May 15. The ***employee*** is entitled to 18 months of continuation from the date coverage is lost. The ***employee's*** dependents are entitled to 36 months of continuation from the date the ***employee*** is enrolled in Medicare.

  If the qualifying event is more than 18 months after Medicare enrollment, is the same day as the Medicare enrollment, or occurs before Medicare enrollment, no extension is available.

- ***Employer's Bankruptcy****:* The bankruptcy rule, technically, is an initial qualifying event rather than an extending rule. However, because it would result in a much longer maximum coverage period than 18 or 36 months, it is included here. If the employer files Chapter 11 bankruptcy, it may trigger COBRA coverage for certain retirees and their related qualified beneficiaries. A retiree is entitled to coverage for life. The retiree's spouse and dependent children are entitled to coverage for the life of the retiree, and if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's spouse is covered by the health care plan, then that surviving spouse is entitled to coverage for life.

Termination of Continuation Coverage Before the End of Maximum Coverage Period

Continuation coverage of the ***employee*** and dependents will automatically terminate when any one of the following events occur:

- The employer no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due.
- After electing continuation, you or your dependents become covered under another group health plan that has an exclusion or limitation with respect to any preexisting condition that you have. Your continuation coverage will terminate after any applicable exclusion or limitation no longer applies.
- After electing continuation coverage, you or your dependent becomes entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
- If during a 29-month maximum coverage period due to disability, the SSA makes the final determination that the qualified beneficiary is no longer disabled.
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered ***employees*** or their dependents whether or not they are on continuation coverage.
- Voluntarily canceling your continuation coverage.

When termination takes effect earlier than the end of the maximum period of continuation coverage, a notice will be

sent from the plan administrator. The notice will contain the reason continuation coverage has been terminated, the date of the termination, and any rights to elect alternative coverage that may be available.

Children Born to or Placed for Adoption with the Covered Employee During Continuation Period

A child born to, adopted by or placed for adoption with a covered ***employee*** during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered ***employee*** is a qualified beneficiary and has elected continuation coverage for himself/herself. The child's continuation coverage begins on the date of birth, adoption or placement for adoption as outlined in "Who is Eligible," and it lasts for as long as continuation coverage lasts for other family members of the ***employee***.

Open Enrollment Rights and Special Enrollment Rights

Qualified beneficiaries who have elected continuation will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. Special enrollment rights apply to those who have elected continuation. Except for certain children described above, dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries - their coverage will end at the same time that coverage ends for the person who elected continuation and later added them as dependents.

Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes

If your or your dependents address changes, you *must* notify the plan administrator in writing so the plan administrator may mail you or your dependent important continuation notices and other information. Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the terms of the health care plan, you or your dependent *must* notify the plan administrator in writing. In addition, you must notify the plan administrator if a disabled ***employee*** or family member is no longer disabled.

Special Second Election Period

Special continuation rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect continuation coverage for themselves and certain family members (if they did not already elect continuation coverage) during a special second election period. This election period is the 60-day period beginning on the first day of the month in which an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within six (6) months of losing coverage. Please contact the plan administrator for additional information.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustments assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under USERRA. This continuation right runs concurrently with your continuation right under COBRA and allows you to extend an 18-month continuation period to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the Commissioned Corps of the Public Health Services and any other category of persons designated by the President of the United States.

Questions

If you have general questions about continuation of coverage, please call the telephone number on the back of your identification card for assistance.

Overview

The following chart is an overview of the information outlined in the previous section. For more detail, please refer to the previous section.

Qualifying Event/Extension	Who May Continue	Maximum Continuation Period
Employment ends (for reasons other than gross misconduct) Reduction in hours of employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment)	Employee and dependents	Earlier of: 1. 18 months, or 2. Enrollment date in other group coverage.
Divorce or legal separation	Ex-spouse/spouse who was covered on the day before the entry of a valid decree of dissolution or marriage and any dependent children that lose coverage	Earlier of: 1. 36 months; or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Death of employee	Surviving spouse and dependent children	Earlier of: 1. 36 months; or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end if the employee had lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to the employee's enrollment in Medicare	All dependents	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Retirees of the employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree	Lifetime continuation.
	Dependents	Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Extensions to 18-month maximum continuation period: Disability, as determined by the Social Security Administration, of employee or dependent(s)	Disabled individual and all other covered family members	Earliest of: 1. 29 months after the employee leaves employment, or 2. Date total disability ends, or 3. Date coverage would otherwise end.

Coordination of Benefits

This section applies when you have health care coverage under more than one (1) plan, as defined below. If this section applies, you should look at the Order of Benefits Rules first to determine which plan determines benefits first. Your benefits under this plan are not reduced if the Order of Benefits Rules require this plan to pay first. Your benefits under this plan may be reduced if another plan pays first.

Definitions

These definitions apply only to this section.

1. "Plan" is any of the following that provides benefits or services for, or because of, medical or dental care or treatment:
   a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage;
   b. coverage under a government plan or one required or provided by law;
   c. individual coverage; or,
   d. the medical payment ("medpay") or personal injury protection benefit available to you under an automobile insurance policy.

   "Plan" does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). "plan" does not include any benefits that, by law, are excess to any private or other nongovernmental program.

   "Plan" does not include hospital indemnity, specified accident, specified disease, or limited benefit insurance policies.

   Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two (2) parts and this section applies only to one (1) part, each of the parts is a separate plan.

2. "This plan" means the part of the plan document that provides health care benefits.

3. "Primary plan/secondary plan" is determined by the Order of Benefits Rules.

   When this plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

   When you are covered under more than two (2) plans, this plan may be a primary plan as to some plans, and may be a secondary plan as to other plans.

   a. NOTES: If you are covered under this plan and Medicare: this plan will comply with the Medicare Secondary Payor ("MSP") provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which plan is a primary plan and which is a Secondary plan. Medicare will be primary and this plan will be secondary only to the extent permitted by MSP rules. When Medicare is the primary plan, this plan will coordinate benefits up to Medicare's allowed amount.
   b. If you are covered under this plan and TRICARE: this plan will comply with the TRICARE provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which plan is a primary plan and which is a secondary plan. TRICARE will be primary and this plan will be secondary only to the extent permitted by TRICARE rules. When TRICARE is the primary plan, this plan will coordinate benefits up to TRICARE'S allowed amount.

4. "Allowable expense" means the necessary, reasonable, and customary item of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. "Allowable expense" does not include an item of expense that exceeds benefits that are limited by statute or this plan. "Allowable expense" does not include outpatient prescription drugs, except those eligible under Medicare (see number 3 above).

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

5. "Claim determination period" means a calendar year. However, it does not include any part of a year the person is not covered under this plan, or any part of a year before the date this section takes effect.

Order of Benefits Rules

1. General: When a claim is filed under this plan and another plan, this plan is a Secondary plan and determines benefits after the other plan, unless:
   a. the other plan has rules coordinating its benefits with this plan’s benefits; and
   b. the other plan’s rules and this plan’s rules, in part 2. below, require this plan to determine benefits before the other plan.

2. Rules: This plan determines benefits using the first of the following rules that applies:
   a. The plan that covers a person as automobile insurance medical payment ("medpay") or personal injury protection coverage determines benefits before a plan that covers a person as a group health plan enrollee.

b. Non-dependent/dependent: The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.
c. Dependent child of parents not separated or divorced: When this plan and another plan cover the same child as a dependent of different persons, called "parents":
   1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but,
   2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

   However, if the other plan does not have this rule for children of married parents, and instead the other plan has a rule based on the gender of the parent, and if as a result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.
d. Dependent child of parents divorced or separated: If two (2) or more plans cover a dependent child of divorced or separated parents, this plan determines benefits in this order:
   1) first, the plan of the parent with physical custody of the child;
   2) then, the plan that covers the spouse of the parent with physical custody of the child;
   3) finally, the plan that covers the parent not having physical custody of the child; or,
   4) in the case of joint physical custody, c. above applies.

   However, if the court decree requires one (1) of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.
e. Active/inactive employee: The plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) determines benefits before a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.
f. Longer/shorter length of coverage: If none of the above determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for a shorter time.

Effect on Benefits of This Health Care Plan

When this section applies:

1. When the Order of Benefits Rules require this health care plan to be a secondary plan, this part applies. Benefits of this health care plan may be reduced.
2. Reduction in this plan's benefits may occur under circumstances such as the following:

   The benefits that would be payable under this health care plan without applying coordination of benefits are reduced by the benefits payable under the other plans for the expenses covered in whole or in part under this health care plan. This applies whether or not claim is made under a plan.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered is considered both an expense incurred and a benefit payable. When benefits of this health care plan are reduced each benefit is reduced in proportion and charged against any applicable benefit limit of this health care plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. The claims administrator has the right to decide which facts are needed. The claims administrator may get needed facts from, or give them to, any other organization or person. They do not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts needed to pay the claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If this happens, this plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under this plan. This plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If this plan pays more than it should have paid under these coordination of benefit rules, this plan may recover the excess from any of the following:

1. the persons this plan paid for whom this plan has paid;
2. insurance companies; and
3. other organizations.

The amount paid includes the reasonable cash value of any benefits provided in the form of services.

Reimbursement and Subrogation

This plan maintains both a right of reimbursement and a separate right of subrogation**. As an express condition of your participation in this plan, you agree that the health care plan has the subrogation rights and reimbursement rights explained below.**

The Health Care Plan's Right of Subrogation

If you or your dependents receive benefits under this plan arising out of an illness or injury for which a responsible party is or may be liable, this plan shall be subrogated to your claims and/or your dependents' claims against the responsible party.

Obligation to Reimburse the Health Care Plan

You are obligated to reimburse the health care plan in accordance with this provision if the health care plan pays any benefits and you, or your dependent(s), heirs, guardians, executors, trustees, or other representatives recover compensation or receive payment related in any manner to an illness, accident or condition, regardless of how characterized, from a responsible party, a responsible party's insurer or your own (first party) insurer. You must reimburse the health care plan for 100 percent of benefits paid by the health care plan before you or your dependents, including minors, are entitled to keep or benefit by any payment, regardless of whether you or your dependent has been fully compensated and regardless of whether medical or dental expenses are itemized in a settlement agreement, award or verdict.

You are also obligated to reimburse the health care plan from amounts you receive as compensation or other payments as a result of settlements or judgments, including amounts designated as compensation for pain and suffering, non-economic damages and/or general damages. The health care plan is entitled to recover from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured motorist's plan, a homeowner's plan, a renter's plan, or a liability plan) that is or may be liable for:

1. the accident, injury, sickness, or condition that resulted in benefits being paid under the health care plan; and/or,
2. the medical, dental, and other expenses incurred by you or your dependents for which benefits are paid or will be paid under the health care plan.

Until the health care plan has been fully reimbursed, all payments received by you, your dependents, heirs, guardians, executors, trustees, attorneys or other representatives in relation to a judgment or settlement of any claim of yours or of your dependent(s) that arises from the same event as to which payment by the health care plan is related shall be held by the recipient in constructive trust for the satisfaction of the health care plan's subrogation and/or reimbursement claims.

Complying with these obligations to reimburse the health care plan is a condition of your continued coverage and the continued coverage of your dependents.

Duty to Cooperate

You, your dependents, your attorneys or other representatives must cooperate to secure enforcement of these subrogation and reimbursement rights. This means you must take no action - including, but not limited to, settlement of any claim - that prejudices or may prejudice these subrogation or reimbursement rights. As soon as you become aware of any claims for which the health care plan is or may be entitled to assert subrogation and reimbursement rights, you must inform the health care plan by providing written notification to the claims administrator of:

1. the potential or actual claims that you and your dependents have or may have;
2. the identity of any and all parties who are or may be liable; and
3. the date and nature of the accident, injury, sickness or condition for which the health care plan has or will pay benefits and for which it may be entitled to subrogate or be reimbursed.

You and your dependents must provide this information as soon as possible, and in any event, before the earlier of the date on which you, your dependents, your attorneys or other representatives:

1. agree to any settlement or compromise of such claims; or,
2. bring a legal action against any other party.

You have a continuing obligation to notify the claims administrator of information about your efforts or your

dependents' efforts to recover compensation.

In addition, as part of your duty to cooperate, **you and your dependents must complete and sign all forms and papers, including a Reimbursement Agreement,** as required by the health care plan and provide any other information required by the health care plan. A violation of the reimbursement agreement is considered a violation of the terms of the health care plan.

The health care plan may take such action as may be necessary and appropriate to preserve its rights, including bringing suit in your name or intervening in any lawsuit involving you or your dependent(s) following injury. The health care plan may require you to assign your rights of recovery to the extent of benefits provided under the health care plan. The health care plan may initiate any suit against you or your dependent(s) or your legal representatives to enforce the terms of this plan. The health care plan may commence a court proceeding with respect to this provision in any court of competent jurisdiction that the health care plan may elect.

Attorney's Fees and Other Expenses You Incur

The health care plan will not be responsible for any attorneys' fees or costs incurred by you or your dependents in connection with any claim or lawsuit against any party, unless, prior to incurring such fees or costs, the health care plan in the exercise of its sole and complete discretion has agreed in writing to pay all or some portion of fees or costs. The common fund doctrine or attorneys' fund doctrine shall not govern the allocation of attorney's fees incurred by you or your dependents in connection with any claim or lawsuit against any other party and no portion of such fees or costs shall be an offset against the health care plan's right to reimbursement without the express written consent of the claims administrator.

The plan administrator may delegate any or all functions or decisions it may have under this Reimbursement and Subrogation section to the claims administrator.

What May Happen to Your Future Benefits

If you or your dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, without first reimbursing the health care plan, the health care plan in the exercise of its sole and complete discretion, may determine that you, your dependents, your attorneys or other representatives have failed to cooperate with the health care plan's subrogation and reimbursement efforts. If the health care plan determines that you have failed to cooperate the health care plan may decline to pay for any additional care or treatment for you or your dependent(s) until the health care plan is reimbursed in accordance with the health care plan terms or until the additional care or treatment exceeds any amounts that you or your dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to treatment related to the injury, but will apply to all benefits otherwise payable under the health care plan for you and your dependents.

Interpretation

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

IDENTIFICATION (ID) CARD

If your card is lost or stolen, please contact customer service immediately. You can also request additional or replacement cards online by logging onto www.bluecrossmnonline.com.

HOW TO FILE A CLAIM

Under Department of Labor regulations, claimants are entitled to a full and fair review of any claims made under this plan. The claims procedures described in this benefit booklet are intended to comply with those regulations by providing reasonable procedures governing the filing of claims, notification of benefit decisions, and appeals of adverse benefit determinations. A claimant must follow these procedures in order to obtain payment of benefits under this plan. If the claims administrator, in its sole discretion, determines that a claimant has not incurred a covered expense or that the benefit is not covered under this plan, no benefits will be payable under this plan. All claims and questions regarding claims should be directed to the claims administrator.

Types of Claims

A "claim" is any request for a plan benefit made in accordance with these claims procedures. You become a "claimant" when you make a request for a plan benefit in accordance with these claims procedures. There are four (4) types of claims, each with different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim.

Pre-Service Claim

A "pre-service claim" is any request for a plan benefit where the plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. If the plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no "pre-service claim." The claimant simply follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Urgent Care Claim

An "urgent care claim" is a special type of pre-service claim. An "urgent care claim" is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The claims administrator will determine whether a pre-service claim involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim.

IMPORTANT: If a claimant needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the claims administrator for prior approval. The claimant should obtain such care without delay.

Concurrent Care Claim

A "concurrent care claim" arises when the claims administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the claims administrator determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the claims administrator has approved. If the plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the claims administrator to request an extension of a course of treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Post-Service Claim

A "post-service claim" is any request for a plan benefit that is not a pre-service claim or an urgent care claim.

Change in Claim Type

The claim type is determined when the claim is initially filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim. It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding the type of claim and/or what claims procedure to follow, contact the claims administrator.

Filing Claims

Except for urgent care claims, discussed below, a claim is made when a claimant (or authorized representative) submits a request for plan benefits to the claims administrator. A claimant is not responsible for submitting claims for services received from network or out-of-network participating providers. These providers will submit claims directly to the local Blue Cross and Blue Shield plan on the claimant's behalf and payment will be made directly to these providers. If a claimant receives services from nonparticipating providers, they may have to submit the claims themselves. If the provider does not submit the claims on behalf of the claimant, the claimant should send the claims to the claims administrator. The necessary forms may be obtained by contacting the claims administrator. A claimant may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that they have incurred a covered expense that is eligible for reimbursement.

Payment of a claim does not preclude the right of the claims administrator to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

Urgent Care Claims

An urgent care claim may be submitted to the claims administrator by calling the telephone number located on the back of your ID card.

Pre-Service Claims

A pre-service claim (including a Concurrent Care claim that is also a pre-service claim) is considered filed when the request for approval of treatment or services is made and received by the claims administrator.

Post-Service Claims

A post-service claim must be filed within 30 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment or product to which the claim relates.

Incorrectly Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly-filed pre-service claim, the claims administrator will notify the claimant as soon as possible but no later than five (5) days following receipt of the incorrectly-filed claim; and (b) in the case of an incorrectly-filed urgent care claim, the claims administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incorrectly-filed claim. The notice will explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless the claimant specifically requests written notice.

Timeframes for Deciding Claims

Urgent Care Claims

The claims administrator will decide an urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-Service Claims

The claims administrator will decide a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request

If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments, the claims administrator will decide the claim within 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

Concurrent Care Reduction or Early Termination

The claims administrator's decision to reduce or terminate an approved course of treatment is an adverse benefit determination that a claimant may appeal under these claims procedures, as explained below. The claims administrator will notify the claimant of the decision to reduce or terminate an approved course of treatment sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse benefit determination and receive a decision on appeal before the reduction or termination.

Post-Service Claims

The claims administrator will decide a post-service claim within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

A claimant may voluntarily agree to extend the timeframes described above. In addition, if the claims administrator is not able to decide a pre-service or post-service claim within the timeframes described above due to matters beyond its control, these timeframes may be extended for up to 15 days, provided the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The notice will describe the matters beyond the claims administrator's control that justify the extension and the date by which the claims administrator expects to render a decision. No extension of time is permitted for urgent care claims.

Incomplete Claims

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. If an urgent care claim is incomplete, the claims administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The notice may be oral unless the claimant specifically requests written notice. The claims administrator will decide the claim as soon as possible but no later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

If a pre-service or post-service claim is incomplete, the claims administrator will notify the claimant as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. The timeframe for deciding the claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to the claims administrator. The claims administrator will decide the claim following receipt of the requested information and provide the claimant with written notice of the decision.

Notification of Initial Benefit Decision

The claims administrator will provide the claimant with written notice of an adverse benefit determination on a claim. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit. The claims administrator will provide the claimant written notice of the decision on a pre-service or urgent care claim whether the decision is adverse or not. The claims administrator may provide the claimant with oral notice of an adverse benefit determination on an urgent care claim, but written notice will be furnished no later than three (3) days after the oral notice.

Right of Examination

The claims administrator and the plan administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The plan pays for the examination whenever either the claims administrator or the plan administrator requests the examination. A claimant's failure to comply with this request may result in denial of the claimant's claim.

Appeals of Adverse Benefit Determinations

Appeal Procedures

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination.

The claims administrator will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, or a rescission of coverage;
2. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;
3. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;
4. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;

5. The claims administrator will give no deference to the initial benefit decision;
6. The claims administrator will 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 decision;
7. The claims administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;
8. The claims administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the claims administrator did not rely upon their advice;
9. The claims administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the claims administrator;
10. The claims administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination;
11. The claims administrator will provide a claimant any new rationale for an adverse benefit determination prior to making a final benefit determination; and
12. The claims administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the plan administrator.

Filing Appeals

A claimant must file an appeal within 180 days following receipt of the notice of an adverse benefit determination. A claimant's failure to comply with this important deadline may cause the claimant to forfeit any right to any further review under these claims procedures or in a court of law. An appeal is filed when a claimant (or authorized representative) submits a written request for review to the claims administrator. A claimant is responsible for submitting proof that the claim for benefits is covered and payable under the plan.

Urgent Care Appeals

An urgent care appeal may be submitted to the claims administrator by telephone at 1-866-873-5943. The claims administrator will transmit all necessary information, including the claims administrator's determination on review, by telephone, fax, or other available similar methods.

Timeframes for Deciding Appeals

Urgent Care Claims

The claims administrator will decide the appeal of an urgent care claim as soon as possible, taking into account the medical emergencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

The claims administrator will decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

Post-Service Claims

The claims administrator will decide the appeal of a post-service claim within a reasonable period, but no later than 60 days after receipt of the written request for review.

Concurrent Care Claims

The claims administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. The claims administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

Notification of Appeal Decision

The claims administrator will provide the claimant with written notice of the appeal decision. The notification will include the reason for the final adverse benefit determination, reference to the relevant plan provision(s) and other information as required by ERISA. The claims administrator may provide the claimant with oral notice of an adverse decision on an urgent care claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. If the claimant does not receive a written response to the appeal within the timeframes described above, the claimant may assume that the appeal has been denied. Unless these procedures are deemed to be exhausted, the decision by the claims administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures must be exhausted before any legal action is commenced**.

Following notification of the appeal decision, a claimant may appeal further to a voluntary internal appeal or to an external appeal (for eligible claims). An adverse benefit determination relating to a claimant's failure to meet eligibility requirements is not eligible for external review.

Voluntary Appeals

A voluntary appeal may be available to a claimant receiving an adverse decision on a pre-service or post-service claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse pre-service or post-service claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the claims administrator. The claims administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeal process, contact the claims administrator.

External Review

Standard External Review

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

1. Within five (5) business days following the date of receipt of the external review request, the claims administrator will complete a preliminary review of the request to determine whether:
   a. you are or were covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;
   b. the adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the plan;
   c. you have exhausted the plan's internal appeal process (unless exhaustion is not required); and
   d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If your request is not complete, but eligible, the claims administrator will tell you what information or materials are needed to complete the request and will give you 48 hours (or more) to provide the required information.
2. The claims administrator will assign an accredited independent review organization (IRO) to conduct the external review.

   The IRO will utilize legal experts where appropriate to make coverage determinations under the plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

   The claims administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

   The IRO will review all of the information and documents timely received and is not bound by the claims administrator's prior determination. The IRO may consider the following in reaching a decision:
   a. your medical records;
   b. the attending health care professional's recommendation;
   c. reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider;
   d. the terms of the plan;
   e. evidence-based practice guidelines;

f. any applicable clinical review criteria developed and used by the claims administrator; and
g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

1. You may request an expedited external review when you receive:
   a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or,
   b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. Immediately upon receipt of the request for expedited external review, the claims administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.
3. When the claims administrator determines that your request is eligible for external review an IRO will be assigned. The claims administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

   The IRO must consider the information or documents provided and is not bound by the claims administrator’s prior determination.
4. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO’s notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the plan.

Additional Provisions

Authorized Representative

A claimant may appoint an "authorized representative" to act on his or her behalf solely with respect to an appeal of an adverse benefit determination or an inquiry concerning an adverse benefit decision. To appoint an authorized representative, a claimant must complete a form that can be obtained from the claims administrator. However, in connection with an urgent care claim, the claims administrator will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. Once an authorized representative is appointed, all future communication from the claims administrator will be made with the representative rather than the claimant, unless the claimant provides specific written direction otherwise. An assignment for purposes of payment (e.g., to a health care professional) does not constitute an appointment of an authorized representative under these claims procedures. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant.

A claimant may not assign to any other person or entity his or her right to legally challenge any decision, action, or inaction of the claims administrator.

Claims Payment

When a claimant uses network or out-of-network participating providers, the plan pays the provider. When a claimant uses a nonparticipating provider, the plan pays the claimant. A claimant may not assign his or her benefits to a nonparticipating provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the plan pay a nonparticipating provider for covered services for a child. When the plan pays the provider at the request of the custodial parent, the plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and certain institutional and medical/surgical providers outside the state of

Minnesota at the discretion of the claims administrator.

The plan does not pay claims to providers or to employees for services received in countries that are sanctioned by the United States Department of Treasury's Office of Foreign Assets Control (OFAC), except for medical emergency services when payment of such services is authorized by OFAC. Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

No Third Party Beneficiaries

The plan benefits described in this benefit booklet are intended solely for the benefit of you and your covered dependents. No person who is not a plan participant or dependent of a plan participant may bring a legal or equitable claim or cause of action pursuant to this benefit booklet as an intended or third party beneficiary or assignee hereof.

Release of Records

Claimants agree to allow all health care providers to give the claims administrator needed information about the care that they provide to them. This includes information about care received prior to the claimants enrollment with the claims administrator where necessary. The claims administrator may need this information to process claims, conduct utilization review, care management, quality improvement activities, reimbursement and subrogation, and for other health plan activities as permitted by law. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant's failure to provide authorization or requested information may result in denial of the claimant's claim.

Right of Examination

The claims administrator and the plan administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The plan pays for the examination whenever either the claims administrator or the plan administrator requests the examination. A claimant's failure to comply with this request may result in denial of the claimant's claim.

PRIVACY OF PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) is individually identifiable information created or received by a health care provider or a Health Care plan. This information is related to your past, present, or future health or the payment for such health care. PHI includes demographic information that either identifies you or provides a reasonable basis to believe that it could be used to identify you.

Restrictions on the Use and Disclosure of Protected Health Information

The employer may not use or disclose PHI for employment-related actions or decisions. The employer may only use or further disclose PHI as permitted or required by law and will report any use or disclosure of PHI that is inconsistent with the allowed uses and disclosures.

Separation Between the Employer and the Plan

The employees, classes of employees or other workforce members below will have access to PHI only to perform the plan administration functions that the employer provides for the plan. The following may be given access to PHI: plan administrator.

This list includes every employee or class of employees or other workforce members under the control of the employer who may receive PHI relating to the ordinary course of business.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that is in violation of these provisions. The employer will promptly report such instances to the plan and will cooperate to correct the problem. The employer will impose appropriate disciplinary actions on each employee or workforce member and will reduce any harmful effects of the violation.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) STATEMENT OF RIGHTS

As a participant in the plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants will be entitled to:

Receive Information About Your Plan and Benefits

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

b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated benefit booklet. The Administrator may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this benefit booklet and the documents governing the plan on the rules governing your continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

IMPORTANT PLAN INFORMATION

Plan Name:	Intact Services USA LLC HSA Plan
Type of Plan:	A group health Plan (a type of welfare benefits Plan that is subject to the provisions of ERISA)
ERISA Plan Year:	January 1 through December 31
Plan Number:	506
Funding Medium:	This Plan is self-funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the Claims Administrator. Your contribution toward the cost of coverage under the Plan will be determined by the employer each year. The Claims Administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The Claims Administrator's payment of Claims is contingent upon the Plan Administrator continuing to provide sufficient funds for benefits.
Type of Plan Administration:	Claims are administered by Blue Cross and Blue Shield of Minnesota pursuant to a contract between the Plan and Blue Cross and Blue Shield of Minnesota.
Plan Sponsor:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441-6533 (952) 852-2431
Plan Sponsor's Employer Identification Number:	26-3300555
Plan Administrator:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441-6533 (952) 852-2431
Named Fiduciary for Claims Purposes:	Blue Cross
Named Fiduciary for all other Purposes:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441-6533 (952) 852-2431
Agent for Services of Legal Process:	General Counsel Intact Services USA Services, LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441-6533 (952) 852-2431 Service of legal process may also be made on the Plan Administrator.

Plan Document:	The Plan and its attachments, if any, constitute the written Plan document required by ERISA §402.

TERMS YOU SHOULD KNOW

90dayRx - Participating 90dayRx retail pharmacies and mail service pharmacy used for the dispensing of a supply of long-term prescription drug refills.

Accountable Care Organization (ACO) - A group of physicians, other health care professionals, hospitals, and other health care providers that accept a shared responsibility to deliver a broad set of medical services to a defined set of patients.

Admissions - A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.

Advanced Practice Nurses - Licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).

Aftercare/Continuing Care Services - The stage following discharge, when the patient no longer requires services at the intensity required during primary treatment.

Allowed Amount - The amount that payment is based on for a given covered service of a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as provided in "Benefit Overview." For in-network providers, the allowed amount is the negotiated amount of payment that the in-network provider has agreed to accept as full payment for a covered service at the time your claim is processed. The claims administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at in-network providers as a result of expected settlements or other factors. The negotiated amount of payment with in-network providers for certain covered services may not be based on a specified charge for each service. Through annual or other global settlements, rebates, prospective payments or other methods, the claims administrator may adjust the amount due to in-network providers without reprocessing individual claims. These annual or other global adjustments will not cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the claims administrator, and the percentage of the allowed amount paid by the claims administrator is lower than the stated percentage for the covered service. If the payment to the provider is increased, the claims administrator pays that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

The allowed amount for all nonparticipating providers

For nonparticipating providers, the allowed amount may also be determined by the provider type, provider location, and the availability of certain pricing methods. The allowed amount may not be based upon or related to a usual, customary or reasonable charge. The claims administrator will pay the stated percentage of the allowed amount for a covered service. In most cases, the claims administrator will pay this amount to you. The determination of the allowed amount is subject to all business rules as defined in the claims administrator's provider policy and procedure manual. As a result, the claims administrator may bundle services, take multiple procedure discounts and/or other reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The allowed amount for nonparticipating providers in Minnesota

For nonparticipating provider services within Minnesota, except those described under special circumstances below, the allowed amount will be based upon one of the following payment options to be determined at the claims administrator's discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; or, (3) pricing based upon a nationwide provider reimbursement database. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator.

The allowed amount for nonparticipating provider services outside Minnesota

For nonparticipating provider physician or clinic services outside of Minnesota, except those described under special circumstances below, the allowed amount will be based upon one of the following payment options to be determined at the claims administrator's discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; (3) pricing determined by another Blue Cross or Blue Shield plan; or, (4) fee negotiations. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator.

Special circumstances

There may be circumstances where you require immediate medical or surgical care and you do not have the opportunity to select the provider of care, such as in the event of a medical emergency. Some hospital-based providers (e.g., anesthesiologists) may not be participating providers. Typically, when you receive care from nonparticipating providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care, and were not able to choose the provider who rendered such care, the claims administrator may pay an additional amount. The extent of reimbursement in these circumstances may also be subject to federal law. The extent of reimbursement in certain medical emergency circumstances may also be subject to state and federal law - please refer to "Emergency Care" for coverage of benefits.

If you have questions about the benefits available for services to be provided by a nonparticipating provider, you will need to speak with your provider and you may contact customer service at the telephone number listed on the back of your member ID card for more information.

Applied Behavioral Analysis - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Artificial Insemination (AI) - The introduction of semen from a donor (which may have been a preserved specimen), into a woman's vagina, cervical canal, or uterus by means other than sexual intercourse.

Assisted Fertilization - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, artificial insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

Attending Health Care Professional - A health care professional with primary responsibility for the care provided to a sick or injured person.

Autism Spectrum Disorders - Any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Behavioral Health Care Treatment - Treatment for mental health disorders and substance use disorder/addiction diagnoses as listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. Does not include developmental disability.

Biological Products - Products that are regulated by the Food and Drug Administration (FDA) and are medicines made from living organisms through highly complex manufacturing processes and must be handled and administered under carefully monitored conditions. There are a wide variety of biological products such as drugs, gene and cell therapies and vaccines.

Biosimilars - Products that are regulated by the Food and Drug Administration (FDA) and are highly similar to the reference biological brand name product in terms of safety, purity and potency, but may have minor differences in clinically inactive components.

BlueCard Program - A Blue Cross and Blue Shield program which allows you to access covered health care services while traveling outside of your service area. You must use in-network providers of a Host Blue and show your member ID card to secure BlueCard program access.

Board-Certified - A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board representing their specialty.

Brand Drug - A recognized trade name prescription drug product, usually either the innovator product for new prescription drugs still under patent protection or a more expensive product marketed under a brand name for multi-source prescription drugs and noted as such in the pharmacy database used by the claims administrator.

Calendar Year - The period starting on January 1st of each year and ending at midnight December 31st of that year.

Care Coordination - Organized, information-driven patient care activities intended to facilitate the appropriate responses to your health care needs across the continuum of care.

Care/Case Management Plan- A plan for health care services developed for a specific patient by a care/case manager after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.

Chronic Condition - Any physical or mental condition that requires long-term monitoring and/or management to control symptoms and to shape the course of the disease.

Claim - A request for prior authorization or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

- **Pre-service claim -** A request for prior authorization or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent care claim -** A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. Whether a request involves an urgent care claim will be determined by your attending health care provider.
- **Post-service claim -** A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Claims Administrator - Blue Cross and Blue Shield of Minnesota (Blue Cross).

Coinsurance - The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays until you reach your out-of-pocket limits. For covered services from participating providers, coinsurance is calculated based on the lesser of the allowed amount or the participating provider's billed charge. Because payment amounts are negotiated with in-network providers to achieve overall lower costs, the allowed amount for participating providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for participating providers, the percentage of the allowed amount paid by us will be greater than the stated percentage.

For covered services from nonparticipating providers, coinsurance is calculated based on the allowed amount. In addition, you are responsible for any excess charge over the allowed amount.

Your coinsurance and deductible amount will be based on the negotiated payment amount we have established with the provider or the provider’s charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements we may receive from other parties.

Coinsurance Example:
You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim:

For instance, when Blue Cross pays 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount. In addition, you would be responsible for any excess charge over our allowed amount when a nonparticipating provider is used. For example, if a nonparticipating provider ordinarily charges $100 for a service, but our allowed amount is $95, Blue Cross will pay 80% of the allowed amount ($76). You must pay the 20% coinsurance on the Blue Cross allowed amount ($19), plus the difference between the billed charge and the allowed amount ($5), for a total responsibility of $24.

Remember, if participating providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Blue Cross allowed amount. If nonparticipating providers are used, your out of pocket costs will be higher as shown in the example above.

Compound Drug - A prescription where two (2) or more drugs/medications are mixed together. All of these drugs/medications must be FDA-approved. The end product must not be available in an equivalent commercial form. A prescription will not be considered as a compound prescription if it is reconstituted or if, to the active ingredient, only water or sodium chloride solutions are added. The compound drug must also be FDA-approved for use in the condition being treated and in the dosage form being dispensed.

Copay - The dollar amount you must pay for certain covered services. The "Benefit Overview" lists the copays and services that require copays. A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.

Cosmetic Services - Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.

Covered Drug List - The claims administrator’s covered drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the claims administrator’s Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee.

Covered Services - A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.

Custodial Care - Care provided primarily for maintenance of the member or which is designed essentially to assist the member in meeting activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Cycle - One (1) partial or complete fertilization attempt extending through the implantation phase only.

Day Treatment - Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.

Deductible - The deductible is a specified dollar amount you must pay for most covered services each calendar year before the health care plan begins to provide payment for benefits. Services such as prenatal care, pediatric preventive care, and primary network preventive care services for adults are not subject to the deductible. Please refer to "Benefit Overview" for the deductible amount. If applicable, the dollar amount reimbursed or paid by a coupon for specialty drugs will not count toward your deductible.

Dependent - Your spouse, child to the dependent child age limit provided in "Who is Eligible," child whom you or your spouse have adopted or been appointed legal guardian to the dependent child age limit provided in "Who is Eligible,", grandchild who meets the eligibility requirements as provided in "Who is Eligible" to the dependent child age limit provided in "Who is Eligible," disabled dependent or dependent child as provided in " Who is Eligible," or any other person whom state or federal law requires be treated as a dependent under this health coverage.

Designated Agent - An entity that has contracted, either directly or indirectly, with the claims administrator to perform a function and/or service in the administration of this health care plan. Such function and/or service may include, but is not limited to, medical management and provider referral.

Durable Medical Equipment - Medical equipment prescribed by a physician that meets each of the following requirements:

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. generally not useful in the absence of illness or injury;
4. determined to be reasonable and necessary; and
5. represents the most cost-effective alternative.

Enrollment Date - The first day of coverage, or if there is a waiting period, the first day of the waiting period (typically the date employment begins).

E-Visit - A member-initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established member.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, prescription drug, device or supply (intervention) which is not determined by the claims administrator to be medically effective for the condition being treated. The claims administrator will consider an intervention to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date. Medical researchers constantly experiment with new medical equipment, prescription drugs and other technologies. In turn, health care plans must evaluate these technologies. The claims administrator believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. Certain routine patient costs for participation in an approved clinical trial will not be considered experimental/investigative. Routine patient costs include items and services that would be covered if the member was not enrolled in an approved clinical trial.

Facility - A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, a home health care agency, or freestanding birthing center when services are billed on a facility claim.

Foot Orthoses - Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity, protect against injury, or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom-made. Pre-fabricated orthoses are manufactured in quantity and are not designed for a specific member. A custom-fitted orthosis is specifically made for an individual member.

Freestanding Ambulatory Surgical Center - A provider that facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by, or under the direction of, a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor's office, or other health care professional's office.

Generic Drug - A prescription drug that is available from more than one manufacturing source and accepted by the FDA as a substitute for those products having the same active ingredients as a brand drug and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orange Book, and

noted as such in the pharmacy database used by the claims administrator.

Habilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.

Halfway House - Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.

Health Care Provider - A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech, and occupational therapists, licensed nutritionists, licensed registered dieticians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facilities licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.

Home Health Care Agency - A Medicare-approved or other preapproved facility that sends health care professionals and home health aides into a person's home to provide health services.

Hospice Care - A coordinated set of services provided at home or in an inpatient hospital setting for covered individuals suffering from a terminal disease or condition.

Hospital - A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.), or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.

Host Blue - A Blue Cross and/or Blue Shield organization outside of Minnesota that has contractual relationships with in-network providers in its designated service area that require such in-network providers to provide services to members of other Blue Cross and/or Blue Shield organizations.

Illness - A sickness, injury, pregnancy, mental illness, substance use disorder, or condition involving a physical disorder.

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

Infertility - The medically documented inability to conceive with unprotected sexual intercourse between a male and female partner for a period of at least 12 months. The inability to conceive may be due to either the male or female partner.

In-Network - Depending on where you receive services, the in-network is designated as one of the following:

- When you receive services within the health care plan service area, the designated in-network for professional providers and facility providers is the Aware network.
- When you receive services within the claims administrator’s service area, the designated in-network for professional providers and facility providers is the Aware network.
- When you receive services outside Minnesota, the designated participating in-network for professional providers and facility providers is the local BlueCard PPO network.

In-Network Provider - An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, the claims administrator or with any licensee of the Blue Cross and Blue Shield Association located out-of-area, pertaining to payment as a participant in a network for covered services rendered to a member.

Inpatient Care - Care that provides 24-hour-a-day professional registered nursing (R.N.) services for short-term medical and behavioral health services in a hospital setting.

Intensive Outpatient Programs (IOPs) - A behavioral health care service setting that provides structured, multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance use disorder treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.

Lifetime Maximum - The cumulative maximum payable for covered services incurred by a member during their lifetime or by each covered dependent during their lifetime under all health care plans with the employer. The lifetime maximum does not include amounts which are the member's responsibility, such as deductibles, coinsurance, copays, and other amounts. Please refer to "Benefit Overview" for specific dollar maximums on certain services.

Mail Service Pharmacy - A pharmacy that dispenses prescription drugs through the U.S. Mail.

Maintenance Services - Services that are neither habilitative nor rehabilitative that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and appropriate and part of specialized therapy for the member's condition.

Marital/Couples Therapy/Counseling - Behavioral health care services for the primary purpose of working through relationship issues.

Marital/Couples Training - Services for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.

Medical Emergency - Medically necessary and appropriate care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the member in serious jeopardy.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease; and (iii) not primarily for the convenience of the member, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease. The claims administrator reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless the claims administrator determines that the service, supply or covered medication is medically necessary and appropriate.

With respect to mental health care services: services appropriate, in terms of type, frequency, level, setting, and duration, to the member's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary and appropriate care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

(1) help restore or maintain the member's health; or,
(2) prevent deterioration of the member's condition.

Medicare - A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B, and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B, and D do not pay the entire cost of services and are subject to cost-sharing requirements and certain benefit limitations.

Mental Illness - A mental disorder as defined in the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. It does not include substance dependence, nondependent

substance use disorder, or developmental disability.

Nonparticipating Provider - A provider who has not entered into an in-network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

Out-of-Network Participating Provider - Providers who have a contract with the claims administrator or the local Blue Cross and/or Blue Shield plan (participating providers), but are not in-network providers because the contract is not specific to this plan.

Out-of-Network Provider - A provider with a Blue Cross contract that is not specific to this plan; and nonparticipating providers.

Out-of-Pocket Limit - The out-of-pocket limit refers to the specified dollar amount of member cost-sharing incurred for covered services in a calendar year. When the specified dollar amount is attained, the claims administrator begins to pay 100% of the allowed amount for all covered expenses. Please refer to "Benefit Overview" for the out-of-pocket limit. If applicable, the dollar amount reimbursed or paid by a coupon for specialty drugs will not count toward your out-of-pocket limit.

Outpatient Behavioral Health Treatment Facility - A facility that provides outpatient treatment by, or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance use disorder, or addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

Outpatient Care - Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.

Palliative Care - Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance use disorder services on a planned and regularly scheduled basis in a facility provider designed for a member or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

Participating Pharmacy - A pharmaceutical provider that participates in a network for the dispensing of prescription drugs.

Participating Provider - A provider who has entered into either a specific network contract or a general broader network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

Physician - A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.

Place of Service - Industry standard claim submission standards (established by the Medicare program) used by clinic and hospital providers.

Plan - The plan of benefits established by the plan administrator.

Plan Year - A 12-month period which begins on the effective date of the plan and each succeeding 12-month period thereafter.

Preferred Drug List - The claims administrator’s preferred drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the claims administrator’s Pharmacy and Therapeutics Committee

made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. This list can change throughout the year.

Prescription Drugs - Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.

Provider - A health care professional or facility licensed, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that provider. Provider also includes home infusion therapy providers, pharmacies, medical supply companies, independent laboratories and ambulances.

Rehabilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to regain, maintain, or prevent deterioration of daily living skills or functions acquired but then lost or impaired due to an illness, injury, or disabling condition.

Rescission - A cancellation or discontinuation of coverage.

Residential Behavioral Health Treatment Facility - A facility licensed under state law in the state in which it is located that provides inpatient treatment by, or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance use disorder, or substance addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

Respite Care - Short-term inpatient or home care provided to the member when necessary to relieve family members or other persons caring for the member.

Retail Health Clinic - A clinic located in a retail establishment or worksite that provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or facility provider. Retail health clinics are staffed by eligible nurse practitioners or other eligible health care providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.

Retail Pharmacy - Any licensed pharmacy that you can physically enter to obtain a prescription drug.

Self-Administered Drugs - Medications you would normally take on your own, such as drugs you might take every day to treat high blood pressure. These are drugs that can be safely taken by mouth or administered by injection, inhaled, inserted, or applied topically and are covered under your pharmacy/prescription drug benefit. These drugs do not require direct supervision or administration by a health care provider, regardless of whether initial medical supervision or training is required.

Services - Health care services, procedures, treatments, durable medical equipment, medical supplies, and prescription drugs, including specialty drugs.

Skilled Care - Services rendered other than in a skilled nursing facility that are medically necessary and appropriate and provided by a licensed nurse or other licensed health care professional. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring, that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed nurse, shall not be regarded as skilled care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed nurse provides the service. Only the skilled care component(s) of combined services that include non-skilled care are covered under the plan.

Skilled Nursing Care - Extended Hours - Extended hours home care (skilled nursing services) are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member’s home. skilled nursing care - extended hours services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's heath status and outcomes. The frequency of

the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.

Skilled Nursing Care - Intermittent Hours - Intermittent skilled nursing services consist of up to two (2) consecutive hours per date of service in the member's home provided by a licensed registered nurse or licensed practical nurse who are employees of an approved home health care agency.

Skilled Nursing Facility - A Medicare-approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital/facility stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.

Skills Training - Training of basic living and social skills that restore a patient's skills essential for managing his or her illness, treatment, and the requirements of everyday independent living.

Specialist/Specialty Physician - A physician who limits his or her practice to a particular branch of medicine or surgery.

Specialty Drugs - Specialty drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Specialty drugs are drugs including, but not limited to drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia.

Specialty Pharmacy Network Supplier - A pharmaceutical specialty provider that has an agreement with the claims administrator pertaining to the payment and exclusive dispensing of selected specialty prescription drugs provided to you.

Step Therapy - Step therapy includes, but is not limited to, medications in specific categories or drug classes. If your physician prescribes one of these medications, there must be documented evidence that you have tried another eligible medication that is safe, more clinically effective, and in some cases more cost-effective before the step therapy medication will be paid under the drug benefit.

Substance Use Disorder and/or Addictions - Alcohol, drug dependence or other addictions as defined in the most current editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.

Supervised Employees - Health care professionals employed by a doctor of medicine, osteopathy, chiropractic, dental surgery, or a Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S., or mental health professional must be physically present and immediately available in the same office suite more than 50% of each day when the employed health care professional is providing services. Independent contractors are not eligible.

Supply - Equipment that must be medically necessary and appropriate for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.

Supplies do not include such things as:
1. alcohol swabs;
2. cotton balls;
3. incontinence liners/pads;
4. Q-tips;
5. adhesives; and
6. informational materials.

Surrogate Pregnancy - An arrangement whereby a woman who is not covered under this plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise.

Telemedicine Services - Telemedicine services may also be referred to as televideo consultations or telehealth services. These services provide real-time interaction between a distant site physician/medical practitioner and the member both of whom are not in the same location but are actively communicating through interactive audio and video channels.

Tobacco Cessation Drugs and Products - Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.

Totally Disabled (or Total Disability) - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your Immediate Family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

Treatment - The management and care of a patient for the purpose of combating illness or injury. Treatment includes medical care, surgical care, diagnostic evaluation, giving medical advice, monitoring and taking medication.

Value-Based Program - An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Waiting Period - The period of time that must pass before you or your dependents are eligible for coverage under this plan.

The Blue Cross® and Blue Shield® Association is an association of independent Blue Cross and Blue Shield plans.

You are hereby notified, your health care benefit program is between the employer, on behalf of itself and its employees and Blue Cross and Blue Shield of Minnesota. Blue Cross is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Blue Cross Blue Shield shall be liable to the employer, on behalf of itself and its employees, for any Blue Cross Blue Shield obligations under your health care benefit program.

INTACT SERVICES USA LLC

HRA

Health Reimbursement Arrangement Summary

INTRODUCTION

INTACT SERVICES USA LLC's HRA (the "Plan") permits Eligible Employees be reimbursed for Eligible Medical Expenses. The HRA is funded solely through Employer Contribution Credits. The amount of the Employer Contribution Credits is stated in this summary. There are no Participant contributions.

This *Summary* describes the Plan. Through the Plan, you can receive tax-free reimbursement from the Company for uninsured Eligible Medical Expenses for yourself and eligible family members. Defined terms are capitalized. For a complete understanding of Plan terms, you should review the *Plan Document,* which can be requested from the Plan Administrator.

DETAILS REGARDING THE HRA BENEFIT

(a) Eligible Medical Expenses: To be eligible for reimbursement, an expense must be for medical care provided to diagnose, treat, or prevent disease or for sickness or injury and must be included on the list of eligible medical expenses for this Plan.

(b) Expenses cannot be reimbursed from any other source, including Tax Credits or Tax Deductions: Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud, and you personally will be responsible for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.

(c) Limitations for HSA and HRA Combination: You cannot participate in a general purpose HRA and remain eligible to participate in a Health Savings Account ("HSA"). If the Company sponsors an HSA Benefit and you elect to participate in both the HSA Benefit and the HRA, your HRA will reimburse only HSA-compatible medical expenses, including vision and dental (if applicable). You may also choose to participate in an HSA-Compatible HRA to maintain your eligibility and/or the eligibility of your spouse to participate in an HSA. You must, however, notify Further that you wish to participate in an HSA-Compatible HRA, and you will be required to complete and submit an election form.

ELIGIBLE EMPLOYEES

Only eligible employees may participate. An eligible employee may participate in the plan immediately after employment begins. You are eligible if you are:

- Employed by the company or a participating employer
- Enrolled under the Employer's Health Plan
- Satisfy eligibility requirement as stated in the "Eligibility" section of your medical SPD

- Not an Excluded Individual; and
- Satisfy any other eligibility requirements

You are a participant if you are an eligible employee, have enrolled in the Health Reimbursement Plan, and have not terminated participation.

Eligible employees do not include:

- Leased employees
- Independent contractors
- Employees subject to a collective bargaining agreement (except as specifically provided in the collective bargaining agreement)
- Interns
- Employees classified as temporary
- Employees covered by written agreements stating they are not eligible to participate in this Plan.

DEPENDENTS

(a) The HRA can reimburse medical expenses incurred for yourself or your Dependents.

(b) "Dependent" includes: (i) your spouse (to whom you are legally married); (ii) a person whom you can claim as a dependent on your federal income tax return; and (iii) a child whom you can claim as your health care tax dependent within the meaning of Code sections 105 or 106. This includes your son, daughter, stepson, stepdaughter or foster child who was under the age of 26 at the beginning of the calendar year.

ENROLLMENT

(a) **Initial Enrollment:** You must enroll within 30 days of becoming an Eligible Employee and satisfying the "Eligibility" section of your medical plan SPD.

(b) **HIPAA Special Enrollment.**

1. Special Enrollment Period due to Loss of Coverage. You and/or your eligible Dependents will be permitted to enroll in the Plan if:

   i. You and/or your Dependent had been covered under another group health plan or had an individual health policy at the time coverage under the Plan was initially offered;

ii. You and/or your Dependent lost that coverage as a result of a certain event, such as the loss of eligibility for coverage, expiration of COBRA continuation coverage, termination of employment, reduction in the number of hours of employment, or termination of Employer contributions towards such coverage; and

iii. You request enrollment for yourself or your Dependent within 31 days after the loss of the coverage.

2. Special Enrollment Period for newly acquired Dependent. If you get married and you request enrollment within 31 days after the date of the marriage, you will be permitted to enroll any and all of: (i) yourself; (ii) your spouse; and (iii) any new eligible Dependents acquired as a result of the marriage. The coverage will be effective as of the date of marriage. If you acquire a new child by birth, adoption or placement for adoption and you request enrollment within 31 days after the date of the birth, placement for adoption, or adoption, you will be permitted to enroll any and all of: (1) yourself; (2) your spouse; and (3) the Child. The coverage will be effective as of the date of the birth, placement for adoption or adoption.

(c) **Enrollment pursuant to a QMCSO:** A court or administrative agency may issue an order requiring you to provide health coverage for your child. If such an order is submitted to the Plan Administrator, the Plan Administrator will determine whether the order meets the requirements to be considered a Qualified Medical Child Support Order or "QMCSO." If the order is a QMCSO, your child will be added to coverage. If you are not already covered under this Plan, you will also be added to coverage. The Plan Administrator will give you written notice if an order relating to coverage of your child is received and of the Plan Administrator's decision as to whether the order is a QMCSO.

(d) **Annual Open Enrollment:** If you do not enroll when you are first eligible, you must wait until the next Open Enrollment Period for another chance to participate, unless you experience a HIPAA special enrollment right. (See above.) The Open Enrollment Period for each Plan Year will be determined by the Plan Administrator.

(e) **Enrollment Procedure:** The Plan Administrator will provide enrollment instructions. You must complete your enrollment within the time specified by the Plan Administrator.

(f) **HRA Election:** You must elect to participate in the HRA. This Plan is funded by Employer contributions. There are no Employee contributions. Maximum Employer Contribution Credits per Plan year:

Employee/Single: $0

Employee + Child: $0

Employee + Spouse: $0

Employee + Children: $0

Employee + Family: $0

The Employer Contribution Credits will be added to a Participant's HRA in full on the first day of the Plan Year.

(g) **Mid-Year Enrollment:** If you enroll in the Plan during the year, the Employer Contribution Credits for that year will be added in full on the first day of your participation.

(h) **HRA Balance Carry Over from one year to the next* (employee must continue to participate in the Plan):** The amount differs depending on coverage levels:

Employee/Single: $750

Employee + Child: $1500

Employee + Spouse: $1500

Employee + Children: $1500

Employee + Family: $1500

WHEN PARTICIPATION BEGINS

Your participation begins on the first day of the Plan Year. For Mid-year enrollment, you are enrolled the first day of the month following enrollment. Please refer to the "Eligibility" section of your medical plan SPD.

Coverage Change Process: The Plan Administrator will provide instructions for requesting a coverage change. The Plan Administrator will determine whether a coverage change is permitted.

ELECTION CHANGES DURING THE PLAN YEAR

(a) **Mid-Year Coverage Change Events:** If you change your medical coverage level (*e.g.*, single to family) mid-year, the amount of the Employer Contribution Credit for which you are eligible will be adjusted accordingly.

(b) **Time Limit for Making a Coverage Change:** To change your coverage level, you must request a coverage level change not later than 30 days after the event permitting the change (even if you are on leave at the time). You cannot change your coverage level more than 30 days after an event that permits the coverage level change.

(c) **Change in Level of Coverage:** In the event you change coverage options (e.g., single contract to family contract) during the plan year and the annual credit for your new coverage is a larger amount, then your account will be credited with the difference between the annual credit amount for your previous coverage and the annual credit amount for your new coverage. This additional credit will be made effective on the effective date of your new coverage. The change in your full annual credit amount will be effective on the first day of the following plan year.

In the event you change coverage options (e.g., family contract to single contract) during the plan year and the annual credit for our new coverage is a smaller amount, then your account will not be impacted by this change (meaning the account will not be reduced to reflect the change in coverage) during the remainder of the current plan year. The change to your annual credit amount will be effective on the first day of the following plan year.

PARTICIPATION DURING A LEAVE OF ABSENCE

Coverage will continue under this Plan during a leave of absence in accordance with the Company's leave policies and the terms and conditions of the Plan. If there is a conflict between the information provided in this section and the Company's leave policies, the Company's leave policies will control. Your leave must be approved by the Company.

You will be required to make your premium/contribution payments ("payments") for coverage to continue. If you do not make the required payment when due (including any grace period), the Company may retroactively terminate your coverage to the last day for which you have paid. Expenses incurred during the period for which your coverage is retroactively terminated will not be covered. The Company can recover any payments owed. Upon return to work, the payments owed will be taken from your pay.

Contact the Plan Administrator for coverage payment options.

(a) **Paid Leave of Absence:** Your HRA coverage and your contributions for the coverage will automatically continue during a leave of absence as long as you continue to receive pay.

(b) **Unpaid Leave of Absence:** Your right to continue HRA coverage during unpaid leave depends on the type of leave. If you do not elect to continue your HRA coverage at the beginning of leave, you will not be able to submit medical expenses you incur during the leave for reimbursement. Rules regarding specific types of unpaid leave are as follows.

1. *FMLA Leave.*

   i. If you take FMLA Leave, your HRA coverage will continue unless you are required to have High Deductible Health Plan coverage and decide to terminate that coverage during your leave.

   ii. If your HRA coverage terminated, it will be reinstated on return from leave.

   iii. You will not be able to submit expenses you incurred during the leave for reimbursement for periods in which your HRA coverage was terminated.

2. *Military Leave.* If you go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may elect to continue your HRA coverage for up to 24 months during the military leave to the extent required by USERRA. USERRA continuation coverage information is provided in the "Other Legal Notices" section of this *Summary*. You may reinstate your coverage on return from leave to the extent required by USERRA. Contact the Plan Administrator for more information.

3. *Other Types of Leave*. Contact the Plan Administrator for details. If your HRA coverage terminates as a result of your leave, you may elect to continue your coverage through COBRA. HRA COBRA rights are explained in the "Notice of COBRA Continuation Coverage Rights" section of this *Summary*. If you do not elect to continue your coverage through COBRA, you will not be eligible to recommence participation until the next Open Enrollment Period or you experience a HIPAA special enrollment right. (See the "Enrollment" section of this *Summary*).

(c) **Open Enrollment during your Leave:** If the Open Enrollment Period for the next Plan Year occurs during your leave and your participation in the Plan continues, you will be able to elect to participate in the Plan for the new Plan Year in the same manner as active Employees. If you do not elect HRA benefits, you will not be eligible to participate in the HRA in the new Plan Year, unless you experience a HIPAA special enrollment right.

(d) **Making Election Changes on return from Leave:** Election changes other than as noted in this section will not be permitted on return from leave unless you experience another event for which a mid-year change is permitted.

OBTAINING REIMBURSEMENTS

(a) **Amount available for reimbursement:** The amount available for reimbursement is limited to the balance in your HRA at the time that you submit a claim.

(b) **Expense must be eligible for reimbursement under this Plan:** Only Health Plan Eligible Medical and Prescription Expenses will be reimbursed. **The Plan pays 100% of Eligible Health Plan Medical and Prescription Expenses and pharmacy expenses that qualify as Eligible Medical Expenses.**

(c) **Expense must have been incurred during your Period of Coverage:** You may only use your HRA to pay for Eligible Medical Expenses that you incurred while covered under the Plan. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter.

(d) **Expense cannot be reimbursed out of other accounts:** The HRA cannot be used to reimburse expenses that are reimbursed from any other Account, including a Medical FSA.

(e) **Coordination with Other Health Care Accounts:** If you participate in the Company's Medical FSA Benefit and an HRA, your claims will be paid from your HRA first.

(f) **Claim submission requirements must be satisfied.** You may submit a completed claim form and independent third-party documentation of the claim to the Administrator. You may also submit your claim Online by signing into the Member Online Service Center via www.HelloFurther.com. If your Company implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the HRA Plan, some expenses may be validated at the time the expense is incurred (like copays for medical care). For other expenses, the card payment is only conditional. You will still have to submit supporting documents. You will receive more information from the Company about what you must do to obtain reimbursement if such a system is implemented.

1. *Claims must be submitted during the Plan's Claims Submission Period.* **Further must receive all claims for reimbursement in our office no later than 6 months after the plan year end date to be reimbursed. For employees that have terminated during the plan year and if the employee has elected COBRA (if available), claims must be received 6 months from earlier of the end of the plan year or termination of the COBRA election.**

2. **For employees that have been terminated and they have not elected COBRA (if available) claims must be received in our office 6 months from their termination date.**

3. *Documentation must be provided.* To receive reimbursement for Eligible Medical Expenses, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill, receipt or an Explanation of Benefits) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is incomplete, the claim may be denied and payment delayed.

4. *Claims cannot be reimbursed by Health Insurance.* You cannot request reimbursement of an expense that has been or will be reimbursed by health insurance.

5. *Limitation on reimbursement of claims incurred one year from Employer Contribution Credits for a subsequent Plan Year:* Employer Contribution Credits for a Plan Year cannot be used to reimburse claims incurred in a prior Plan Year.

(g) **Method of Reimbursement:** The Claims Administrator will reimburse Eligible Medical Expenses through a check or, if you so choose, direct deposit. Reimbursements will be issued as scheduled by the Claims Administrator.

(h) **Recovery of improper Reimbursements:** You will be required to repay the Plan for reimbursements the Claims Administrator determines to have been improper. The Claims Administrator may use one or more of the following recovery methods: (i) your repaying the amount to your HRA or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount from future reimbursements to you for Eligible Medical Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement will be treated as a business debt and the amount reimbursed will be included in your W-2 income.

CLAIMS AND APPEAL PROCEDURE

(a) **Initial determination on claim for Reimbursement.**

1. *Time Period.* The Claims Administrator will make its decision on the claim within 30 days after receipt of the claim. The 30-day period for the initial determination may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Administrator; and (ii) the Administrator provides notice of the extension to you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Administrator expects to render its decision. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.

2. *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notice of the denial to you, which will include the specific reason for the denial, a reference to the Plan provision on which the denial is based, a description of additional information or documents necessary in order

for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure. If a denial is based on an internal rule or guideline or medical judgment, information regarding the internal rule or guideline or medical judgment will either be included in the written response or you will be able to obtain a copy of the internal rule or guideline or an explanation of the medical judgment on request and free of charge.

(b) **Appeal Rights and Procedures.**

1. *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Claims Administrator. You must send a written request for an appeal review to the Claims Administrator within 180 days of your receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.

2. *Right to Review Documents/Submit Comments.* You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Plan Administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.

3. *Person Conducting Review.* The review will be conducted by a named fiduciary for the Plan who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination. In deciding an appeal of any adverse benefit determination that is based, in whole or in part, on a medical judgment, the administrator will consult with a medical care professional who has appropriate training and experience in the applicable medical field and who is neither the individual who was consulted in connection with the initial adverse determination nor a subordinate of such individual.

4. *Notice of Continued Denial.* If the denial is upheld in whole or part, the Claims Administrator will send notification of the denial to you. You will be notified of the decision on appeal in writing within 60 days after the Claims Administrator received your appeal. The notice will include the reason for the decision.

    i. *Level Two Appeal Process.* Following the Level One Appeal Process, you have additional voluntary appeal rights through Further. If you are not satisfied with our decision, you may elect to further appeal to Further by sending a letter within 30 days or the later of your run out end date requesting our Appeals Committee to reconsider the decision. If you have terminated employment during the year or if you are unsure of your plan's

run out end date please contact your group representative or our customer service department. You have the option to present your concerns to the Appeals Committee either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.

ii. *External Review Process.* If you still disagree with the Claims Administrator's decision, you have the right to an external review of the Claims Administrator's denial of your internal appeal unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the HRA Plan's eligibility requirements. Your external appeal must be filed with the Claims Administrator within four (4) months of the date you were served with the Administrator's response to your internal appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether the adverse benefit determination qualifies for external review. The Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review. The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

TERMINATION OF PARTICIPATION DUE TO TERMINATION OF EMPLOYMENT

(a) **When Participation ends:** Your participation in the Plan will end as of the date of your termination of employment with the Company.

(b) **Medical Expenses incurred after Termination:** Medical expenses incurred after the date of your termination of employment will be eligible for reimbursement if you elect to continue your participation in the HRA through COBRA. Please refer to the "Notice of COBRA Continuation Rights" section of this *Summary.*

The HRA balance is forfeited unless you elect COBRA.

(c) **Amounts remaining after Termination:** Any amounts remaining in an Account after the end of the Claims Submission Period for the Plan Year in which the termination occurred will be forfeited unless you elect COBRA.

(d) **Re-employment by a Participating Employer:** A Participant who terminates employment and is re-employed by a Participating Employer as an Eligible Employee within the same Plan Year will be provided the same HRA Balance that he or she had at termination, less any reimbursements made after termination, or, if he or she elected COBRA, the most recent COBRA HRA balance.

OTHER REASONS FOR TERMINATION OF PARTICIPATION

(a) Your participation in this Plan can also end if:

1. you no longer qualify as an Eligible Employee;

2. your Employer stops participating in this Plan;

3. you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan;

4. the Company terminates the Plan; or

5. if the certifications you made to participate are no longer accurate.

(b) The rules discussed above for termination of participation as a result of termination of employment also apply if termination of participation occurs for other reasons.

NOTICE OF COBRA CONTINUATION COVERAGE

(a) **Continuation:** You or your covered Dependents may continue this coverage if coverage ends due to any of the qualifying events listed below. You and your eligible Dependents must be covered under this Plan before the qualifying event in order to continue coverage. In all cases, continuation ends if the Plan ends or required charges are not paid when due.

(b) **Qualifying Events:** If you are the Employee and are covered, you have the right to elect continuation coverage if you lose coverage because of any one (1) of the following qualifying events:

- Voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

- Reduction in the hours of your employment (layoff, leave of absence, strike, lockout, change from full-time to part-time employment).

If you are the spouse of a covered Employee, you have the right to elect continuation coverage if you lose coverage because of any of the following qualifying events:

- The death of the Employee.

- A termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours of employment with the Employer.
- Entering of decree in the event of a divorce or legal separation from the Employee. (Also, if the Employee eliminates coverage for his or her spouse in anticipation of a divorce, and a divorce later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the later divorce and can establish that the coverage was eliminated earlier in anticipation of the divorce, then continuation coverage may be available for the period after the divorce).
- The Employee becomes enrolled in Medicare.

In the case of a Dependent child of a covered Employee, the Dependent child has the right to elect continuation coverage if he or she loses coverage because of any of the following qualifying events:

- The death of the Employee.
- The termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours of employment with the Employer.
- Parents' divorce or legal separation.
- The Employee becomes enrolled in Medicare.
- The Dependent ceases to be a "Dependent child" under the Plan.

(c) **Your notice of obligations:** You and your Dependents must notify the Employer of any of the following events within 60 days of the occurrence of the event:

- Divorce or legal separation.
- A Dependent child no longer meets the Plan's eligibility requirements.

Note: Refer to "Disability Extensions" in "Extension of Maximum Coverage Periods" below for three (3) additional notification requirements.

If you or your Dependents fail to provide this notice during this 60-day notice period, any Dependent who loses coverage will NOT be offered the option to elect continuation coverage. Furthermore, if you or your Dependents fail to provide this notice, and if any claims are mistakenly paid for expenses incurred after the date coverage was to terminate, then you and your Dependents will be required to reimburse the Plan for any claims paid.

When you notify the Employer that a divorce or a loss of Dependent status will cause a loss of coverage, then the Employer will notify the affected family member(s) of the right to elect continuation coverage. If you notify the Employer of a qualifying event or disability determination and the Employer determines that there is no extension

available, the Employer will provide an explanation as to why you or your Dependents are not entitled to elect continuation coverage.

(d) **Employer's and Plan Administrator's Notice Obligations.** The Employer has 30 days to notify the Plan Administrator of events they know have occurred, such as termination of employment or death of the Employee. This 30-day notice to the Plan Administrator is not often used because usually the Plan Administrator is the Employer. After plan administrators are put on notice of the qualifying event, they have 14 days to send the qualifying event notice. The qualified beneficiaries must be allowed 60 days to elect continuation coverage. The 60-day time frame begins on the date coverage would end due to the qualifying event or the date of the qualifying-event notice, whichever is later. The Employer will also notify you and your Dependents of the right to elect continuation coverage after receiving notice that one of the following events occurred and resulted in a loss of coverage: the Employee's termination of employment (other than for gross misconduct), reduction in hours, death, or the Employee's becoming enrolled in Medicare.

(e) **Election Procedures:** You and your Dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. If you or your Dependents do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.

You or your Dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, a spouse may not decline coverage for the other spouse and a parent cannot decline coverage for a non-minor Dependent child eligible for coverage. In addition, a Dependent may elect continuation coverage even if the covered Employee does not elect continuation coverage.

You and your Dependents may elect continuation coverage even if covered under another Employer-sponsored group health plan or enrolled in Medicare.

(f) **How to Elect:** Contact the Employer to determine how to elect continuation coverage.

(g) **Type of Coverage:** Ordinarily, the continuation coverage that is offered will be the same coverage that you or your Dependent had on the day before the qualifying event. Therefore, anyone who is not covered under the Plan on the day before the qualifying event generally is not entitled to continuation coverage. (Exceptions: 1) If coverage was eliminated in anticipation of a qualifying event such as divorce and a divorce later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse had lost coverage earlier. The ex-spouse must notify the Employer within 60 days after the later divorce and establish that the coverage was eliminated earlier in anticipation of divorce; and 2) A child born to or placed for adoption with the covered Employee during

the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary's maximum continuation period).

Qualified beneficiaries must be provided the same rights and benefits as similarly situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly situated active Employees or their Dependents, then continuation coverage will be modified in the same way. (Examples: 1) If the Employer offers an Open Enrollment Period that allows active Employees to switch between plans without being considered late entrants, all qualified beneficiaries on continuation should be allowed to switch plans as well; and 2) If active Employees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage, qualified beneficiaries who get married while on continuation should also be afforded this same right).

(h) **Maximum Coverage Periods:** The maximum duration for continuation coverage is described below. Continuation coverage terminates before the maximum coverage period in certain situations described later under the heading “Termination of Continuation Coverage before the end of the Maximum Coverage Period.” In other instances, the maximum coverage period can be extended as described under the heading "Extension of Maximum Coverage Periods."

1. *18 Months.* If you or your Dependent loses coverage due to the Employee's termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the first of the month following termination or reduction in hours.

2. *36 Months*. If a Dependent loses coverage because of the Employee's death, divorce, legal separation, the Employee became enrolled in Medicare or because of a loss of Dependent status under the Plan, and then the maximum coverage period (for spouse and Dependent child) is three (3) years from the date of the qualifying event.

(i) **Extension of Maximum Coverage Periods:** Maximum coverage periods of 18 or 36 months can be extended in certain circumstances.

1. The general rule is that the maximum coverage period runs from the date of the triggering (qualifying) event, even if the actual loss of coverage per the terms of the Plan does not occur until later. The Employer has 30 days from the date of the triggering event to notify the Plan Administrator of the qualifying event.

2. *Extended Notice Rule*: Under the extended notice rule, the maximum coverage period runs from the date that a qualified beneficiary's loss of coverage occurs (rather than the triggering event), if the Employer also sends its notice of the qualifying event to the Plan Administrator within 30 days after the loss of coverage instead of 30 days after the occurrence of the triggering event. Use of this delayed

commencement of coverage period coupled with the extension of the Employer's notice period has the effect of extending the maximum coverage period.

i. This extension is applicable only when loss of coverage is due to termination of employment, reduction of hours, death of the Employee, or the Employee's Medicare enrollment, and the extension applies to all qualified beneficiaries.

ii. Example: The triggering event, termination of employment, occurs on January 5. The loss of coverage under the terms of the Plan, however, does not occur until January 31. Under the Extended Notice Rule, the Employer must notify the Plan Administrator of the qualifying event within 30 days after coverage is lost and the maximum coverage period begins when coverage is lost, January 31).

3. *Disability Extension*: This extension is applicable when the qualifying event is the Employee's termination of employment or reduction of hours, and the extension applies to all qualified beneficiaries. If you or your Dependent who is a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation, then the continuation period for all qualified beneficiaries is extended to 29 months from the date coverage terminated.

   Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the Plan Administrator of the Social Security Administration disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the qualifying event (the Employee's termination of employment or reduction of hours); 3) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; and 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the administrator.

   Notice Obligation: The qualified beneficiary must notify the Plan Administrator of the Social Security disability determination before the end of the 18-month period following the qualifying event (the Employee's termination of employment or reduction of hours.)

   Notice Obligation: If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of 1) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that the formerly disabled

qualified beneficiary is no longer disabled; or 2) the end of the coverage period that applies without regard to the disability extension.

4. *Multiple Qualifying Events*: This extension is applicable when the qualifying event is the Employee's termination of employment or reduction of hours (each of which triggers an 18-month maximum coverage period) is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month maximum coverage period (i.e., death of the Employee, divorce, legal separation, the Employee becoming enrolled in Medicare or a Dependent child losing Dependent status). The extension applies to the Employee's Dependents that are qualified beneficiaries.

   If a second qualifying event occurs within an 18-month or 29-month coverage period that gives rise to a 36-month maximum coverage period for the Dependent, then the maximum coverage period (for the Dependent) becomes three (3) years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of continuation coverage will occur.

5. *Pre-Termination or Pre-Reduction Medicare Enrollment*: This extension applies when the qualifying event is the reduction of hours or termination of employment that occurs within 18 months after the date of the Employee's Medicare enrollment. The extension applies to the Employee's Dependents who are qualified beneficiaries. If the qualifying event occurs within 18 months after the Employee becomes enrolled in Medicare, regardless of whether the Employee's Medicare enrollment is a qualifying event (causing a loss of coverage under the group Plan), the maximum period of continuation for the Employee's Dependents who are qualified beneficiaries is three (3) years from the date the Employee became enrolled in Medicare. (Example: Employee becomes enrolled in Medicare on January 1. Triggering/qualifying event, Employee's termination of employment or reduction of hours is May 15. The Employee is entitled to 18 months of continuation from the date coverage is lost. The Employee's Dependents are entitled to 36 months of continuation from the date the Employee is enrolled in Medicare.) If the qualifying event (Employee's termination of employment or reduction of hours) is more than 18 months after Medicare enrollment, is the same day as the Medicare enrollment or occurs before Medicare enrollment, no extension is available.

6. *Employer's Bankruptcy*: The bankruptcy rule technically is an initial qualifying event rather than an extending rule. However, because it would result in a much longer maximum coverage period than 18 or 36 months, it is included here. If the Employer files Chapter 11 bankruptcy, it may trigger COBRA coverage for certain

retirees and their related qualified beneficiaries. A retiree is entitled to coverage for life. The retiree's spouse and Dependent children are entitled to coverage for the life of the retiree, and, if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's spouse is covered by the Plan, then that surviving spouse is entitled to coverage for life.

(j) **Termination of Continuation Coverage before the end of Maximum Coverage Period:** Continuation coverage of the Employee and Dependents will automatically terminate (before the end of the maximum coverage period) when any one of the following events occurs:

- The Employer no longer provides group health coverage to any of its Employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due. Charges for continuation can be up to the group rate plus a two (2) percent administration fee. In the event of a disability, the charges for continuation can be up to the group rate plus a 50% administration fee for months 19-29. All charges are paid directly to the Employer.
- After electing continuation, you or your Dependents become covered under another group health plan (as an Employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable preexisting condition exclusions or limitations, then your continuation coverage will terminate after the exclusion or limitation no longer applies. This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note: An exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the new group health plan.)
- You or your Dependent became entitled to a 29-month maximum coverage period due to the disability of a qualified beneficiary, but then the Social Security Administration makes the final determination that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their Dependents who have coverage under the Plan for a reason other than the continuation coverage requirements of federal law.
- Voluntarily dropping your continuation coverage.

When termination takes effect earlier than the end of the maximum period of continuation coverage, a notice will be sent from the Plan Administrator. The notice will contain the reason continuation coverage has been terminated; the date of the termination, and any rights to elect alternative coverage that may be available.

(k) **Children born to or placed for adoption with the covered employee during Continuation Period.** A child born to, adopted by or placed for adoption with a covered Employee during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered Employee is a qualified beneficiary and has elected continuation coverage for himself/herself. The child's continuation coverage begins on the date of birth, adoption, or placement for adoption and it lasts for as long as continuation coverage lasts for other family members of the Employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

(l) **Open Enrollment Rights and Special Enrollment Rights:** Qualified beneficiaries who have elected continuation will be given the same opportunity available to similarly situated active Employees to change their coverage options or to add or eliminate coverage for Dependents at Open Enrollment. Special enrollment rights will apply to those who have elected continuation. Except for certain children described above, Dependents who are enrolled in a special enrollment period or Open Enrollment Period do not become qualified beneficiaries – their coverage will end at the same time that coverage ends for the person who elected continuation and later added them as Dependents.

(m) **Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes:** If your or your Dependent's address changes, you must notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important continuation notices and other information). Also, if your marital status changes or if a Dependent ceases to be a Dependent eligible for coverage under the terms of the Plan, you or your Dependent must notify the Plan Administrator in writing. In addition, you must notify the Plan Administrator if a disabled Employee or family member is no longer disabled.

(n) **Special Second Election Period:** Special continuation rights apply to certain Employees who are eligible for the health coverage tax credit. These Employees are entitled to a second opportunity to elect continuation coverage for themselves and certain family members (if they did not already elect continuation coverage) during a special second election period. This election period is the 60-day period beginning on the first day of the month in which an eligible Employee becomes eligible for the health coverage tax credit, but only if the election is made within six (6) months of losing coverage. Please contact the Plan Administrator for additional information.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustments assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

(o) **Questions:** If you have general questions about continuation of coverage, please call the telephone number on the back of your identification card for assistance.

(p) **Overview:** The following chart is an overview of the information outlined in the previous sections. For more details, refer to the previous sections.

Qualifying Event/ Extension	Who May Continue	Maximum Continuation Period
• Employment ends (for reasons other than gross misconduct) • Reduction in hours of employment (layoff, leave of absence, strike, lockout, change from full-time to part-time employment)	Employee and Dependents	Earlier of: 1. 18 months; or 2. Enrollment date in other group coverage.
• Divorce or legal separation	Former spouse and any Dependent children who lose coverage	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Death of Employee	Surviving spouse and Dependent children	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end if the Employee had lived.
• Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Dependents lose eligibility due to the Employee's enrollment in Medicare	All Dependents	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Retirees of the Employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree Dependents	Lifetime continuation Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Extensions to 18-month maximum continuation period: • Disability, as determined by the Social Security Administration, of Employee or Dependent(s)	Disabled individual and all other covered family members	Earliest of: 1. 29 months after the Employee leaves employment; or 2. Date disability ends; or 3. Date coverage would otherwise end.

OTHER LEGAL NOTICES.

(a) **Uniformed Services Employment and Reemployment Rights Act (USERRA) Continuation Coverage:** If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible Dependents under USERRA. This continuation right runs concurrently with your continuation right under COBRA and allows you to extend an 18-month continuation period to 24 months. You and your eligible Dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. Your eligible Dependents do not have independent election rights for USERRA continuation coverage so you must elect to continue coverage for USERRA coverage to be provided beyond any COBRA coverage period. You will be required to pay for USERRA continuation coverage.

(b) **HIPAA Privacy Rule Notice of Privacy Practices:** The Plan is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the Plan's *Notice of Privacy Practices* (which summarizes the Plan's Privacy Rule obligations, your Privacy Rule rights, and how the Plan may use or disclose health information protected by the Privacy Rule) from the Plan Administrator.

(c) **Statement of ERISA Rights of Plan Participants:** As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. *Receive Information about your Plan and Benefits.*

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

   ii. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 series) and the latest updated summary plan description. This *Summary*, along with the Plan Document for the HRA, comprise the Plan Document for this benefit. The Plan Administrator may make a reasonable charge for the copies.

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

2. *Continue Group Health Plan Coverage.* Continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary for your HRA COBRA continuation rights.

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

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

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

5. *Assistance with your Questions***.** If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W.,

Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

(d) **Company's Right to Terminate or Amend the Plan.** The Company reserves the right to amend or terminate the Plan at any time and without notice.

(e) **No Guarantee of Employment:** Participation in this Plan is not a guarantee of employment.

(f) **Plan Administrator's Discretion:** The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

PLAN SPECIFICATIONS

Employer, Plan Sponsor and Plan Administrator:

INTACT SERVICES USA LLC
605 North Highway 169 Ste 800
Plymouth, MN 55441

Telephone: 952-852-6748

Health Plan Coverage:

You are required to enroll in the INTACT SERVICES USA LLC Health Plan coverage to be eligible to participate in the HRA.

For details regarding the Health Plan Coverage, review the summary for that plan.

Claims Administrator:

Further
3535 Blue Cross Road
Eagan, MN 55122-1154
651-662-5065 or 800-859-2144
www.HelloFurther.com

Plan Year:

January 1 through December 31

DELTA DENTAL PPO PLUS PREMIER - COMPREHENSIVE ENHANCED

Dental Benefit Plan Summary

Intact Services USA LLC
Basic Plan
Client Number 100417

ADMINISTRATION

The following information is provided as required by the Employee Retirement Income Security Act (ERISA) of 1974.

EMPLOYER, PLAN SPONSOR, FIDUCIARY AND PLAN ADMINISTRATOR:
Intact Services USA LLC
605 Highway 169 N, Suite 800
Plymouth, MN 55441
Telephone: (952) 852-6748

AGENT FOR SERVICE OF LEGAL PROCESS:
Intact Services USA LLC
605 Highway 169 N, Suite 800
Plymouth, MN 55441
Telephone: (952) 852-6748

PARTICIPATING EMPLOYERS:
Intact Services USA LLC
A.W.G. Dewar, Inc.
Atlantic Specialty Insurance Company

FUNDING: Your contribution towards the cost of the coverage under the Plan will be determined by the Employer each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

EMPLOYER IDENTIFICATION NUMBER: 26-3300555

PLAN NAME: Intact Insurance Group USA Welfare Plan

EMPLOYER PLAN NUMBER: 506

TYPE OF PLAN: Health and welfare benefits plan including dental benefits

PLAN YEAR: January 1 – December 31

DELTA DENTAL CLIENT NUMBER: 100417

PLAN BENEFITS ADMINISTERED BY:
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815
www.deltadentalmn.org

DENTAL BENEFIT PLAN SUMMARY

This is a Summary of your Client Dental Program
(**PROGRAM**) prepared for Covered Persons with:

Intact Services USA LLC
(**CLIENT**)

This Program has been established and is maintained and administered in accordance with the provisions of your Client Dental Plan Contract Number **100417** issued by Delta Dental of Minnesota (**PLAN**).

This booklet is subject to the provisions of the Client Dental Plan Contract. If there is an inconsistency between this booklet and the Client Dental Plan Contract, the Client Dental Plan Contract controls.

DELTA DENTAL OF MINNESOTA

Administrative Offices
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815
www.deltadentalmn.org

DELTA DENTAL OF MINNESOTA
NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Delta Dental of Minnesota is required by law to maintain the privacy of your Protected Health Information, to provide you with this notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rules"). Individually identifiable information about your past, present or future health condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI"). Health care includes dental care.

Our Permitted Uses and Disclosures of Your Protected Health Information

We use and disclose PHI about you without your authorization for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information from us as to whether the service has been previously provided.

Payment: We use and disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we use and disclose your PHI in order to process your claims.

Health Care Operations: We use and disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use and disclose your PHI to evaluate the quality of dental services that were performed or to check for fraud and abuse.

We may not, however, use or disclose any PHI that is considered genetic information under Federal Law for underwriting purposes.

We may be asked by the sponsor of your dental benefits to provide your PHI to the sponsor. We will do so if permitted by law.

Unless you object, we may disclose your PHI to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only PHI relevant to that person's involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, we will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

We may also use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may use or disclose your PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We may disclose PHI in response to a court or administrative order, subpoena, discovery request or other lawful process if certain conditions are met and the required assurances are received. We provide PHI when otherwise required by law, such as for law enforcement purposes. We may disclose your PHI to public health or other appropriate authorities to lessen a serious or imminent threat to the health or safety of you or the public. In other situations not described here, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).

We reserve the right to change this notice at any time and for any reason. We reserve the right to make the revised or changed notice effective for PHI we currently maintain as well as any information received in the future. A copy of our most current notice will be posted at www.deltadentalmn.org.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI which is held in a particular record set by us. You may request copies for a nominal per-page charge. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you. You also have the right to receive notice following an unauthorized access, use or disclosure of your PHI if that unauthorized access, use or disclosure is considered a "breach" as defined by the HIPAA Privacy Rules.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, request a paper copy of this Notice or if you have any questions, complaints or concerns, please contact:

Customer Service
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815

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SUMMARY OF DENTAL BENEFITS

After you have satisfied the deductible, if any, your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta Dental is different for participating dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

Service Category Description	***Delta Dental PPO Dentists***	***Delta Dental Premier Dentists***	***Nonparticipating Dentists***
Diagnostic and Preventive Service	100%	100%	100%
Basic Services	50%	50%	50%
Endodontics	50%	50%	50%
Periodontics	50%	50%	50%
Oral Surgery	50%	50%	50%
Major Restorative Services	50%	50%	50%
Prosthetic Repairs and Adjustments	50%	50%	50%
Prosthetics	50%	50%	50%

Benefit Maximums

The Program pays up to a maximum of $1,500.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Deductible

There is a $50.00 deductible per Covered Person each Coverage Year not to exceed three (3) times that amount ($150.00) per Family Unit.

The deductible does not apply to Diagnostic and Preventive Services.

Coverage Year

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is January 1 to December 31.

DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate
(Estimate of Benefits)

IT IS A GOOD IDEA TO GET A PRETREATMENT ESTIMATE FOR YOUR DENTAL CARE THAT INVOLVES MAJOR RESTORATIVE, PERIODONTICS, PROSTHETICS OR ORTHODONTIC CARE. THE PRETREATMENT IS RECOMMENDED, BUT NOT REQUIRED FOR YOU TO RECEIVE BENEFITS FOR COVERED DENTAL CARE. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND YOU. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND YOU TO KNOW WHAT BENEFITS YOU HAVE AND IF THE TREATMENT IS COVERED. THE PRETREATMENT ESTIMATE OUTLINES WHAT YOU HAVE TO PAY TO THE DENTIST, SUCH AS CO-PAYMENTS AND DEDUCTIBLES. IT ALLOWS THE DENTIST AND YOU TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE YOUR TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED PAYMENT IS BASED ON YOUR CURRENT ELIGIBILITY AND CONTRACT BENEFITS IN EFFECT AT THE TIME OF THE ESTIMATE. THIS IS AN ESTIMATE ONLY. FINAL PAYMENT WILL BE BASED ON THE CLAIM THAT IS SUBMITTED ONCE THE TREATMENT IS COMPLETED. SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN YOUR COVERAGE OR OTHER COVERAGE YOU HAVE MAY ALTER THE PAYMENT AMOUNT.

After the exam, your dentist will tell you the dental treatment that should be given. If the dental treatment involves major restorative, periodontics, prosthetics or orthodontic care, the dentist should submit a claim form to the Plan for the proposed treatment. The plan will review and determine if the treatment is covered and estimate the amount of payment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible to pay for any deductibles and coinsurance amounts. You will also be responsible to pay for any dental treatment that is not considered a covered service under the Plan.

Benefits

The Program covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PPO AND DELTA DENTAL PREMIER NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Minnesota does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. The decision as to what dental care treatment is best for you is solely between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this booklet.

PREVENTIVE CARE
(Diagnostic & Preventive Services)

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Radiographs (X-rays)

- **Bitewings** - Covered at 2 series of films per 12 month period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 36-month period.
- **Periapical(s)** - 4 single X-rays are covered per 12-month period.
- **Occlusal** - Covered at 2 series per 24-month period.

Dental Cleaning

- **Prophylaxis or Periodontal Maintenance** - Any combination of these procedures is covered 4 times per calendar year.

  Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

  Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment (Topical application of fluoride) - Covered 2 times per 12-month period for dependent children through the age of 18.

Oral Hygiene Instructions - Instructions which include tooth-brushing techniques, flossing and use of oral hygiene aids are covered 1 time per lifetime.

Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances is not a covered benefit.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 36-month period for permanent first and second molars of eligible dependent children through the age of 18.

EXCLUSIONS - Coverage is NOT provided for:

1. Restorations placed for preventive or cosmetic purposes.

BASIC SERVICES

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth** - This service is not covered under Basic Services. Refer to the Complex or Major Restorative Services section of your benefits.

LIMITATION: Coverage for amalgam or composite restorations will be limited to only 1 service per tooth surface per 12-month period.

Other Basic Services

- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.
- **Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 24-month period for eligible dependent children through the age of 18.

Adjunctive General Services

- **Intravenous Conscious Sedation and IV Sedation** - Covered when performed in conjunction with complex surgical service.

  LIMITATION: Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS - Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.
5. Placement or removal of sedative filling, base or liner used under a restoration.
6. Pulp vitality tests.
7. Diagnostic casts.
8. Adjunctive diagnostic tests.
9. Restorations placed for preventive or cosmetic purposes.

10. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Apicoectomy**
- **Root Amputation on posterior (back) teeth**

Complex or other Endodontic Services

- **Apexification** – Covered once per 24-month period for dependent children through the age of 16.
- **Retrograde filling** – Covered once per 24-month period.
- **Hemisection, includes root removal**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

Root Canal Therapy - Covered 1 time per 12-month period.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Pulp vitality tests.
6. Incomplete root canals.

PERIODONTICS (GUM & BONE TREATMENT)

Basic Non Surgical Periodontal Care - Treatment for diseases for the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** - Covered 1 time per 24 months.
- **Full mouth debridement** - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

- **Gingivectomy/gingivoplasty**
- **Gingival flap**
- **Apically positioned flap**

- **Osseous surgery**
- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 1 time per 36-month period per single tooth or multiple teeth in the same quadrant.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)

Basic Extractions

- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Oroantral fistula closure
- Tooth reimplantation - accidentally evulsed or displaced tooth
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odontogenic cyst or tumor
- Removal of exostosis
- Partial ostectomy

- Incision & drainage of abscess
- Frenulectomy (frenectomy or frenotomy)

Temporomandibular Joint Disorder (TMJ) as covered under Minnesota Statutes Section 62A.043 Subd. 3 -

Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended.

NOTE: If you or your dependents currently have medical insurance coverage, the claim must first be submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to this Plan.

If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this dental Plan within the noted Plan limitations, maximums, deductibles and payment percentages of treatment costs.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by Minnesota Statute 62A.25 provided, however, that such procedures are dental reconstructive surgical procedures.
2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statute section 62A.042.

   For programs without orthodontic coverage: Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit plan.

For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.
2. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
5. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
6. Surgical repositioning of teeth.
7. Inpatient or outpatient hospital expenses.

8. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.

COMPLEX OR MAJOR RESTORATIVE SERVICES
Services performed to restore lost tooth structure as a result of decay or fracture

Posterior (back) Teeth Composite (white) Resin Restorations

- If the posterior (back) tooth requires a restoration due to decay or fracture;
- If no other posterior (back) composite (white) resin restoration for the same or additional tooth surface(s) was performed within the last 12 months.

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Inlays - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Onlays and/or Permanent Crowns - Covered 1 time per 5-year period per tooth.

Implant Crowns - See Prosthetic Services.

Crown Repair - Covered 1 time per 12-month period per tooth.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5-year period when done in conjunction with covered services.

Canal prep & fitting of preformed dowel & post

Occlusal Guard

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Temporary, provisional or interim crown.
6. Occlusal procedures including adjustments.
7. Inlays, onlays or crowns placed for preventive or cosmetic purposes.
8. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered when:

- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Adjustments - Covered 2 times per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 5-year period for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
3. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
5. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
7. Services or supplies that have the primary purpose of improving the appearance of your teeth.
8. Placement or removal of sedative filling, base or liner used under a restoration.

9. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
10. Coverage shall be limited to the least expensive professionally acceptable treatment.

Exclusions
Coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.

b) Dental services or health care services not specifically covered under the Client Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible for coverage.

f) Services of anesthesiologists.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

k) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.

n) Case presentations, office visits and consultations.

o) Incomplete, interim or temporary services.

p) Athletic mouth guards, enamel microabrasion and odontoplasty.

q) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

r) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

s) Bacteriologic tests.

t) Cytology sample collection.

u) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

v) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).

w) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

x) The replacement of an existing partial denture with a bridge.

y) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

z) Provisional splinting, temporary procedures or interim stabilization.

aa) Placement or removal of sedative filling, base or liner used under a restoration.

bb) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

cc) Occlusal procedures including adjustments.

dd) Pulp vitality tests

ee) Adjunctive diagnostic tests.

ff) Diagnostic casts.

gg) Incomplete root canals.

hh) Cone beam images.

ii) Anatomical crown exposure.

jj) Temporary anchorage devices.

kk) Sinus augmentation.

ll) Brush biopsy and the accession of a brush biopsy.

mm) Restorations placed for preventive or cosmetic purposes.

nn) Inlays, onlays and crowns placed for preventive or cosmetic purposes.

oo) Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

pp) Orthodontic Services.

Limitations

a) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by MN Statute 62A.25 provided, however, that such services are dental reconstructive surgical services.

b) Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statues Section 62A.042. For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For Programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

For other dental procedure exclusions and limitations, refer to the Description of Coverages in this Dental Benefit Plan Summary.

Post Payment Review

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 - Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed are subject to recovery. Delta Dental's right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

ELIGIBILITY

Covered Persons under this Program are:

Employees

a) All eligible employees who have met the eligibility requirements as established by the Client and stated within this Dental Benefit Plan Summary under Effective Date of Coverage.

b) Employees on Family and Medical Leave as mandated by the Federal FMLA.

Dependents

A) Spouse, meaning:

   1. Married;

B) Dependent children to the age of 26, including:

   1. Natural-born and legally adopted children (including children placed with you for legal adoption). NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
   2. Stepchildren who reside with you.
   3. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan Administrator.
   4. Children for whom you or your spouse are the legal guardian.

5. Disabled children age 26 and older if:
    - they are primarily dependent upon you; and
    - are incapable of self-sustaining employment because of developmental delay, mental illness or mental disorder or physical disability.

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under either parent's coverage, but not both.

Effective Dates of Coverage

Eligible Employee:

You are eligible to be covered under this Program when the Program first became effective, January 1, 2015, or if you are a new employee of the Client, on your date of hire.

Eligible Dependents:

Your eligible dependents, as defined, are covered under this Program:

a) On the date you first become eligible for coverage, if dependent coverage is provided or elected.

b) On the date you first acquire eligible dependents, or add dependent coverage subject to the open enrollment requirements of the Client, if any.

c) On the date a new dependent is acquired if you are already carrying dependent coverage.

LIMITATION: Dependents of an eligible employee who are in active military service are not eligible for coverage under the Program.

Children may be added to the Program at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child's 3rd birthday. If a child is born or adopted after the employee's original effective date, such child may be added anytime between birth (or date of adoption) and 30 days following the child's 3rd birthday. In the event that the child is not added by 30 days following their 3rd birthday, that child may be added only if there is a Family Status Change or at the next Open Enrollment period, if any.

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Program, shall, at all times, be contingent upon the applicable monthly payment having been made for such Covered Person by the Client on a current basis.

Open Enrollment

The Open Enrollment under this Contract shall be held annually.

Family Status Change

Your benefit elections are intended to remain the same for the entire Coverage Year. During the Coverage Year, you will be allowed to change your benefits only if you experience an eligible Family Status Change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of dependents in the event of birth, adoption, placement for adoption or death.
- Change in your or your spouse's employment - either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in dependent status, such as if a child reaches maximum age under the Plan.

- Change in residence or work location so you are no longer eligible for your current health plan.
- Become eligible for Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage.
- Termination of Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage because you or your dependents are no longer eligible.
- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it is not consistent to drop your dental coverage altogether.

If you experience one of the above eligible Family Status Changes during the year, you have 31 days (except in the case of qualification for or termination of employment assistance under Medicaid/CHIP, in which case the employee has 60 days after the date of eligibility) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain a Family Status Change Form by contacting your Employer. All changes are effective the date of the change.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation of Benefits: Covered employees who are absent due to service in the uniformed services and/or their covered dependents may continue coverage under USERRA for up to 24 months after the date the covered employee is first absent due to uniformed service duty. To continue coverage under USERRA, covered employees and/or their dependents should contact their Employer.

Eligibility: A covered employee is eligible for continuation under USERRA if he or she is absent from employment because of service in the uniformed services as defined in USERRA. This includes voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

Covered employees and dependents who have coverage under the Plan immediately prior to the date of the covered employee's covered absence are eligible to elect continuation under USERRA.

Contribution Payment: If continuation of Plan coverage is elected under USERRA, the covered employee or covered dependent is responsible for payment of the applicable cost of COBRA coverage. If, however, the covered employee is absent for not longer than 31 calendar days, the cost will be the amount the covered employee would otherwise pay for coverage (at employee rates). For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the covered employee's share and any portion previously paid by the Employer.

Duration of Coverage: Elected continuation coverage under USERRA will continue until the earlier of:

- 24 months, beginning the first day of absence from employment due to service in the uniformed services;
- the day after the covered employee fails to apply for or return to employment as required by USERRA, after completion of a period of service;
- the early termination of USERRA continuation coverage due to the covered employee's court-martial or dishonorable discharge from the uniformed services; or
- the date on which this Plan is terminated so that the covered employee loses coverage.

Covered employees should contact their Employer with any questions regarding continuation coverage and notify the Employer of any changes in marital status or a change of address.

Reemployment: An individual whose coverage under the Plan was terminated by reason of service in the

uniformed services and who did not continue coverage during leave must, nevertheless, be entitled to reinstatement of coverage upon reemployment.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the earliest of the following dates:

a) On the date in which you cease to be eligible.

b) The end of the month in which your dependent is no longer eligible as a dependent under the Program.

c) On the date the Program is terminated.

d) On the date the Client terminates the Program by failure to pay the required Client Subscriber payments, except as a result of inadvertent error.

For extended eligibility, see Continuation of Coverage.

The Client or Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons. If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination.

Continuation of Coverage

Dental benefits may be continued should any of the following events (called Qualifying Events) occur, provided that at the time of occurrence this Program remains in effect and you or your spouse or your dependent child is a Covered Person under this Program. You and your dependents may have to pay for this coverage. There are also other coverage options available to you and your family through the Health Insurance Marketplace (also called the Exchange) in your state. Being eligible for Continuation of Coverage under this Plan does not limit your eligibility for coverage through the Marketplace. For more information about health and dental insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or a reduction in hours that causes the employee to become ineligible(except gross misconduct dismissal)	Employee and dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage. 3. Date coverage would otherwise end.
Divorce, marriage dissolution or legal separation	Former Spouse and any dependent children who lose coverage	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would otherwise end.
Death of Employee	Surviving spouse and dependent children	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would have otherwise terminated under the contract had the employee lived.

Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to Employee's entitlement to Medicare	Spouse and dependents	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Employee's total disability	Employee and dependents	Earliest of: 1. Date total disability ends, or 2. Date coverage would otherwise end.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving Spouse and dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

You or your eligible dependents have 60 days from the date you lose coverage, due to one of the events described above, to inform the Client that you wish to continue coverage; except that, in the case of death of an eligible employee, such notification period to continue coverage shall be 90 days.

1. Choosing Continuation

   If you lose coverage, due to a termination of employment (except if the termination is for gross misconduct), retirement, leave of absence, lay-off, or reduction in hours, your employer should notify you of the option to continue coverage within 10 days after your loss of coverage. You or your covered dependents must notify your employer of divorce, legal separation, or any other change in dependent status within 60 days of the event.

   You or your covered dependents must choose to continue coverage by completing, in writing, the election notice that your employer sends to you. You or your covered dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered dependents ineligible to choose continuation at a later date. You or your covered dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered dependents must pay charges monthly in advance to the employer to maintain coverage in force.

   Charges for continuation are the group rate plus a two percent administration fee. All charges are paid directly to your employer. If you or your covered dependents are totally disabled, charges for continuation are the group rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the group rate plus a 50 percent administration fee.

2. Second qualifying event

   If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled

to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

When a second qualifying event occurs such as the death of the former covered employee, the dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

A qualified beneficiary is any individual covered under the health plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage

Continuation of Coverage for you and your eligible dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

a) The expiration of the specified period of time for which Continuation of Coverage can be maintained; as mandated by applicable State or Federal law;

b) This Program is terminated by the Client Subscriber;

c) The Client Subscriber's or Covered Person's failure to make the payment for the Covered Person's Continuation of Coverage

Questions regarding Continuation of Coverage should be directed to your employer. Your employer will explain the regulations, qualifications and procedures required when you continue coverage.

PLAN PAYMENTS

Participating Dentist Network

A Delta Dental Premier dentist is a dentist who has signed a participating and membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept Delta Dental's Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Maximum Amount Payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed dentist who is a participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental Premier dentist has agreed not to bill more than Delta Dental's allowable charge. A Delta Dental Premier dentist has also agreed to file the claim directly with Delta Dental.

A Delta Dental PPO network dentist is a dentist who has signed Delta Dental PPO agreement with Delta Dental of Minnesota. The dentist has agreed to accept the Delta Dental PPO Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO dentist has agreed not to bill more than the Delta Dental PPO Maximum Amount Payable. A Delta Dental PPO dentist has also agreed to file the claim directly with Delta Dental.

Names of Participating Dentists can be obtained, upon request, by calling Delta, or from the Plan's internet web site at www.deltadentalmn.org. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan's internet web site.

Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a Delta Dental PPO or Delta Dental Premier dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta Dental. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's charges in relation to the Table of Allowances determined by Delta Dental.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PPO AND DELTA DENTAL PREMIER NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Notice of Claim

Written notice of claim must be given to Delta Dental within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Policyholder or the beneficiary shall be presented to Delta Dental at P.O. Box 9120, Farmington Hills, MI 48333-9120.

Claim Forms

Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished for filing proofs of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you shall be deemed to have complied with the requirements of this policy.

Claim Payments

PAYMENTS ARE MADE BY THE PLAN ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSON OR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental Premier Dentists:

Claim payments are based on the Plan’s Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental Premier dentists is the lesser of: (1) The Maximum Amount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental Premier dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient’s Delta Dental program.

Delta Dental PPO Dentists:

Claim payments are based on the Plan’s Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPO dentists is the lesser of: (1) The Delta Dental PPO Maximum Amount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental PPO dentist regardless of the amount charged. All Plan Payment Obligations are determined

prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Nonparticipating Dentists:

Claim payments are based on the Plan's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the Table of Allowances established solely by Delta Dental, whichever is less. The Table of Allowances is a schedule of fixed dollar maximums established by Delta Dental for services rendered by a licensed dentist who is a nonparticipating dentist. Claim payments are sent directly to the Covered Person.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NONPARTICIPATING PROVIDER, ANY BENEFITS PAYABLE UNDER THE CLIENT CONTRACT ARE PAID DIRECTLY TO THE COVERED PERSON.

Coordination of Benefits (COB)

If you or your dependents are eligible for dental benefits under this Program and under another dental program, benefits will be coordinated so that no more than 100% of the "Allowable Charges" is paid jointly by the programs. The Plan Payment Obligation is determined prior to calculating all percentages, deductibles and benefit maximums.

The Coordination of Benefits provision determines which program has the primary responsibility for providing the first payment on a claim. In establishing the order, the program covering the patient as an employee has the primary responsibility for providing benefits before the program covering the patient as a dependent. If the patient is a dependent child, the program with the parent whose month and day of birth falls earlier in the calendar year has the primary payment responsibility. If both parents should have the same birth date, the program in effect the longest has the primary payment responsibility. If the other program does not have a Coordination of Benefits provision, that program most generally has the primary payment responsibility.

NOTE: When Coordination of Benefits applies for dependent children, provide your dentist with the birth dates of both parents.

Assignment of Benefits

Any benefits which may be payable under this dental benefit Plan are not assignable.

Time of Payment of Claim

Any benefits due under this Policy for any loss other than loss for which this Policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss.

Claim and Appeal Procedures

Proof of Loss
All claims should be submitted within 12 months of the date of service**.** If you do not submit a claim within the time required, it will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. You must submit your proof as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Initial Claim Determinations
An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive a written notice of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you

prior to the end of the initial 30-day period. We will tell you the reasons we require an extension and the date by which we expect to make a decision. If the extension is needed for us to get additional information from you, the notice will describe the specific information we need. You will have 45 days from the receipt of the notice to provide us with the information. Without complete information, your claim will be denied.

Appeals

In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted to us within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, Client number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Delta Dental of Minnesota
Attn: Professional Services Appeals and Grievances
PO Box 30416
Lansing, MI 48909

You may submit written comments, documents, or other information that you feel supports your appeal. Upon request, you will also be given reasonable access to and copies of all relevant records that are used in making the decision. These records will be given to you at no charge. The review will take into account all information about the denied or reduced claim, even if the information was not present or available at the time of the initial determination. In this review, the initial determination of the claim will not be given any weight.

The review will be done by someone different from the original decision-makers and will not take into consideration any prior decisions made in your claim. Because all decisions are based on a preset schedule of dental services that are covered by your plan, claims are not reviewed to determine dental necessity or appropriateness. If we need to consult a professional to determine if a service is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. This professional will not be the same person who was involved in the initial adverse benefit determination (nor a subordinate of any such person). We will identify any dental professional whose advice was obtained on our behalf, even if the advice was not used in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to your estate. Any other accrued indemnities unpaid at your death may, at your option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to you.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

GENERAL INFORMATION

Health Plan Issuer Involvement

The benefits under the Plan are not guaranteed by Delta Dental under the Contract. As Claims Administrator, Delta Dental pays or denies claims on behalf of the Plan and reviews requests for review of claims as described in the Claim and Appeals Procedures section.

Privacy Notice

Delta Dental of Minnesota will not disclose non-public personal financial or health information concerning persons covered under this dental benefit Program to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under this dental benefit Program.

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at the Plan's user friendly web site, www.deltadentalmn.org. The Plan highly recommends use of the web site for the most accurate network information. Go to http://www.deltadentalmn.org/find-a-dentist and enter your zip code, city or state to find local participating dentists. You can also search by dentist or clinic name. The Web site also allows you to print out a map directing you to the dental office you select. **The Find A Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.**

To search for and verify the status of participating providers, select "Find A Dentist" on the www.deltadentalmn.org home page. Select the Product or Network in the drop-down menu, and search by city and state, zip code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

If you do not have Internet access, other options are available to find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. **Be sure to specifically state that your employer is providing the Dental program.**
- Contact our Customer Service Center at: (800) 448-3815. Customer Service hours are 7 a.m. to 7 p.m., Monday through Friday, Central Standard Time.

Using Your Dental Program

Dentists who participate with Delta Dental under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta Dental cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is a participating dentist, the claim form will be available at the dentist's office.

If your dentist is nonparticipating, claim forms are available by calling:

Delta Dental of Minnesota - (651) 406-5901 or (800) 448-3815

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

* YOUR DELTA DENTAL CLIENT NUMBER
* YOUR EMPLOYER (CLIENT NAME)
* YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** identification number)
* YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

Cancellation and Renewal

The Program may be canceled by the Plan only on an anniversary date of the Client Dental Plan Contract, or at any time the Client fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Client have no right to continue coverage under the Program or convert to an individual dental coverage contract.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Plan Administration

The Plan Administrator, who is listed on the inside front cover of this brochure, is a named fiduciary under the Program and shall be responsible for the management and control of this Program.

The Plan Administrator is responsible for determining the level of benefits for the Program as described in this brochure. The Plan Administrator reserves the power at any and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the Plan, provided, however, that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the Plan.

Funding Policy and Payment

The funding policy and method requires that the Client Subscriber submit payments on a monthly basis.

Procedure to Request Information

If you have any questions about this Program, contact the Plan Administrator who is listed in the inside front cover of this brochure.

Statement of ERISA Rights

As a participant in the Program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine without charge at the Plan Administrator's office and at other specified locations such as work sites and union halls, all Plan documents, including insurance contracts, and copies of all documents such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor.
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. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fee, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DELTA DENTAL OF MINNESOTA

FOR CLAIMS
Delta Dental of Minnesota
P.O. Box 9120
Farmington Hills, MI 48333-9120
(651) 406-5901 or (800)448-3815

FOR ELIGIBILITY
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815

CORPORATE LOCATION
500 Washington Avenue South
Suite 2060
Minneapolis, MN 55415
(651) 406-5900 or (800) 328-1188
www.deltadentalmn.org

Updated and Approved 1/2021
Updated 12/2020
Approved 11/2020
Updated 10/2020
Updated 9/2020
Approved 1/2020
Updated 11/2019
Updated 7/2018
Approved 12/2017(PDF only)

DELTA DENTAL PPO PLUS PREMIER - COMPREHENSIVE ENHANCED

with Orthodontic Coverage

Dental Benefit Plan Summary

Intact Services USA LLC
Enhanced Plan
Client Number 100417

ADMINISTRATION

The following information is provided as required by the Employee Retirement Income Security Act (ERISA) of 1974.

EMPLOYER, PLAN SPONSOR, FIDUCIARY AND PLAN ADMINISTRATOR:
Intact Services USA LLC
605 Highway 169 N, Suite 800
Plymouth, MN 55441
Telephone: (952) 852-6748

AGENT FOR SERVICE OF LEGAL PROCESS:
Intact Services USA LLC
605 Highway 169 N, Suite 800
Plymouth, MN 55441
Telephone: (952) 852-6748

PARTICIPATING EMPLOYERS:
Intact Services USA LLC
A.W.G. Dewar, Inc.
Atlantic Specialty Insurance Company

FUNDING: Your contribution towards the cost of the coverage under the Plan will be determined by the Employer each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

EMPLOYER IDENTIFICATION NUMBER: 26-3300555

PLAN NAME: Intact Insurance Group USA Welfare Plan

EMPLOYER PLAN NUMBER: 506

TYPE OF PLAN: Health and welfare benefits plan including dental benefits

PLAN YEAR: January 1 – December 31

DELTA DENTAL CLIENT NUMBER: 100417

PLAN BENEFITS ADMINISTERED BY:
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815
www.deltadentalmn.org

DENTAL BENEFIT PLAN SUMMARY

This is a Summary of your Client Dental Program
(**PROGRAM**) prepared for Covered Persons with:

Intact Services USA LLC
(**CLIENT**)

This Program has been established and is maintained and administered in accordance with the provisions of your Client Dental Plan Contract Number **100417** issued by Delta Dental of Minnesota (**PLAN**).

This booklet is subject to the provisions of the Client Dental Plan Contract. If there is an inconsistency between this booklet and the Client Dental Plan Contract, the Client Dental Plan Contract controls.

DELTA DENTAL OF MINNESOTA

Administrative Offices
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815
www.deltadentalmn.org

DELTA DENTAL OF MINNESOTA
NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Delta Dental of Minnesota is required by law to maintain the privacy of your Protected Health Information, to provide you with this notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rules"). Individually identifiable information about your past, present or future health condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI"). Health care includes dental care.

Our Permitted Uses and Disclosures of Your Protected Health Information

We use and disclose PHI about you without your authorization for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information from us as to whether the service has been previously provided.

Payment: We use and disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we use and disclose your PHI in order to process your claims.

Health Care Operations: We use and disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use and disclose your PHI to evaluate the quality of dental services that were performed or to check for fraud and abuse.

We may not, however, use or disclose any PHI that is considered genetic information under Federal Law for underwriting purposes.

We may be asked by the sponsor of your dental benefits to provide your PHI to the sponsor. We will do so if permitted by law.

Unless you object, we may disclose your PHI to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only PHI relevant to that person's involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, we will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

We may also use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may use or disclose your PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We may disclose PHI in response to a court or administrative order, subpoena, discovery request or other lawful process if certain conditions are met and the required assurances are received. We provide PHI when otherwise required by law, such as for law enforcement purposes. We may disclose your PHI to public health or other appropriate authorities to lessen a serious or imminent threat to the health or safety of you or the public. In other situations not described here, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).

We reserve the right to change this notice at any time and for any reason. We reserve the right to make the revised or changed notice effective for PHI we currently maintain as well as any information received in the future. A copy of our most current notice will be posted at www.deltadentalmn.org.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI which is held in a particular record set by us. You may request copies for a nominal per-page charge. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you. You also have the right to receive notice following an unauthorized access, use or disclosure of your PHI if that unauthorized access, use or disclosure is considered a "breach" as defined by the HIPAA Privacy Rules.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, request a paper copy of this Notice or if you have any questions, complaints or concerns, please contact:

Customer Service
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815

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SUMMARY OF DENTAL BENEFITS

After you have satisfied the deductible, if any, your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta Dental is different for participating dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

Service Category Description	***Delta Dental PPO Dentists***	***Delta Dental Premier Dentists***	***Nonparticipating Dentists***
Diagnostic and Preventive Service	100%	100%	100%
Basic Services	80%	80%	80%
Endodontics	80%	80%	80%
Periodontics	80%	80%	80%
Oral Surgery	80%	80%	80%
Major Restorative Services	50%	50%	50%
Prosthetic Repairs and Adjustments	80%	80%	80%
Prosthetics	50%	50%	50%
Orthodontics	80%	80%	80%

Benefit Maximums

The Program pays up to a maximum of $2,500.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Orthodontics is subject to a separate lifetime maximum of $1,500.00 per Covered Person. Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must remain eligible under the Plan in order to receive continued benefit payments.

Deductible

There is a $25.00 deductible per Covered Person each Coverage Year not to exceed three (3) times that amount ($75.00) per Family Unit.

The deductible does not apply to Diagnostic and Preventive or Orthodontic Services.

Coverage Year

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is January 1 to December 31.

DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate
(Estimate of Benefits)

IT IS A GOOD IDEA TO GET A PRETREATMENT ESTIMATE FOR YOUR DENTAL CARE THAT INVOLVES MAJOR RESTORATIVE, PERIODONTICS, PROSTHETICS OR ORTHODONTIC CARE. THE PRETREATMENT IS RECOMMENDED, BUT NOT REQUIRED FOR YOU TO RECEIVE BENEFITS FOR COVERED DENTAL CARE. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND YOU. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND YOU TO KNOW WHAT BENEFITS YOU HAVE AND IF THE TREATMENT IS COVERED. THE PRETREATMENT ESTIMATE OUTLINES WHAT YOU HAVE TO PAY TO THE DENTIST, SUCH AS CO-PAYMENTS AND DEDUCTIBLES. IT ALLOWS THE DENTIST AND YOU TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE YOUR TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED PAYMENT IS BASED ON YOUR CURRENT ELIGIBILITY AND CONTRACT BENEFITS IN EFFECT AT THE TIME OF THE ESTIMATE. THIS IS AN ESTIMATE ONLY. FINAL PAYMENT WILL BE BASED ON THE CLAIM THAT IS SUBMITTED ONCE THE TREATMENT IS COMPLETED. SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN YOUR COVERAGE OR OTHER COVERAGE YOU HAVE MAY ALTER THE PAYMENT AMOUNT.

After the exam, your dentist will tell you the dental treatment that should be given. If the dental treatment involves major restorative, periodontics, prosthetics or orthodontic care, the dentist should submit a claim form to the Plan for the proposed treatment. The plan will review and determine if the treatment is covered and estimate the amount of payment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible to pay for any deductibles and coinsurance amounts. You will also be responsible to pay for any dental treatment that is not considered a covered service under the Plan.

Benefits

The Program covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PPO AND DELTA DENTAL PREMIER NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Minnesota does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. The decision as to what dental care treatment is best for you is solely between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this booklet.

PREVENTIVE CARE
(Diagnostic & Preventive Services)

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Radiographs (X-rays)

- **Bitewings** - Covered at 2 series of films per 12 month period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 36-month period.
- **Periapical(s)** - 4 single X-rays are covered per 12-month period.
- **Occlusal** - Covered at 2 series per 24-month period.

Dental Cleaning

- **Prophylaxis or Periodontal Maintenance** - Any combination of these procedures is covered 4 times per calendar year.

  Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

  Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment (Topical application of fluoride) - Covered 2 times per 12-month period for dependent children through the age of 18.

Oral Hygiene Instructions - Instructions which include tooth-brushing techniques, flossing and use of oral hygiene aids are covered 1 time per lifetime.

Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances is not a covered benefit.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 36-month period for permanent first and second molars of eligible dependent children through the age of 18.

EXCLUSIONS - Coverage is NOT provided for:

1. Restorations placed for preventive or cosmetic purposes.

BASIC SERVICES

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth** - This service is not covered under Basic Services. Refer to the Complex or Major Restorative Services section of your benefits.

LIMITATION: Coverage for amalgam or composite restorations will be limited to only 1 service per tooth surface per 12-month period.

Other Basic Services

- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.
- **Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 24-month period for eligible dependent children through the age of 18.

Adjunctive General Services

- **Intravenous Conscious Sedation and IV Sedation** - Covered when performed in conjunction with complex surgical service.

  LIMITATION: Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS - Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.
5. Placement or removal of sedative filling, base or liner used under a restoration.
6. Pulp vitality tests.
7. Diagnostic casts.
8. Adjunctive diagnostic tests.
9. Restorations placed for preventive or cosmetic purposes.

10. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Apicoectomy**
- **Root Amputation on posterior (back) teeth**

Complex or other Endodontic Services

- **Apexification** – Covered once per 24-month period for dependent children through the age of 16.
- **Retrograde filling** – Covered once per 24-month period.
- **Hemisection, includes root removal**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

Root Canal Therapy - Covered 1 time per 12-month period.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Pulp vitality tests.
6. Incomplete root canals.

PERIODONTICS (GUM & BONE TREATMENT)

Basic Non Surgical Periodontal Care - Treatment for diseases for the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** - Covered 1 time per 24 months.
- **Full mouth debridement** - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

- **Gingivectomy/gingivoplasty**
- **Gingival flap**
- **Apically positioned flap**

- **Osseous surgery**
- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 1 time per 36-month period per single tooth or multiple teeth in the same quadrant.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)

Basic Extractions

- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Oroantral fistula closure
- Tooth reimplantation - accidentally evulsed or displaced tooth
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odontogenic cyst or tumor
- Removal of exostosis

- Partial ostectomy
- Incision & drainage of abscess
- Frenulectomy (frenectomy or frenotomy)

Temporomandibular Joint Disorder (TMJ) as covered under Minnesota Statutes Section 62A.043 Subd. 3 -

Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended.

NOTE: If you or your dependents currently have medical insurance coverage, the claim must first be submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to this Plan.

If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this dental Plan within the noted Plan limitations, maximums, deductibles and payment percentages of treatment costs.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by Minnesota Statute 62A.25 provided, however, that such procedures are dental reconstructive surgical procedures.
2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statute section 62A.042.

   For programs without orthodontic coverage: Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit plan.

   For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.
2. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
5. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
6. Surgical repositioning of teeth.

7. Inpatient or outpatient hospital expenses.
8. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.

COMPLEX OR MAJOR RESTORATIVE SERVICES
Services performed to restore lost tooth structure as a result of decay or fracture

Posterior (back) Teeth Composite (white) Resin Restorations

- If the posterior (back) tooth requires a restoration due to decay or fracture;
- If no other posterior (back) composite (white) resin restoration for the same or additional tooth surface(s) was performed within the last 12 months.

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Inlays - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Onlays and/or Permanent Crowns - Covered 1 time per 5-year period per tooth.

Implant Crowns - See Prosthetic Services.

Crown Repair - Covered 1 time per 12-month period per tooth.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5-year period when done in conjunction with covered services.

Canal prep & fitting of preformed dowel & post

Occlusal Guard

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Temporary, provisional or interim crown.
6. Occlusal procedures including adjustments.
7. Inlays, onlays or crowns placed for preventive or cosmetic purposes.
8. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is

damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

PROSTHETIC REPAIR AND ADJUSTMENT SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered when:

- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Adjustments - Covered 2 times per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
3. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
5. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
7. Services or supplies that have the primary purpose of improving the appearance of your teeth.
8. Placement or removal of sedative filling, base or liner used under a restoration.
9. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
10. Coverage shall be limited to the least expensive professionally acceptable treatment.

PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;

- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 5-year period for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
3. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
5. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
7. Services or supplies that have the primary purpose of improving the appearance of your teeth.
8. Placement or removal of sedative filling, base or liner used under a restoration.
9. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
10. Coverage shall be limited to the least expensive professionally acceptable treatment.

ORTHODONTICS

Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

Limited Treatment
Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment
A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment
Full treatment includes all records, appliances and visits.

Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.

Other Complex Surgical Procedures

- **Surgical exposure of impacted or unerupted tooth for orthodontic reasons**

- **Surgical repositioning of teeth**

LIMITATION: Treatment in progress (appliances placed prior to eligibility under this Plan) will be benefited on a pro-rated basis.

EXCLUSIONS - Coverage is NOT provided for:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses; and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally takes place over a long period of time, payments for benefits are made over the course of treatment. The Covered Person must continue to be eligible under the Plan in order to receive ongoing payments for orthodontic benefits.

Benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and 6-month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted (see Benefit Maximums in this Plan Summary).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to you and your dentist that will tell you the estimated plan payment amount. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and their signature. After the Plan has verified your benefit and eligibility, a benefit payment will be issued. We will also send a new/revised Estimate of Benefits form to you and your dentist. This again will serve as the claim form to be submitted 6 months from the date the appliance was placed.

Exclusions
Coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.

b) Dental services or health care services not specifically covered under the Client Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible for coverage.

f) Services of anesthesiologists.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

k) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.

n) Case presentations, office visits and consultations.

o) Incomplete, interim or temporary services.

p) Athletic mouth guards, enamel microabrasion and odontoplasty.

q) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

r) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

s) Bacteriologic tests.

t) Cytology sample collection.

u) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

v) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).

w) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

x) The replacement of an existing partial denture with a bridge.

y) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

z) Provisional splinting, temporary procedures or interim stabilization.

aa) Placement or removal of sedative filling, base or liner used under a restoration.

bb) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

cc) Occlusal procedures including adjustments.

dd) Pulp vitality tests

ee) Adjunctive diagnostic tests.

ff) Diagnostic casts.

gg) Incomplete root canals.

hh) Cone beam images.

ii) Anatomical crown exposure.

jj) Temporary anchorage devices.

kk) Sinus augmentation.

ll) Brush biopsy and the accession of a brush biopsy.

mm) Restorations placed for preventive or cosmetic purposes.

nn) Inlays, onlays and crowns placed for preventive or cosmetic purposes.

oo) Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

Limitations

a) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by MN Statute 62A.25 provided, however, that such services are dental reconstructive surgical services.

b) Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statues Section 62A.042. For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For Programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

For other dental procedure exclusions and limitations, refer to the Description of Coverages in this Dental Benefit Plan Summary.

Post Payment Review

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 - Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed are subject to recovery. Delta Dental's right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

ELIGIBILITY

Covered Persons under this Program are:

Employees

a) All eligible employees who have met the eligibility requirements as established by the Client and stated within this Dental Benefit Plan Summary under Effective Date of Coverage.

b) Employees on Family and Medical Leave as mandated by the Federal FMLA.

Dependents

A) Spouse, meaning:

1. Married;

B) Dependent children to the age of 26, including:

1. Natural-born and legally adopted children (including children placed with you for legal adoption). NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
2. Stepchildren who reside with you.
3. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan Administrator.
4. Children for whom you or your spouse are the legal guardian.
5. Disabled children age 26 and older if:
   - they are primarily dependent upon you; and
   - are incapable of self-sustaining employment because of developmental delay, mental illness or mental disorder or physical disability.

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under either parent's coverage, but not both.

Effective Dates of Coverage

Eligible Employee:

You are eligible to be covered under this Program when the Program first became effective, January 1, 2015, or if you are a new employee of the Client, on your date of hire.

Eligible Dependents:

Your eligible dependents, as defined, are covered under this Program:

a) On the date you first become eligible for coverage, if dependent coverage is provided or elected.

b) On the date you first acquire eligible dependents, or add dependent coverage subject to the open enrollment requirements of the Client, if any.

c) On the date a new dependent is acquired if you are already carrying dependent coverage.

LIMITATION: Dependents of an eligible employee who are in active military service are not eligible for coverage under the Program.

Children may be added to the Program at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child's 3rd birthday. If a child is born or adopted after the employee's original effective date, such child may be added anytime between birth (or date of adoption) and 30 days following the child's 3rd birthday. In the event that the child is not added by 30 days following their 3rd birthday, that child may be added only if there is a Family Status Change or at the next Open Enrollment period, if any.

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Program, shall, at all times, be contingent upon the applicable monthly payment having been made for such Covered Person by the Client on a current basis.

Open Enrollment

The Open Enrollment under this Contract shall be held annually.

Family Status Change

Your benefit elections are intended to remain the same for the entire Coverage Year. During the Coverage Year, you will be allowed to change your benefits only if you experience an eligible Family Status Change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of dependents in the event of birth, adoption, placement for adoption or death.
- Change in your or your spouse's employment - either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in dependent status, such as if a child reaches maximum age under the Plan.
- Change in residence or work location so you are no longer eligible for your current health plan.
- Become eligible for Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage.
- Termination of Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage because you or your dependents are no longer eligible.
- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it is not consistent to drop your dental coverage altogether.

If you experience one of the above eligible Family Status Changes during the year, you have 31 days (except in the case of qualification for or termination of employment assistance under Medicaid/CHIP, in which case the employee has 60 days after the date of eligibility) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain a Family Status Change Form by contacting your Employer. All changes are effective the date of the change.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation of Benefits: Covered employees who are absent due to service in the uniformed services and/or their covered dependents may continue coverage under USERRA for up to 24 months after the date the covered employee is first absent due to uniformed service duty. To continue coverage under USERRA, covered employees and/or their dependents should contact their Employer.

Eligibility: A covered employee is eligible for continuation under USERRA if he or she is absent from employment because of service in the uniformed services as defined in USERRA. This includes voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for

training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

Covered employees and dependents who have coverage under the Plan immediately prior to the date of the covered employee's covered absence are eligible to elect continuation under USERRA.

Contribution Payment: If continuation of Plan coverage is elected under USERRA, the covered employee or covered dependent is responsible for payment of the applicable cost of COBRA coverage. If, however, the covered employee is absent for not longer than 31 calendar days, the cost will be the amount the covered employee would otherwise pay for coverage (at employee rates). For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the covered employee's share and any portion previously paid by the Employer.

Duration of Coverage: Elected continuation coverage under USERRA will continue until the earlier of:

- 24 months, beginning the first day of absence from employment due to service in the uniformed services;
- the day after the covered employee fails to apply for or return to employment as required by USERRA, after completion of a period of service;
- the early termination of USERRA continuation coverage due to the covered employee's court-martial or dishonorable discharge from the uniformed services; or
- the date on which this Plan is terminated so that the covered employee loses coverage.

Covered employees should contact their Employer with any questions regarding continuation coverage and notify the Employer of any changes in marital status or a change of address.

Reemployment: An individual whose coverage under the Plan was terminated by reason of service in the uniformed services and who did not continue coverage during leave must, nevertheless, be entitled to reinstatement of coverage upon reemployment.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the earliest of the following dates:

a) On the date in which you cease to be eligible.

b) The end of the month in which your dependent is no longer eligible as a dependent under the Program.

c) On the date the Program is terminated.

d) On the date the Client terminates the Program by failure to pay the required Client Subscriber payments, except as a result of inadvertent error.

For extended eligibility, see Continuation of Coverage.

The Client or Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons. If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination.

Continuation of Coverage

Dental benefits may be continued should any of the following events (called Qualifying Events) occur, provided that at the time of occurrence this Program remains in effect and you or your spouse or your dependent child is a Covered Person under this Program. You and your dependents may have to pay for this coverage. There are also other coverage options available to you and your family through the Health Insurance Marketplace (also called the Exchange) in your state. Being eligible for Continuation of Coverage under this Plan does not limit your eligibility for coverage through the Marketplace. For more information

about health and dental insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or a reduction in hours that causes the employee to become ineligible(except gross misconduct dismissal)	Employee and dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage. 3. Date coverage would otherwise end.
Divorce, marriage dissolution or legal separation	Former Spouse and any dependent children who lose coverage	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would otherwise end.
Death of Employee	Surviving spouse and dependent children	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would have otherwise terminated under the contract had the employee lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to Employee's entitlement to Medicare	Spouse and dependents	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Employee's total disability	Employee and dependents	Earliest of: 1. Date total disability ends, or 2. Date coverage would otherwise end.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving Spouse and dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

You or your eligible dependents have 60 days from the date you lose coverage, due to one of the events described above, to inform the Client that you wish to continue coverage; except that, in the case of death of an eligible employee, such notification period to continue coverage shall be 90 days.

1. Choosing Continuation

If you lose coverage, due to a termination of employment (except if the termination is for gross misconduct), retirement, leave of absence, lay-off, or reduction in hours, your employer should notify you of the option to continue coverage within 10 days after your loss of coverage. You or your covered dependents must notify your employer of divorce, legal separation, or any other change in dependent status within 60 days of the event.

You or your covered dependents must choose to continue coverage by completing, in writing, the election notice that your employer sends to you. You or your covered dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered dependents ineligible to choose continuation at a later date. You or your covered dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered dependents must pay charges monthly in advance to the employer to maintain coverage in force.

Charges for continuation are the group rate plus a two percent administration fee. All charges are paid directly to your employer. If you or your covered dependents are totally disabled, charges for continuation are the group rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the group rate plus a 50 percent administration fee.

2. Second qualifying event

   If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

   When a second qualifying event occurs such as the death of the former covered employee, the dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

   A qualified beneficiary is any individual covered under the health plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage

   Continuation of Coverage for you and your eligible dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

   a) The expiration of the specified period of time for which Continuation of Coverage can be maintained; as mandated by applicable State or Federal law;

   b) This Program is terminated by the Client Subscriber;

   c) The Client Subscriber's or Covered Person's failure to make the payment for the Covered Person's Continuation of Coverage

Questions regarding Continuation of Coverage should be directed to your employer. Your employer will explain the regulations, qualifications and procedures required when you continue coverage.

PLAN PAYMENTS

Participating Dentist Network

A Delta Dental Premier dentist is a dentist who has signed a participating and membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept Delta Dental's Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Maximum Amount Payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed dentist who is a participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental Premier dentist has agreed not to bill more than Delta Dental's allowable charge. A Delta Dental Premier dentist has also agreed to file the claim directly with Delta Dental.

A Delta Dental PPO network dentist is a dentist who has signed Delta Dental PPO agreement with Delta Dental of Minnesota. The dentist has agreed to accept the Delta Dental PPO Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO dentist has agreed not to bill more than the Delta Dental PPO Maximum Amount Payable. A Delta Dental PPO dentist has also agreed to file the claim directly with Delta Dental.

Names of Participating Dentists can be obtained, upon request, by calling Delta, or from the Plan's internet web site at www.deltadentalmn.org. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan's internet web site.

Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a Delta Dental PPO or Delta Dental Premier dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta Dental. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's charges in relation to the Table of Allowances determined by Delta Dental.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PPO AND DELTA DENTAL PREMIER NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Notice of Claim

Written notice of claim must be given to Delta Dental within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Policyholder or the beneficiary shall be presented to Delta Dental at P.O. Box 9120, Farmington Hills, MI 48333-9120.

Claim Forms

Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished for filing proofs of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you shall be deemed to have complied with the requirements of this policy.

Claim Payments

PAYMENTS ARE MADE BY THE PLAN ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING.

IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSON OR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental Premier Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental Premier dentists is the lesser of: (1) The Maximum Amount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental Premier dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Delta Dental PPO Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPO dentists is the lesser of: (1) The Delta Dental PPO Maximum Amount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental PPO dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Nonparticipating Dentists:

Claim payments are based on the Plan's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the Table of Allowances established solely by Delta Dental, whichever is less. The Table of Allowances is a schedule of fixed dollar maximums established by Delta Dental for services rendered by a licensed dentist who is a nonparticipating dentist. Claim payments are sent directly to the Covered Person.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NONPARTICIPATING PROVIDER, ANY BENEFITS PAYABLE UNDER THE CLIENT CONTRACT ARE PAID DIRECTLY TO THE COVERED PERSON.

Coordination of Benefits (COB)

If you or your dependents are eligible for dental benefits under this Program and under another dental program, benefits will be coordinated so that no more than 100% of the "Allowable Charges" is paid jointly by the programs. The Plan Payment Obligation is determined prior to calculating all percentages, deductibles and benefit maximums.

The Coordination of Benefits provision determines which program has the primary responsibility for providing the first payment on a claim. In establishing the order, the program covering the patient as an employee has the primary responsibility for providing benefits before the program covering the patient as a dependent. If the patient is a dependent child, the program with the parent whose month and day of birth falls earlier in the calendar year has the primary payment responsibility. If both parents should have the same birth date, the program in effect the longest has the primary payment responsibility. If the other program does not have a Coordination of Benefits provision, that program most generally has the primary payment responsibility.

NOTE: When Coordination of Benefits applies for dependent children, provide your dentist with the birth dates of both parents.

Assignment of Benefits

Any benefits which may be payable under this dental benefit Plan are not assignable.

Time of Payment of Claim

Any benefits due under this Policy for any loss other than loss for which this Policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss.

Claim and Appeal Procedures

Proof of Loss
All claims should be submitted within 12 months of the date of service**.** If you do not submit a claim within the time required, it will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. You must submit your proof as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Initial Claim Determinations
An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive a written notice of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the end of the initial 30-day period. We will tell you the reasons we require an extension and the date by which we expect to make a decision. If the extension is needed for us to get additional information from you, the notice will describe the specific information we need. You will have 45 days from the receipt of the notice to provide us with the information. Without complete information, your claim will be denied.

Appeals
In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted to us within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, Client number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Delta Dental of Minnesota
Attn: Professional Services Appeals and Grievances
PO Box 30416
Lansing, MI 48909

You may submit written comments, documents, or other information that you feel supports your appeal. Upon request, you will also be given reasonable access to and copies of all relevant records that are used in making the decision. These records will be given to you at no charge. The review will take into account all information about the denied or reduced claim, even if the information was not present or available at the time of the initial determination. In this review, the initial determination of the claim will not be given any weight.

The review will be done by someone different from the original decision-makers and will not take into consideration any prior decisions made in your claim. Because all decisions are based on a preset schedule of dental services that are covered by your plan, claims are not reviewed to determine dental necessity or appropriateness. If we need to consult a professional to determine if a service is covered under your plan's

schedule of benefits, we will consult with a dental professional who has appropriate training and experience. This professional will not be the same person who was involved in the initial adverse benefit determination (nor a subordinate of any such person). We will identify any dental professional whose advice was obtained on our behalf, even if the advice was not used in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to your estate. Any other accrued indemnities unpaid at your death may, at your option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to you.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

GENERAL INFORMATION

Health Plan Issuer Involvement

The benefits under the Plan are not guaranteed by Delta Dental under the Contract. As Claims Administrator, Delta Dental pays or denies claims on behalf of the Plan and reviews requests for review of claims as described in the Claim and Appeals Procedures section.

Privacy Notice

Delta Dental of Minnesota will not disclose non-public personal financial or health information concerning persons covered under this dental benefit Program to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under this dental benefit Program.

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at the Plan's user friendly web site, www.deltadentalmn.org. The Plan highly recommends use of the web site for the most accurate network information. Go to http://www.deltadentalmn.org/find-a-dentist and enter your zip code, city or state to find local participating dentists. You can also search by dentist or clinic name. The Web site also allows you to print out a map directing you to the dental office you select. **The Find A Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.**

To search for and verify the status of participating providers, select "Find A Dentist" on the www.deltadentalmn.org home page. Select the Product or Network in the drop-down menu, and search by city and state, zip code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

If you do not have Internet access, other options are available to find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. **Be sure to specifically state that your employer is providing the Dental program.**

- Contact our Customer Service Center at: (800) 448-3815. Customer Service hours are 7 a.m. to 7 p.m., Monday through Friday, Central Standard Time.

Using Your Dental Program

Dentists who participate with Delta Dental under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta Dental cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is a participating dentist, the claim form will be available at the dentist's office.

If your dentist is nonparticipating, claim forms are available by calling:

Delta Dental of Minnesota - (651) 406-5901 or (800) 448-3815

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

* YOUR DELTA DENTAL CLIENT NUMBER
* YOUR EMPLOYER (CLIENT NAME)
* YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** identification number)
* YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

Cancellation and Renewal

The Program may be canceled by the Plan only on an anniversary date of the Client Dental Plan Contract, or at any time the Client fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Client have no right to continue coverage under the Program or convert to an individual dental coverage contract.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Plan Administration

The Plan Administrator, who is listed on the inside front cover of this brochure, is a named fiduciary under the Program and shall be responsible for the management and control of this Program.

The Plan Administrator is responsible for determining the level of benefits for the Program as described in this brochure. The Plan Administrator reserves the power at any and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the Plan, provided, however, that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the Plan.

Funding Policy and Payment

The funding policy and method requires that the Client Subscriber submit payments on a monthly basis.

Procedure to Request Information

If you have any questions about this Program, contact the Plan Administrator who is listed in the inside front cover of this brochure.

Statement of ERISA Rights

As a participant in the Program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine without charge at the Plan Administrator's office and at other specified locations such as work sites and union halls, all Plan documents, including insurance contracts, and copies of all documents such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor.
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. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fee, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DELTA DENTAL OF MINNESOTA

FOR CLAIMS
Delta Dental of Minnesota
P.O. Box 9120
Farmington Hills, MI 48333-9120
(651) 406-5901 or (800)448-3815

FOR ELIGIBILITY
Delta Dental of Minnesota
P.O. Box 9124
Farmington Hills, MI 48333-9124
(651) 406-5901 or (800) 448-3815

CORPORATE LOCATION
500 Washington Avenue South
Suite 2060
Minneapolis, MN 55415
(651) 406-5900 or (800) 328-1188
www.deltadentalmn.org

Updated and Approved 1/2021
Updated 12/2020
Approved 11/2020
Updated 10/2020
Updated 9/2020
Approved 1/2020
Updated 11/2019
Updated 7/2018
Approved 12/2017(PDF only)

Intact Services USA LLC

40% OFF
additional complete pair of prescription eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Find an eye doctor
(Access Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $70
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $55	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $180 allowance	Up to $100
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $80
Bifocal	$10 copay	Up to $110
Trifocal	$10 copay	Up to $150
Progressive - Standard	$75 copay	Up to $110
Progressive - Premium	$75 copay; 20% off retail price less $120 allowance	Up to $110
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium	20% off retail price	Not covered
Polycarbonate - Standard	$0 copay	Up to $5
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $100
Contacts - Disposable	$0 copay; 100% of balance over $130 allowance	Up to $100
Contacts - Medically Necessary	$0 copay; paid in full	Up to $200
OTHER		
Hearing Care from Amplifon network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
Lasik or PRK From U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every calendar year	Once every calendar year
Frame	Once every calendar year	Once every calendar year
Lenses	Once every calendar year	Once every calendar year
Contact Lenses	Once every calendar year	Once every calendar year

(Plan allows member to receive either contacts and frame, or frames and lens services)

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

[1] Based on weighted average of sample transactions; EyeMed Insight network/$10 exam copay/$10 materials copay/$120 frame or contact lens allowance.

Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 TARGET OPTICAL

PDF-2004-M-377

FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

POLICY NUMBER: VC-146

POLICYHOLDER: Intact Services USA LLC

POLICY EFFECTIVE DATE: January 1, 2015

POLICY ANNIVERSARY DATE: January 1 of the following year and each January 1 thereafter

Fidelity Security Life Insurance Company represents that the Insured Person is insured for the benefits described in the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name, group number, and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

GROUP VISION INSURANCE CERTIFICATE
THIS IS A LIMITED BENEFIT CERTIFICATE
Non-Qualified
Please read the Certificate carefully.

THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.

TABLE OF CONTENTS

DEFINITIONS

Allowance means the benefit amount shown in the Schedule of Benefits that is the maximum amount payable by the Company, subject to the expenses incurred. The Insured Person is responsible for any amounts due above the Allowance. The Allowance cannot be used to satisfy a Copayment.

Benefit Frequency means the period of time in which a benefit is payable as shown in the Schedule of Benefits.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Copayment or **Copay** means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials per Benefit Frequency.

Comprehensive Eye Examination means a general evaluation of the complete visual system. The examination includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, basic sensorimotor examination and Refraction. It always includes initiation of diagnostic and treatment programs. It may include biomicroscopy, examination with cycloplegia or mydriasis and tonometry, as determined by the Provider. These services may be performed at different sessions, but comprise only one Comprehensive Eye Examination.

Dependent means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse;
2. each child of the Insured or the Insured's spouse who is under 26 years of age;
3. each unmarried child at least 26 years of age who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of a developmental disability, mental illness or disorder, or physical disability.

Dependent includes a step-child, foster child, grandchild, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree.

Insured means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

Insured Person means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

In-Network Provider means a Provider who has signed a Preferred Provider Agreement with the PPO.

Medically Necessary Contact Lenses means that adequate functional vision correction cannot be achieved with spectacles but can be achieved with contact lenses. Conditions that qualify for Medically Necessary Contact Lenses are:

1. Anisometropia of 3D in meridian powers;
2. High Ametropia exceeding -12D or +12D in meridian powers;
3. Keratoconus when vision is not correctable to 20/25 in either eye or both eyes using standard spectacle lenses; or
4. vision impairments, other than Keratoconus, when vision can be improved by two lines on the visual acuity chart when compared to best corrected standard spectacle lenses.

Out-of-Network Provider means a Provider, located within the PPO Service Area, but is not an In-Network Provider.

Policy means the Vision Insurance Policy issued to the Policyholder.

Policyholder means the employer named as the Policyholder in the face page of the Policy.

PPO Service Area means the geographical area where the PPO is located.

Preferred Provider Agreement means the agreement between the PPO and a Provider who agrees to become an In-Network Provider. The Preferred Provider Agreement contains the rates and reimbursement methods for services and supplies furnished by an In-Network Provider.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area that have signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license. Provider also includes a dispensing optician.

Refraction means a test performed by a Provider to determine the glasses or contact lens prescription due to a refractive error (for example, nearsightedness, farsightedness, astigmatism or presbyopia).

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials means those materials provided for visual health and welfare shown in the Schedule of Benefits.

EFFECTIVE DATES

Effective Date of Insured's Insurance. The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible, provided;
   a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured becomes eligible; and
   b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

Effective Date of Dependents' Insurance. Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth. To continue coverage, the Insured must agree to pay any premium contribution that may be required.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of placement. To continue coverage, the Insured must agree to pay any premium contribution that may be required. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

In-Network Provider Benefits. The Insured Person must pay any Copayment or any cost above the Allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company on behalf of the Insured Person.

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Schedule of Benefits.

LIMITATIONS

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy.

Allowances provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
4. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
5. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
6. safety eyewear;
7. solutions, cleaning products or frame cases;
8. non-prescription sunglasses;
9. plano (non-prescription) lenses;
10. plano (non-prescription) contact lenses;
11. two pair of glasses in lieu of bifocals;
12. electronic vision devices;
13. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
14. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

For All Insureds. The Insureds' insurance will cease on the earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
   a. does so without individual selection between Insureds; and
   b. continues to pay any premium contribution for those individuals.

For Dependents. A Dependent's insurance will cease on the earlier of:

1. the date the Insured's coverage ends;
2. the date the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not request it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earlier of:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

Continuation Privilege For Certain Dependents. If coverage terminates as a result of an Insured's death, divorce or eligibility under Title XVIII of the Social Security Act (Medicare), the Dependent's coverage can continue. The coverage will end at the earliest of:

1. the date the Dependent becomes eligible for coverage under any other group plan providing similar benefits;
2. 36 months after continuation was elected if due to the Insured being covered under Title XVIII of the Social Security Act (Medicare);
3. the Dependent fails to make timely premium payments; or
4. the Policy terminates.

Notification Requirements. The Dependent must notify the Policyholder of the Insured's death or divorce. The Policyholder will provide written notice to the Dependent of the right to continue coverage and will send the election form and instructions for premium payments immediately. The Policyholder, upon request, will provide the Dependent with written verification from the Company the cost of this coverage at the time of eligibility. The premium charged will not exceed 102% of the group premium.

If termination is due to the surviving Dependent's failure to make the required premium payment, written notice of cancellation must be mailed to the last known address at least 30 days before the cancellation. Failure of the surviving Dependent to make

the premium payment within 90 days after notice of the requirement to pay the premiums will be the basis of termination of coverage without written consent.

PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company by the Policyholder on behalf of the Insured Person. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date. The initial premium rates are shown in the Policyholder's application.

Premium Changes. The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 31 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

Grace Period. The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. Coverage will terminate at the end of the grace period if all premiums due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

Unpaid Premium. When a claim is paid during the grace period, any premium due and unpaid for the Insured Person will be deducted from the claim payment.

CLAIMS

Notice of Claim. Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Payment of Claims. All claims will be paid to the Insured, unless assigned. Any benefits payable on or after the Insured's death will be paid to the Insured's beneficiary. If there is no designated beneficiary when the Insured dies, the Company will pay the benefits to the Insured's estate.

If any benefit is payable to an estate or to a minor or person not otherwise competent to give a valid release, the Company may pay such benefit, up to $1,000. Such payment will be made to the legal guardian of the minor or incompetent. Any payment made by the Company in good faith under this provision will fully discharge the Company to the extent of the payment.

The Insured may change the beneficiary at any time unless an irrevocable beneficiary is named or the insurance is assigned. The change date is the date the Insured signed the written request. If the Company pays the benefit before the Company receives the request, the Company is released from further liability under the Policy to the extent of the Company's payment.

Assignment. Benefits under the Policy may be assigned.

Right of Recovery. If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

GENERAL PROVISIONS

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement will be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. No misstatement, except fraudulent misstatements, can be used to void the Policy or deny a claim after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

SCHEDULE OF BENEFITS

Intact Services USA LLC

BENEFIT FREQUENCY		
Vision Examination	once every 12 months	Insured Person
Vision Materials		
Frame	once every 12 months	Insured Person
Lenses and Lens Options	once every 12 months	Insured Person
Contact Lenses	once every 12 months	Insured Person

BENEFIT	*In-Network Provider*	*Out-of-Network Provider* *(Reimbursement up to)*
Vision Examination		
Comprehensive Eye Examination	$10 Copayment	$70
Vision Materials		
Frame	$0 Copayment up to $180 Allowance	$100
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses and Lens Options.		
Conventional	$0 Copayment up to $130 Allowance	$100
Disposable	$0 Copayment up to $130 Allowance	$100
Medically Necessary	Paid in Full	$200
Standard Plastic Lenses		
Single Vision	$10 Copayment	$80
Bifocal	$10 Copayment	$110
Trifocal	$10 Copayment	$150
Progressive – Standard	$75 Copayment	$110
Progressive – Premium	$75 Copayment up to $120 Allowance	$110
Lens Options		
Polycarbonate Lenses – Standard Insured, Spouse, and Dependent Children age 19 and older	$0 Copayment	$5
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	$0 Copayment	$5

FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance organization coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations.

Minnesota Life & Health Insurance Guaranty Association
90 South Seventh Street, 3300 Wells Fargo Center
Minneapolis, MN 55402
(612) 322-8713

The maximum amount the guaranty association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under Section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY, CONTRACT, OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

NOTICE OF ADMINISTRATOR'S CAPACITY

PLEASE READ: This notice advises insured persons of the identity and relationship among the administrator, the policyholder and the insurer:

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for First American Administrators, Inc. to provide administrative services for your insurance plan. As administrator, First American Administrators, Inc., is authorized to process claim payments, and perform other services, according to the terms of its agreement with the insurance company. First American Administrators, Inc. is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. Fidelity Security Life Insurance Company is liable for the funds to pay your insurance claims.

As First American Administrators, Inc. is authorized to process claims for the insurance company, they will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against First American Administrators, Inc. than would otherwise be afforded to you by law.

YOUR GROUP TERM LIFE INSURANCE PLAN

For Employees of
Intact Services USA LLC

D1186 (03/20)

GROUP TERM LIFE INSURANCE CERTIFICATE

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

Claims: 888-238-4840 Customer Service: 800-955-7736 http://voya.com

POLICYHOLDER: Intact Services USA LLC

GROUP POLICY NUMBER: 64381-5GAT2

POLICY EFFECTIVE DATE: January 1, 2016

POLICY ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Minnesota

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. Subject to the provisions of this Certificate, we certify that eligible Employees are insured for the benefits described in this Certificate.

This Certificate summarizes and explains the parts of the Policy which apply to you, if you are an eligible Employee as defined. The Certificate is part of the group Policy but by itself is not a policy. This Certificate replaces any other Certificates we may have given you under the Policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. Your rights and benefits under the Policy will not be less than those stated in your Certificate.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address.

In this Certificate, "you" and "your" refer to an Employee who is eligible for coverage under the Policy; "we", "us" and "our" refer to ReliaStar Life Insurance Company.

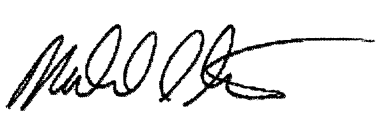
READ THIS CERTIFICATE CAREFULLY! Insurance benefits may be subject to certain requirements, reductions, limitations and exclusions.

GROUP TERM LIFE INSURANCE

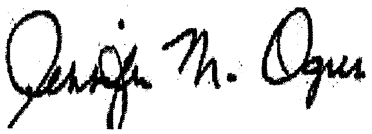
Term life insurance provides a benefit to a named beneficiary upon the death of a person insured under a policy, with benefits payable only if a loss occurs within its term. Group insurance covers a group of persons under a single policy issued to a group policyholder.

Premiums for Basic Life Insurance are Noncontributory by insured Employees. Premiums for Supplemental Life Insurance are Contributory by insured Employees.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.



Michael S. Smith
President



Jennifer M. Ogren
Secretary

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Policyholder's Contact Information:
Intact Services USA LLC, 605 North Highway 169, Suite 800, Plymouth, Minnesota 55441

Minnesota Insurance Department Phone Number: (651) 539-1500

California residents:
If you are age 65 or older on the effective date of any Contributory coverage under the Policy, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full Premium contribution refunded, by returning the Certificate to the Policyholder for cancellation without claim.

Florida Residents:
The benefits of the Policy providing your coverage are governed primarily by the law of a state other than Florida.

SCHEDULE OF BENEFITS

EMPLOYER(S): Intact Services USA LLC

GROUP POLICY NUMBER: 64381-5GAT2

ELIGIBLE CLASS(ES)

All Eligible Employees in Active Employment with the Employer in the United States.
You must be an Employee of the Employer and in an eligible class.
Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT FOR ALL ELIGIBLE EMPLOYEES

All Eligible Employees 20 hours per week.

ELIGIBILITY WAITING PERIOD FOR ALL ELIGIBLE EMPLOYEES

Persons in an eligible class on or before the Policy effective date: None.

Persons entering an eligible class after the Policy effective date: None.

BASIC LIFE INSURANCE

Basic Life Insurance is Noncontributory by Employees.

Eligible Class(es)	Amount
All Eligible Employees	1 times your Basic Yearly Earnings

An insurance amount that does not equal an increment of $1,000 is rounded to the next higher $1,000.

MAXIMUM AMOUNT OF BASIC LIFE INSURANCE FOR ALL ELIGIBLE EMPLOYEES

$500,000

GUARANTEED ISSUE AMOUNT OF BASIC LIFE INSURANCE FOR ALL ELIGIBLE EMPLOYEES

$500,000

SUPPLEMENTAL LIFE INSURANCE

Supplemental Life Insurance is Contributory by Employees.

Eligible Class(es)	Amount
All Eligible Employees	Election of 1, 2, 3, 4, 5 or 6 times your Basic Yearly Earnings, with a minimum amount of $10,000

An insurance amount that does not equal an increment of $1,000 is rounded to the next higher $1,000.

MAXIMUM AMOUNT OF SUPPLEMENTAL LIFE INSURANCE FOR ALL ELIGIBLE EMPLOYEES

$1,700,000

GUARANTEED ISSUE AMOUNT OFSUPPLEMENTAL LIFE INSURANCE FOR ALL ELIGIBLE EMPLOYEES

$500,000

BENEFIT REDUCTIONS FOR ALL ELIGIBLE EMPLOYEES

Supplemental Life Insurance

Your insurance amount will decrease as follows:

- To 65% of the original amount on the Policy anniversary that is on or next follows your 65th birthday.
- To 50% of the original amount on the Policy anniversary that is on or next follows your 70th birthday.

Reduced insurance amounts are not rounded.

DEFINITIONS

Active Employment or **Active Employee** means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:
- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.
Temporary and seasonal workers are excluded from coverage.

Basic Yearly Earnings means the yearly salary or wage you receive for work done for the Employer as of the later of the Policy effective date, or the immediately preceding Policy anniversary date, or your hire date. It does not include bonuses, commissions or overtime pay.

Beneficiary means the person(s) or entity to whom we will pay the life insurance benefits in accordance with the BENEFICIARY and PAYMENT OF PROCEEDS provisions.

Certificate means this document that describes the benefits and rights of insured Employees under the Policy. It may include riders, endorsements or amendments.

Contributory means insurance for which insured Employees are required to pay any part of the Premium.

Eligibility Waiting Period means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Employee means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Evidence of Insurability means your affirmation, on a form acceptable to us, of various factors that we will use to determine if you are approved for coverage. Those factors may include, but are not limited to, your medical history and treatment, driving record, and/or family medical history. We may also, at our expense, request additional information to determine your eligibility for coverage.

Guaranteed Issue Amount means the benefit amount (as shown on the SCHEDULE OF BENEFITS) for which you are eligible to enroll without providing Evidence of Insurability, according to the EVIDENCE OF INSURABILITY provision.

Noncontributory means insurance for which insured Employees are not required to pay any part of the Premium.

Policy means the Written group insurance contract between us and the Policyholder, including the Certificates issued to insured Employees. It may include riders, endorsements or amendments.

Policyholder means the entity to whom the Policy is issued, as shown on the first page of this Certificate.

Premium(s) means the amount the Policyholder and/or you must pay to us for the insurance provided under the Policy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform any other job for which you are fit by education, training or experience.

Written or **Writing** means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

GENERAL PROVISIONS

ELIGIBILITY

If you are an Employee in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The day after you complete your Eligibility Waiting Period.

ENROLLMENT

If you are eligible for Contributory coverage, you must enroll for any Contributory coverage before it will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment. You may need to provide Evidence of Insurability, as described below.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and you were covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory coverage that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

EVIDENCE OF INSURABILITY

Evidence of Insurability is required for coverage under the conditions described below. Coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of coverage. Any increase to coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of the increase. We must approve any required Evidence of Insurability before coverage becomes effective.

Basic Life Insurance	Evidence Required
Coverage on the Policy effective date continued from the Policyholder's prior plan...	None.
Initial eligibility after the Policy effective date...	Any amount over the Guaranteed Issue Amount.
Increases due to salary, job or class changes...	Any amount of total coverage that exceeds the Guaranteed Issue Amount.

Supplemental Life Insurance	Evidence Required
Coverage on the Policy effective date continued from the Policyholder's prior plan...	None.
Enrollment for supplemental coverage on the Policy effective date, for Employees who had no supplemental coverage under the Policyholder's prior plan...	All amounts.
Initial eligibility for supplemental coverage after the Policy effective date...	Any amount over the Guaranteed Issue Amount.

Initial eligibility for supplemental coverage on or after the Policy effective date...	Any amount over the Guaranteed Issue Amount.
Increases due to salary, job or class changes...	Any amount of total coverage that exceeds the Guaranteed Issue Amount.
All other enrollments for new supplemental coverage more than 31 days after the date you become eligible for supplemental coverage...	All amounts.
All other enrollments for an increase to existing supplemental coverage...	All increased amounts.
Enrollment at a scheduled enrollment period for an increase to existing supplemental coverage, when total coverage does not exceed the Guaranteed Issue Amount...	All increased amounts that exceed the lesser of $50,000 or one plan increment.

EFFECTIVE DATE OF COVERAGE

For Noncontributory coverage, you will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for coverage.

For Contributory coverage, you will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you enroll for coverage on or before that date.
- The date you enroll for coverage.
- The date we approve your Evidence of Insurability, if Evidence of Insurability is required.
- The date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The Policy anniversary that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The January 1st that is on or next follows the date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.
- The January 1st that is on or next follows the date we approve your Evidence of Insurability, if Evidence of Insurability is required.

Any decrease in coverage other than benefit reductions noted on the SCHEDULE OF BENEFITS will take effect on the next Policy anniversary but will not affect a payable claim that occurs prior to the decrease.

CHANGE OF INSURANCE CARRIERS

We will provide continuity of coverage under our Policy if both of the following are true:

- You are not in Active Employment due to sickness or injury other than Total Disability or due to an Employer-approved non-medical leave of absence on the date the Employer changes insurance carriers to our Policy.
- You were covered under the prior group life policy, including payment of premiums to the prior insurance carrier when due, on the day before the coverage for your eligible class under our Policy became effective.

You are not eligible under this provision if any of the following are true:

- Your coverage is being continued under a waiver of premium (or any similar) provision of the prior policy.
- Your coverage is being continued under a continuation or portability provision of the prior policy.
- You converted or were eligible to convert your coverage with the prior insurance carrier.
- You are not in Active Employment due to reasons other than sickness, injury or an Employer-approved non-medical leave of absence.

If you are eligible for continuity of coverage under this provision, we will provide limited coverage under our Policy. Coverage under this provision will begin on the date your eligible class is covered under our Policy and will continue until the earliest of the following:

- The date you return to Active Employment.
- The date the Employer-approved leave of absence ends.
- The date your continuation would end under the terms of our Policy.
- The date your continuation would have ended under the terms of the prior policy.
- The date coverage would otherwise end, according to the provisions of our Policy.
- 12 months following the date you were last in Active Employment.

Your coverage under this provision is subject to payment of Premiums.

Any benefits payable under this provision will be the lesser of the amount of coverage under the prior policy had it remained in force, or the amount you are eligible for under our Policy. We will reduce our payment by any amount paid under the prior policy.

If your coverage under this provision ends while the Policy is in force, and you are not otherwise eligible for insurance under the Policy, then you will be eligible for conversion as described in the CONVERSION provision.

If you were not covered under the Employer's prior policy on the date that policy terminated, then the EFFECTIVE DATE OF COVERAGE provision will apply.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates.
- The date coverage for all Active Employees under the Policy terminates.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your Contributory coverage, as allowed by the Employer.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the Policy grace period.
- The last day you are in Active Employment.

We will pay benefits for a loss that occurs while you are covered under the Policy.

CONVERSION

You may convert your life insurance, without Evidence of Insurability, to an individual life insurance policy if any part of your life insurance under the Policy stops for one of the following reasons:

- Your coverage ends according to the TERMINATION OF COVERAGE provision other than your voluntary cancellation of your Contributory coverage.
- Any continuation of insurance under the Policy ends.
- Your coverage reduces due to BENEFIT REDUCTIONS as described on the SCHEDULE OF BENEFITS.
- Your coverage reduces due to a Policy change.

Only life insurance is eligible for conversion. The maximum amount of life insurance you are eligible to convert cannot be greater than the amount of life insurance you had prior to termination. Conversion does not include any additional benefits such as accelerated death benefits, accidental death and dismemberment benefits, or waiver of premium benefits. Any amounts of coverage for which you remain eligible under the Policy are not eligible for conversion.

To convert your life insurance, you must apply and pay the first premium to us within 31 days of the date any part of your life insurance under the Policy terminates (the "conversion period"). You will be given Written notice, in person or at your last known address, of your conversion right at least 15 days before the date any part of your life insurance ends. Your right to convert will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your right to convert extend beyond 60 days after the expiration of the conversion period. Any extension of time allowed for returning the completed application and first premium will not change the length of the conversion period itself.

You may apply to convert the entire amount of life insurance that is terminating under the Policy, or a lesser amount. The maximum amount of life insurance coverage you are eligible to convert will be reduced by any amount of life insurance for which you become eligible under any group policy within 31 days after the beginning of the conversion period. Premiums for the conversion policy will be based on our rates then in use, the form and amount of insurance, your class of risk, and your attained age at the beginning of the conversion period. The conversion policy may be any individual life insurance policy then customarily offered by us for conversion, other than term insurance. The conversion policy will not include any additional benefits. When we accept your application and first premium, the conversion policy will become effective on the 32nd day after the date the life insurance under the Policy terminated.

During the conversion period, your life insurance will continue under the terms of the Policy. If you die within the conversion period, any life insurance amount that you were entitled to convert will be payable as a death benefit under the Policy and any premiums paid for conversion will be refunded to the Beneficiary.

If you have made an absolute assignment of your insurance, only the current owner may apply for conversion.

INCONTESTABILITY

Any statement made by you is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written statement of insurability which has been Signed by you and a copy of such statement of insurability has been given to you or to the Beneficiary. Except for fraud, we will not use such statement relating to insurability to contest life insurance after it has been in force for two years during your lifetime. Except for fraud, we will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during your lifetime. Fraud in the procurement of coverage under the Policy is only contestable after the coverage has been in force for two years from its effective date when permitted by applicable law in the governing jurisdiction.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

CLERICAL ERROR

Clerical error or omission by us or by the Policyholder will not:

- Prevent you from receiving coverage, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the Premium.

An error will not end insurance validly in effect, nor will it continue insurance validly ended.

MISSTATEMENT OF AGE

If Premiums are based on your age and you have misstated your age, then your correct age will be used to determine if insurance is in effect and, as appropriate, the Premium and/or benefits will be adjusted. We may require satisfactory proof of your age before paying any claim.

MISSTATEMENT OF TOBACCO USE STATUS

If Premiums are based on your tobacco use status and you have misstated your tobacco use status, then we will adjust the Premium according to the correct tobacco use status. The amount payable upon your death will be the amount that the Premium would have purchased using the correct tobacco use status. During the first two years your coverage under the Policy is effective, we will make this adjustment instead of contesting your insurance for this misstatement.

ASSIGNMENT

You may make an absolute assignment of ownership of your insurance under the Policy to any person or entity by sending us Written notice on a form that we accept. An absolute assignment transfers all your duties, rights, title and interest under the Policy to the new owner. The new owner can make any changes allowed under the Policy and Certificate.

An absolute assignment form is available from the Employer or us. Any assignment form must be Signed by both the current owner and the new owner. The Signed form must be received and accepted by us in order to be valid. An accepted assignment will take effect on the date the form is Signed by you, unless otherwise specified in the Signed form. An assignment does not affect any payment we make or action we take before receiving the Signed form. An assignment does not change the insurance or the Beneficiary designation.

If you want to continue an absolute assignment made under the Employer's prior group life insurance policy, a statement of intent form is available from the Employer or us. The form must be Signed by both you and the assignee. The Signed form must be received and accepted by us in order to be valid. A statement of intent does not affect any payment we make or action we take before receiving the Signed form. A statement of intent does not change the insurance or the Beneficiary designation.

We assume no responsibility for the validity of any assignment. You are responsible to see that the assignment is legal in your state and that it accomplishes the goals that you intend.

BENEFICIARY

The Beneficiary is named by you to receive any proceeds payable at your death. While your coverage is in force, you may change the Beneficiary designation by Written request on a form that is acceptable to us. A Beneficiary designation form is available from the Employer or us. An accepted designation will take effect as of the date it is Signed, unless you specify otherwise in the Signed designation, but will not affect any payment we make or action we take before receiving the Signed form. If you have made an absolute assignment of your insurance, only the current owner may change the Beneficiary designation.

If an irrevocable Beneficiary is named, the Beneficiary designation can only be changed with the consent of the irrevocable Beneficiary.

There can be one or more Beneficiaries. If two or more Beneficiaries are named and their shares are not specified in the Beneficiary designation, then the Beneficiaries will share any insurance proceeds equally. If a primary Beneficiary does not survive you, their share will be payable to the remaining primary Beneficiaries. One or more contingent Beneficiaries may be named to receive the proceeds in the event that all of the primary Beneficiaries named do not survive you.

Please refer to the LIFE INSURANCE BENEFITS section of the Certificate for information about payment.

AGENCY

For purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This Certificate was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this Certificate which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

ENTIRE CONTRACT

Coverage for insured Employees is provided under a contract of group term insurance between us and the Policyholder. The entire contract consists of all of the following:

- The Policy issued to the Policyholder including Part A and Part B.
- The Certificates which are made part of Part B under the Policy.
- Any riders, endorsements and/or amendments issued.
- The Policyholder's Signed application, a copy of which is attached to the Policy when issued.

CHANGES TO POLICY OR CERTIFICATE

The terms and provisions of the Policy and this Certificate may be changed at any time without the consent of you or anyone else with a beneficial interest in the Policy. We will issue riders, endorsements or amendments to effect such changes, and only those forms Signed by one of our executive officers will be valid. We will only make changes consistent with the standards of the Interstate Insurance Product Regulation Commission or the applicable regulatory body in the governing jurisdiction. We will provide a copy of the rider, endorsement or amendment to the Policyholder for attachment to the Policy, and also for the Employees if the change affects the Certificate(s).

Riders, endorsements and amendments are subject to prior approval by the Interstate Insurance Product Regulation Commission or the appropriate regulatory body in the governing jurisdiction. A rider, endorsement or amendment will not affect the insurance provided under the Certificate(s) until the effective date of the change, unless retroactivity is required by the applicable regulatory body.

No agent, representative or employee of ours or of any other entity, except one of our executive officers, may approve a change to or waive the terms of the Policy.

LIFE INSURANCE BENEFITS

We pay a death benefit to the Beneficiary if we receive Written proof that you died while your insurance under the Policy is in force. The death benefit is the amount of life insurance for your class as shown on the SCHEDULE OF BENEFITS in effect on the date of your death minus any amount paid under the Accelerated Death Benefit Rider.

NOTICE OF CLAIM AND PROOF OF LOSS

A claim form is available from the Employer or us. The process for completing the claim form and submitting the claim form will be explained in the claim form paperwork. Proof of loss, including any attachments indicated on the claim form as required, should be sent directly to us at the address indicated on the form. We may also require information from the Employer in order to verify eligibility.

Proof of loss consists of a certified copy of your death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

We will review the claim and proof of loss we receive in order to determine our liability and the correct payee(s). If we approve the claim, we will pay the benefits subject to the terms of this Certificate.

AUTOPSY

We reserve the right to make a reasonable request for an autopsy at our expense where permitted by law.

PAYMENT OF PROCEEDS

To be eligible to receive proceeds, the Beneficiary must be living on the date of your death.

If there is no eligible Beneficiary, we will pay the proceeds to the first survivor(s), who is living on the date of your death, in the following order:

1. Your spouse.
2. Your natural and adopted children.
3. Your parents.
4. Your estate

If the Beneficiary or survivor is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to that person's estate.

"Spouse" means your lawful spouse. It includes your domestic partner or civil union partner who is recognized as equivalent to a spouse in the state with governing jurisdiction. It also includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

PAYMENT OF INTEREST

We pay interest on the death benefit proceeds, accruing from the date of your death up to the date of payment. The minimum interest rate payable will be the interest rate applicable for funds left on deposit with us as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest rate applicable for funds left on deposit beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

- The date we receive due proof of loss following death.
- The date we receive sufficient information to determine our liability, the extent of our liability, and the appropriate payee legally entitled to the proceeds.
- The date that legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of this resolution is provided to us. Legal impediments to payment include but are not limited to: the establishment of guardianships and conservatorships; the appointment and qualification of

trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

LEGAL ACTION

The time period during which any person can start legal action regarding any claim under the Policy is subject to applicable law in the governing jurisdiction. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If we deny a claim in whole or in part (an "adverse benefit determination"), we will provide Written notice of the adverse benefit determination to the claimant as soon as possible, but no more than 90 days after receipt of the claim unless an extension is needed. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension before the end of the initial 90-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to the claimant's failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

A notice of an adverse benefit determination will be Written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
- A description of the claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review.

The claimant may request a review of an adverse benefit determination (an "appeal") at any time during the 60 day period following receipt of the notice of the determination. We will consider an appeal upon Written application of the claimant or his or her duly authorized representative. As part of the appeal the claimant also has the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits. The claimant may, in the course of this appeal, review relevant documents and submit to us Written comments, documents, records and other information relevant to the claimant's claim for benefits.

Following our review of the appeal, we will provide the claimant with a Written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 60 days after the receipt of the appeal unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice of any such extension before the end of the 60-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to the claimant's failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be Written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits.
- A statement of the claimant's right to bring a civil action.

EXCLUSIONS AND LIMITATIONS

For Noncontributory Life Insurance, we pay a death benefit for all causes of death.

For Contributory Life Insurance, if you commit suicide while sane or insane within two years of the date your insurance starts, we will refund to the Beneficiary any Premiums paid instead of paying a death benefit. The two year period includes the period you were continuously covered under the Policy and any previous group term life policy(ies) issued to the Policyholder during your lifetime.

If you commit suicide while sane or insane within two years from the date an increase in Contributory Life Insurance (other than a scheduled or automatic increase) became effective, we will pay a death benefit for the amount of insurance that was effective before the increase. We will refund to the Beneficiary any Premiums paid for the increased amount of insurance.

SPOUSE LIFE INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Intact Services USA LLC

GROUP POLICY NUMBER: 64381-5GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

SUPPLEMENTAL SPOUSE LIFE INSURANCE

Supplemental Spouse Life Insurance is Contributory by Employees.

Eligible Class(es)	Amount
Spouse	Family Option 1: $25,000 Family Option 2: $50,000 Family Option 3: $100,000

MAXIMUM AMOUNT OF SUPPLEMENTAL SPOUSE LIFE INSURANCE

$100,000

GUARANTEED ISSUE AMOUNT OF SUPPLEMENTAL SPOUSE LIFE INSURANCE

$25,000

DEFINITIONS

Evidence of Insurability means your Spouse's affirmation, on a form acceptable to us, of various factors that we will use to determine if your Spouse's coverage is approved. Those factors may include, but are not limited to, your Spouse's medical history and treatment, driving record, and/or family medical history. If we need more information, any costs will be at our expense.

Guaranteed Issue Amount means the Spouse benefit amount (as shown on the SCHEDULE OF BENEFITS) for which you are eligible to enroll without providing Evidence of Insurability, according to the EVIDENCE OF INSURABILITY provision.

Spouse means your lawful spouse. The person must also meet all of the following:

- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee.

The term includes your domestic partner or civil union partner who is recognized as equivalent to a Spouse in the state with governing jurisdiction. It also includes your domestic partner as defined by the Employer if you have completed

and Signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership or civil union. Any reference to divorce includes termination of a domestic partnership or civil union.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Spouse is eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your Supplemental life insurance coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

ENROLLMENT

If you have a Spouse eligible for coverage, you must enroll your Spouse for any Contributory coverage before the coverage will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and your Spouse was covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory coverage for your Spouse that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

You may need to provide Evidence of Insurability on your Spouse, as described below.

EVIDENCE OF INSURABILITY

Evidence of Insurability is required for coverage under the conditions described below. Coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of coverage. Any increase to coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of the increase. We must approve any required Evidence of Insurability before coverage becomes effective.

Supplemental Spouse Life Insurance	Evidence Required
Coverage on the Policy effective date continued from the Policyholder's prior plan...	None.
Enrollment for supplemental Spouse coverage on the date this rider is available to the eligible class of Employees to which you belong, for Employees who had no supplemental Spouse coverage under the Policyholder's prior plan...	All amounts.
Initial eligibility for supplemental Spouse coverage after the date this rider is available to the eligible class of Employees to which you belong...	Any amount over the Guaranteed Issue Amount.
All other enrollments for new supplemental Spouse coverage more than 31 days after the date you become eligible for supplemental Spouse coverage...	All amounts.
All other enrollments for an increase to existing supplemental Spouse coverage...	All increased amounts.

EFFECTIVE DATE OF COVERAGE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you enroll for Spouse coverage on or before that date.
- The date you enroll for Spouse coverage.
- The date we approve your Spouse's Evidence of Insurability, if Evidence of Insurability is required.
- The date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.
- The date your Spouse is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date your Spouse's coverage would otherwise become effective.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Spouse's coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The Policy anniversary that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The January 1st that is on or next follows the date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.
- The January 1st that is on or next follows the date we approve your Spouse's Evidence of Insurability, if Evidence of Insurability is required.
- The January 1st that is on or next follows the date your Spouse is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date the increased or additional coverage would otherwise start.

Any decrease in coverage will take effect on the next Policy anniversary but will not affect a payable claim that occurs prior to the decrease.

CHANGE OF INSURANCE CARRIERS

If your coverage is being provided under the CHANGE OF INSURANCE CARRIERS provision in the Certificate, then we will also provide continuity of Spouse coverage under the same conditions and for the same duration.

Any benefits payable under this provision will be the lesser of the amount of coverage under the prior policy had it remained in force, or the amount of eligible Spouse coverage under our Policy. We will reduce our payment by any amount paid under the prior policy.

If Spouse coverage under this provision ends while the Policy is in force, and your Spouse is not otherwise eligible for insurance under the Policy, then your Spouse coverage will be eligible for conversion as described in the CONVERSION provision.

If your Spouse was not covered under the Employer's prior policy on the date that policy terminated, then the EFFECTIVE DATE OF COVERAGE provision will apply.

SPOUSE ACTIVE MILITARY DUTY

If your Spouse is covered under this rider and your Spouse begins full-time active duty in the armed forces of any country or subdivision thereof then you should notify the Policyholder to cancel this rider. Coverage under this rider will terminate at the beginning of the period during which your Spouse is no longer eligible, and any unearned Premiums that were collected will be refunded.

If your Spouse's full-time active military duty ends, then you may re-enroll for this rider subject to the following:

- If you re-enroll for this rider within 2 months of the date your Spouse is eligible for coverage again, then the maximum amount of Spouse coverage available will be the lesser of the amount that was in effect on the day before coverage ended and the then current maximum amount of Spouse coverage available under this rider. Spouse coverage will be effective on the later of the following:
  - The date you re-enroll.
  - The date your Spouse is not hospitalized or confined at home under a doctor's care.
  - The date your Spouse is not receiving or applying to receive disability benefits from any source.

- If you re-enroll for this rider more than 2 months after your Spouse is eligible for coverage again, then Evidence of Insurability on your Spouse will be required. If Evidence of Insurability is approved by us, Spouse coverage will become effective on the date specified by us.

SPOUSE CHANGE OF LEGAL RESIDENCE

If your Spouse is covered under this rider and your Spouse changes their legal residence to outside the United States or its territories or possessions, then you should notify the Policyholder to cancel this rider. Coverage under this rider will terminate at the beginning of the period during which your Spouse is no longer eligible, and any unearned Premiums that were collected will be refunded.

If your Spouse resumes legal residence in the United States or its territories or possessions, then you may re-enroll for this rider subject to the following:

- If you re-enroll for this rider within 2 months of the date your Spouse is eligible for coverage again, then the maximum amount of Spouse coverage available will be the lesser of the amount that was in effect on the day before coverage ended and the then current maximum amount of Spouse coverage available under this rider. Spouse coverage will be effective on the later of the following:
  - The date you re-enroll.
  - The date your Spouse is not hospitalized or confined at home under a doctor's care.
  - The date your Spouse is not receiving or applying to receive disability benefits from any source.
- If you re-enroll for this rider more than 2 months after your Spouse is eligible for coverage again, then Evidence of Insurability on your Spouse will be required. If Evidence of Insurability is approved by us, Spouse coverage will become effective on the date specified by us.

TERMINATION OF COVERAGE

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The date you voluntarily cancel this rider, as allowed by the Employer.
- The date your Spouse is no longer an eligible Spouse as defined by this rider.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the Policy grace period.

We will pay benefits for a loss that occurs while your Spouse is covered under this rider.

CONVERSION

You may convert Spouse life insurance, without Evidence of Insurability, to an individual life insurance policy if Spouse life insurance under this rider stops for any reason other than nonpayment of Premium, your Spouse ceasing to be an eligible Spouse as defined, or your death. You may also convert any part of Spouse life insurance that reduces due to a Policy change. If you have made an absolute assignment of insurance, only the current owner may apply for conversion under this paragraph.

Your Spouse may convert Spouse life insurance, without Evidence of Insurability, to an individual life insurance policy if Spouse life insurance under this rider stops because your Spouse is no longer an eligible Spouse as defined, or because of your death.

Only life insurance is eligible for conversion. The maximum amount of life insurance eligible for conversion cannot be greater than the amount of Spouse life insurance you had prior to termination. Conversion does not include any additional benefits such as accelerated death benefits, accidental death and dismemberment benefits, or waiver of premium benefits. Any amounts of coverage for which your Spouse remains eligible under the Policy are not eligible for conversion.

To convert Spouse life insurance, application must be made and the first premium paid to us within 31 days of the date any part of Spouse life insurance under this rider terminates (the "conversion period"). You will be given Written notice, in person or at your last known address, of your conversion right at least 15 days before the date any part of Spouse life insurance ends. Your right to convert will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your right to convert extend beyond 60 days after the expiration of the conversion period. Any extension of time allowed for returning the completed application and first premium will not change the length of the conversion period itself.

Application for conversion may be for the entire amount of Spouse life insurance that is terminating under this rider, or a lesser amount. The maximum amount of Spouse life insurance coverage eligible for conversion will be reduced by any amount of Spouse life insurance for which you become eligible under any group policy within 31 days after the beginning of the conversion period. premiums for the conversion policy will be based on our rates then in use, the form and amount of insurance, your Spouse's class of risk, and your Spouse's attained age at the beginning of the conversion period. The conversion policy may be any individual life insurance policy then customarily offered by us for conversion, other than term insurance. The conversion policy will not include any additional benefits. When we accept the application and first premium, the conversion policy will become effective on the 32nd day after the date the life insurance under the Policy terminated.

During the conversion period, Spouse life insurance will continue under the terms of this rider. If your Spouse dies within the conversion period, any life insurance amount that was eligible for conversion will be payable as a death benefit under the Policy and any premiums paid for conversion will be refunded to the Beneficiary.

INCONTESTABILITY

Any statement made by you or your Spouse is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written statement of insurability which has been Signed by you or your Spouse and a copy of such statement of insurability has been given to you or to the Beneficiary. Except for fraud, we will not use such statement relating to insurability to contest life insurance after it has been in force for two years during your Spouse's lifetime. Except for fraud, we will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during your Spouse's lifetime. Fraud in the procurement of coverage under the Policy is only contestable after the coverage has been in force for two years from its effective date when permitted by applicable law in the governing jurisdiction.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

MISSTATEMENT OF AGE

If Premiums are based on your Spouse's age and you have misstated your Spouse's age, then your Spouse's correct age will be used to determine if insurance is in effect and, as appropriate, the Premium and/or benefits will be adjusted. We may require satisfactory proof of your Spouse's age before paying any claim.

MISSTATEMENT OF TOBACCO USE STATUS

If Premiums are based on your Spouse's tobacco use status and you have misstated your Spouse's tobacco use status, then we will adjust the Premium according to the correct tobacco use status. The amount payable upon your Spouse's death will be the amount that the Premium would have purchased using the correct tobacco use status. During the first two years your Spouse's coverage under the Policy is effective, we will make this adjustment instead of contesting your Spouse's insurance for this misstatement.

BENEFICIARY

You are the Beneficiary for proceeds that become payable at your Spouse's death under this rider. If you have made an absolute assignment of your insurance, then during your lifetime the current owner is the Beneficiary. See the Portability Rider for information about the eligible Beneficiary for continued coverage after your death or divorce. This Beneficiary designation may not be changed. If the Beneficiary is not living on the date payment if made, benefits are payable to the Beneficiary's estate. Please refer to the LIFE INSURANCE BENEFITS section for more information about payment.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

LIFE INSURANCE BENEFITS

We pay a death benefit to the Beneficiary if we receive Written proof that your Spouse died while Spouse insurance under this rider is in force. See the CONVERSION provision for information about death benefits payable during the conversion period following your death. The death benefit is the amount of Spouse life insurance for the eligible class as shown on the SCHEDULE OF BENEFITS in effect on the date of your Spouse's death minus any amount paid under the Accelerated Death Benefit Rider.

NOTICE OF CLAIM AND PROOF OF LOSS

A claim form is available from the Employer or us. The process for completing the claim form and submitting the claim form will be explained in the claim form paperwork. Proof of loss, including any attachments indicated on the claim form as required, should be sent directly to us at the address indicated on the form. We may also require information from the Employer in order to verify eligibility.

Proof of loss consists of a certified copy of your Spouse's death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

We will review proof of loss we receive in order to determine our liability and the correct payee(s). If we approve the claim, we will pay the benefits subject to the terms of this rider.

PAYMENT OF PROCEEDS

To be eligible to receive proceeds, the Beneficiary must be living on the date of your Spouse's death. Exception: If your Spouse dies during the conversion period following your death and you would otherwise have been the Beneficiary, we will pay the proceeds to your estate.

If the Beneficiary is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to the Beneficiary's estate.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

PAYMENT OF INTEREST

We pay interest on the death benefit proceeds, accruing from the date of your Spouse's death up to the date of payment. The minimum interest rate payable will be the interest rate applicable for funds left on deposit with us as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest rate applicable for funds left on deposit beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

- The date we receive due proof of loss following death.
- The date we receive sufficient information to determine our liability, the extent of our liability, and the appropriate payee legally entitled to the proceeds.
- The date that legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of this resolution is provided to us. Legal impediments to payment include but are not limited to: the establishment of guardianships and conservatorships; the appointment and qualification of trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

EXCLUSIONS AND LIMITATIONS

If your Spouse commits suicide while sane or insane within two years of the date Spouse insurance starts, we will refund to the Beneficiary any Premiums paid instead of paying a death benefit. The two year period includes the period your Spouse was continuously covered under this rider and any previous group term life policy issued to the Policyholder during your Spouse's lifetime.

If your Spouse commits suicide while sane or insane within two years from the date an increase in Supplemental Spouse Life Insurance (other than a scheduled or automatic increase) became effective, we will pay a death benefit for the amount of insurance that was effective before the increase. We will refund to the Beneficiary any Premiums paid for the increased amount of insurance.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Michael S. Smith
President

Jennifer M. Ogren
Secretary

CHILDREN'S LIFE INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Intact Services USA LLC

GROUP POLICY NUMBER: 64381-5GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

SUPPLEMENTAL CHILDREN'S LIFE INSURANCE

Supplemental Children's Life Insurance is Contributory by Employees.

Eligible Class(es)	Amount
Children -from birth but less than 14 days old	10% of one of the options chosen below
-from 14 days but less than 26 years of age	Family Option 1: $5,000 Family Option 2: $10,000 Family Option 3: $15,000

After the 20th week, the unintended end of a pregnancy is called a stillbirth if the infant is dead at birth. The amount for a stillborn Child is 10% of the amount shown above.

MAXIMUM AMOUNT OF SUPPLEMENTAL CHILDREN'S LIFE INSURANCE

$15,000

DEFINITIONS

Child or **Children** means a child from birth but less than 26 years of age who is one of the following:

- Your natural or adopted child (including a child placed for adoption).
- Your stepchild.
- A child of your domestic partner or civil union partner who is recognized as equivalent to a Spouse in the state with governing jurisdiction.
- A child of your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer.
- Your foster child or a child or grandchild for whom you are a legal guardian.

- Your grandchild if the child's parent is insured as your Child under this rider.

The child must also meet all of the following conditions:
- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.
- Not be insured by an individual policy that was issued under any conversion right of this rider.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing.

Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit. If the Child becomes capable of self-sustaining employment and proof of the Child's incapacity can no longer be furnished to us, you may convert your Child's life insurance to an individual life insurance policy as described in the CONVERSION provision of this rider.

Evidence of Insurability means your affirmation, on a form acceptable to us, of various factors that we will use to determine if your Child's coverage is approved. Those factors may include, but are not limited to, your Child's medical history and treatment, driving record, and/or family medical history. If we need more information, any costs will be at our expense.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If your Child is covered under the Policy as an Employee, then your Child is not eligible for coverage under this rider.

ENROLLMENT
If you have a Child eligible for coverage, you must enroll all Children for any Contributory coverage before the coverage will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and your Children were covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory coverage for your Children that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

EFFECTIVE DATE OF COVERAGE
Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:
- The date your Children are eligible for coverage, if you enroll for Children's coverage on or before that date.
- The date you enroll for Children's coverage.
- The date we approve each Child's Evidence of Insurability, if Evidence of Insurability is required.
- The date you return to Active Employment, if you are not in Active Employment when your Children's coverage would otherwise become effective. **Exception**: Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

- The date your Child is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date that Child's coverage would otherwise become effective.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Children's coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The Policy anniversary that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The January 1st that is on or next follows the date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.
- The January 1st that is on or next follows the date we approve each Child's Evidence of Insurability, if Evidence of Insurability is required.
- The January 1st that is on or next follows the date your Child is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date that Child's increased or additional coverage would otherwise start.

Any decrease in coverage will take effect on the next Policy anniversary but will not affect a payable claim that occurs prior to the decrease.

CHANGE OF INSURANCE CARRIERS

If your coverage is being provided under the CHANGE OF INSURANCE CARRIERS provision in the Certificate, then we will also provide continuity of Children's coverage under the same conditions and for the same duration.

Any benefits payable under this provision will be the lesser of the amount of coverage under the prior policy had it remained in force, or the amount of eligible Children's coverage under our Policy. We will reduce our payment by any amount paid under the prior policy.

If Children's coverage under this provision ends while the Policy is in force, and your Children are not otherwise eligible for insurance under the Policy, then your Children's coverage will be eligible for conversion as described in the CONVERSION provision.

If your Children were not covered under the Employer's prior policy on the date that policy terminated, then the EFFECTIVE DATE OF COVERAGE provision will apply.

TERMINATION OF COVERAGE

Coverage for each Child ends on the earliest of the following:

- The date this rider terminates.
- The date the Child is no longer an eligible Child as defined by this rider. Coverage of a disabled Child ends when there is no longer evidence satisfactory to us that the incapacity is continuing.

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The date you voluntarily cancel this rider, as allowed by the Employer.
- The date you no longer have any eligible Children as defined by this rider.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.

We will pay benefits for a loss that occurs while your Child is covered under this rider.

CONVERSION

You may convert Children's life insurance, without Evidence of Insurability, to an individual life insurance policy if a Child's life insurance under this rider stops for any reason other than nonpayment of Premium, your voluntary cancellation of this rider, your Child reaching the termination age under this rider, or your death. You may also convert any part of Children's life insurance that reduces due to a Policy change. If you have made an absolute assignment of insurance, only the current owner may apply for conversion under this paragraph.

Your Child may convert Children's life insurance, without Evidence of Insurability, to an individual life insurance policy if that Child's life insurance under this rider stops because your Child reaches the termination age under this rider, or because of your death. If a Child is too young to contract for life insurance after your death, then a parent or a court-appointed guardian of the Child may apply for conversion of that Child's coverage.

Only life insurance is eligible for conversion. Conversion does not include any additional benefits such as accelerated death benefits, accidental death and dismemberment benefits, or waiver of premium benefits. Any amounts of coverage for which your Child remains eligible under the Policy are not eligible for conversion.

To convert Children's life insurance, application must be made and the first premium paid to us within 31 days of the date any part of a Child's life insurance under this rider terminates (the "conversion period"). You will be given Written notice, in person or at your last known address, of your conversion right at least 15 days before the date any part of Children's life insurance ends. Your right to convert will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your right to convert extend beyond 60 days after the expiration of the conversion period. Any extension of time allowed for returning the completed application and first premium will not change the length of the conversion period itself.

Application for conversion may be for the entire amount of Children's life insurance that is terminating under this rider, or a lesser amount. The maximum amount of Children's life insurance coverage eligible for conversion will be reduced by any amount of Children's life insurance for which you become eligible under any group policy within 31 days after the beginning of the conversion period. Premiums for the conversion policy will be based on our rates then in use, the form and amount of insurance, your Child's class of risk, and your Child's attained age at the beginning of the conversion period. The conversion policy may be any individual life insurance policy then customarily offered by us for conversion, other than term insurance. The conversion policy will not include any additional benefits. When we accept the application and first premium, the conversion policy will become effective on the 32nd day after the date the life insurance under the Policy terminated.

During the conversion period, Children's life insurance will continue under the terms of this rider. If your Child dies within the conversion period, any life insurance amount that was eligible for conversion will be payable as a death benefit under the Policy and any premiums paid for conversion will be refunded to the Beneficiary.

INCONTESTABILITY

Any statement made by you or your Child is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written statement of insurability which has been Signed by you or your Child and a copy of such statement of insurability has been given to you or to the Beneficiary. Except for fraud, we will not use such statement relating to insurability to contest life insurance after it has been in force for two years during your Child's lifetime. Except for fraud, we will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during your Child's lifetime. Fraud in the procurement of coverage under the Policy is only contestable after the coverage has been in force for two years from its effective date when permitted by applicable law in the governing jurisdiction.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

BENEFICIARY

You are the Beneficiary for proceeds that become payable at your Child's death under this rider. If you have made an absolute assignment of your insurance, then during your lifetime the current owner is the Beneficiary. See the Portability Rider for information about the eligible Beneficiary for continued coverage after your death. This Beneficiary designation may not be changed. Please refer to the LIFE INSURANCE BENEFITS section for more information about payment.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

LIFE INSURANCE BENEFITS

We pay a death benefit to the Beneficiary if we receive Written proof that your Child died while Children's insurance under this rider is in force. See the CONVERSION provision for information about death benefits payable during the conversion period following your death. The death benefit is the amount of Children's life insurance on that Child for the eligible class as shown on the SCHEDULE OF BENEFITS in effect on the date of your Child's death.

NOTICE OF CLAIM AND PROOF OF LOSS

A claim form is available from the Employer or us. The process for completing the claim form and submitting the claim form will be explained in the claim form paperwork. Proof of loss, including any attachments indicated on the claim form as required, should be sent directly to us at the address indicated on the form. We may also require information from the Employer in order to verify eligibility.

Proof of loss consists of a certified copy of your Child's death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

We will review proof of loss we receive in order to determine our liability and the correct payee(s). If we approve the claim, we will pay the benefits subject to the terms of this rider.

PAYMENT OF PROCEEDS

To be eligible to receive proceeds, the Beneficiary must be living on the date of your Child's death. Exception: If your Child dies during the conversion period following your death and you would otherwise have been the Beneficiary, we will pay the proceeds to your estate.

If the Beneficiary is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to the Beneficiary's estate.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

PAYMENT OF INTEREST

We pay interest on the death benefit proceeds, accruing from the date of your Child's death up to the date of payment. The minimum interest rate payable will be the interest rate applicable for funds left on deposit with us as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest rate applicable for funds left on deposit beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

- The date we receive due proof of loss following death.
- The date we receive sufficient information to determine our liability, the extent of our liability, and the appropriate payee legally entitled to the proceeds.
- The date that legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of this resolution is provided to us. Legal impediments to payment include but are not limited to: the establishment of guardianships and conservatorships; the appointment and qualification of trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

EXCLUSIONS AND LIMITATIONS

If your Child commits suicide while sane or insane within two years of the date that Child's insurance starts, we will refund to the Beneficiary any Premiums paid instead of paying a death benefit. The two year period includes the period your Child was continuously covered under this rider and any previous group term life policy issued to the Policyholder during your Child's lifetime.

If your Child commits suicide while sane or insane within two years from the date an increase in Supplemental Children's Life Insurance (other than a scheduled or automatic increase) became effective, we will pay a death benefit for the amount of insurance that was effective before the increase. We will refund to the Beneficiary any Premiums paid for the increased amount of insurance.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Michael S. Smith
President

Jennifer M. Ogren
Secretary

WAIVER OF PREMIUM RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Intact Services USA LLC

GROUP POLICY NUMBER: 64381-5GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

DEFINITIONS

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Normal Retirement Age means your retirement age according to the following table:

Your Year of Birth	Your Normal Retirement Age
before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 to 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
after 1959	67

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform for remuneration or profit any other job for which you are fit by education, training or experience. If we pay you an Employee benefit under the Accelerated Death Benefit Rider, you will automatically meet the definition of Total Disability under this rider following the date you became eligible for an accelerated benefit payment.

Waiting Period means the 6 month period immediately following the date you stop Active Employment during which you are continuously Totally Disabled. If you return to work for a total of 30 days or less during the Waiting Period and then stop work again due to the same Total Disability, your Waiting Period will not be interrupted. If we pay you an Employee benefit under the Accelerated Death Benefit Rider, you will automatically satisfy the Waiting Period requirement under this rider.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER
This rider terminates on the earliest of the following:
- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The date life insurance coverage is being continued under the terms of the Portability Rider.

This rider will not terminate while Premiums are being waived under the terms of this rider.

TERMINATION OF COVERAGE
The TERMINATION OF COVERAGE provision in your Certificate is revised to add this item to the terms under which your coverage ends:
- The date Premiums are no longer being waived under the Waiver of Premium Rider, if you are not in an eligible class on that date.

The TERMINATION OF COVERAGE provision in your Spouse Life Insurance Rider is revised to add this item to the terms under which your Spouse coverage ends:
- The date we approve a claim under the Waiver of Premium Rider.

The TERMINATION OF COVERAGE provision in your Children's Life Insurance Rider is revised to add this item to the terms under which your Children's coverage ends:
- The date we approve a claim under the Waiver of Premium Rider.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS
This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

WAIVER OF PREMIUM BENEFIT

If you become Totally Disabled while covered under this rider and meet the other conditions below, we will waive Premiums due under the Policy and continue insurance during your Total Disability, according to the terms of this rider. When we waive Premiums, the amount of continued life insurance equals the amount that would have been provided if you had not become Totally Disabled. That amount will reduce or stop according to the Certificate and riders in effect on the date Total Disability began. Premiums that are waived are not deducted from any proceeds that may become payable.

Continued life insurance includes the following if effective on the date before your Total Disability began:
- Employee life insurance.
- your coverage under the Accelerated Death Benefit Rider.

Continued life insurance does not include:

- Supplemental coverage under the Spouse Life Insurance Rider.
- Supplemental coverage under the Children's Life Insurance Rider.
- the Portability Rider.
- any continuation rider(s).

Any rider or coverage that is not eligible for waiver of premium under this rider will terminate on the date that coverage would otherwise end due to your termination of Active Employment. See the CONVERSION provision of the Certificate and riders for more information about conversion.

Continued insurance is subject to all other terms of the Policy.

CONDITIONS FOR WAIVER OF PREMIUM

All of the following conditions must be met in order to waive Premiums:

- Total Disability begins before your 65th birthday.
- You are covered under this rider on the date your Total Disability begins.
- You are continuously Totally Disabled for the entire Waiting Period. Premiums due during the Waiting Period are subject to the continuation provision(s) of any riders.
- All Premiums due for life insurance and this rider are paid to us through the date we approve your claim for waiver of Premium or the date the continuation period under any rider ends, whichever is earlier. Premiums due are payable by the Policyholder or you as applicable.
- You provide notice of claim and proof of Total Disability to us as described below.

NOTICE OF CLAIM AND PROOF OF TOTAL DISABILITY

You must send us written notice of claim while you are living, while you are Totally Disabled, and within 9 months of the date your Total Disability begins. Failure to give notice within 9 months will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice of claim includes proof of your Total Disability. Proof of your Total Disability includes information from your Doctor, at your expense, regarding your condition and your inability to work. We may require additional information from the Employer in order to verify eligibility. We may also require you to be interviewed by our authorized representative. Proof of your Total Disability, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s). Claim forms are available from the Employer or us.

We have the right to request a second or third medical opinion, at our expense, in order to determine if you are Totally Disabled. Any second medical opinion may include a physical examination by a Doctor or other medical practitioner of our choice. In the case of conflicting medical opinions, Total Disability will be determined by a third medical opinion that is provided by a Doctor who is mutually acceptable to you and us.

If you die within 12 months of the date your Total Disability began and all of the following are true:

- You didn't previously submit a claim under this rider, and
- You would otherwise have met the CONDITIONS FOR WAIVER OF PREMIUM, and
- Life insurance for you would still have been in force under the Policy on the date of your death if a claim for waiver of Premium had been approved,

then the Beneficiary can submit a claim for death benefit proceeds along with notice of claim under this rider and proof that your Total Disability continued without interruption from the last day you were in Active Employment until your death. For your death, completion of the entire Waiting Period is not required.

EFFECTIVE DATE OF WAIVER OF PREMIUM

When we approve your claim, Premiums are waived as of the date after the Waiting Period ends. We will refund any unearned Premiums we receive to the Policyholder or to you, as appropriate. We will notify you in writing when your claim is approved.

We will notify you and the Employer if we deny your claim. If we deny your claim, conversion is available as described in the CONVERSION provision of the Certificate and riders.

If we approve a claim for which notice of claim was provided to us more than 12 months after the date your Total Disability began, then any refund of unearned Premiums will not exceed 12 months of Premiums dating back from the date the notice of claim was received by us.

If you converted life insurance due to your termination of Active Employment and then a claim under this rider is approved, the conversion policy must be surrendered without claim. We will cancel the conversion policy as of the date of issue and refund any premiums paid. We will retain any beneficiary designation you made under your conversion policy as the Beneficiary under the group Policy, unless you change the Beneficiary as described under the BENEFICIARY provision in the Certificate. If the conversion policy is not surrendered without claim, then Premiums will not be waived under this rider. The same coverage(s) that would otherwise end due to your termination of Active Employment may not be both continued under this rider and converted.

After your claim is approved, we may periodically request additional proof of your continuing Total Disability, but not more frequently than once every six months.

TERMINATION OF WAIVER OF PREMIUM

We will stop waiving Premiums on the earliest of the following dates:

- The date you are no longer Totally Disabled.
- The date you do not give us proof of Total Disability as requested.
- The end of the 12 month period during which your Premiums are waived.
- Your Normal Retirement Age if you were less than age 65 on the date your Total Disability began.

If Premiums are no longer waived, insurance under the Policy will stay in force only if all of the following conditions are met:

- Life insurance is in force for Active Employees under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your Premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your Premium payments are resumed.

You will not be eligible for portability under any Portability Rider on the date we stop waiving your Premiums.

CONVERSION AFTER TERMINATION OF WAIVER OF PREMIUM

When Waiver of Premium under this rider ends, and if you are not otherwise eligible for insurance under the Policy, then conversion will be available as described in the CONVERSION provision of the Certificate and riders.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If we deny a claim in whole or in part (an "adverse benefit determination"), we will provide written notice of the adverse benefit determination to you as soon as possible, but no more than 45 days after receipt of the claim unless an extension is needed. An extension of 30 days will be allowed for processing the claim for matters beyond our control. You will be given notice of any such extension before the end of the initial 45-day period. If, before the end of the 30-day extension period, we are still unable to render a decision on the claim for matters beyond our control, a second extension of 30 days will be allowed for processing the claim. You will be given notice of any such second extension before the end of the first 30-day extension period. The notice(s) will state the circumstances requiring the extension and the date a decision is expected. The notice(s) will also specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. If additional information is needed, you will have 45 days to provide the specified information. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

A notice of an adverse benefit determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable you to receive the benefits sought and an explanation of why it is needed.

- A description of the claim review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

You may request a review of an adverse benefit determination (an "appeal") at any time during the 180 day period following receipt of the notice of the determination. We will consider an appeal upon written application of you or your duly authorized representative. As part of the appeal you also have the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to your claim. This includes the identification of any medical or vocational experts whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. You may, in the course of this appeal, review relevant documents and submit to us written comments, documents, records and other information relevant to your claim.

Our review of the appeal will be conducted by someone who is neither the individual who made the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. If the determination was based in whole or in part on a medical judgment, our review of the appeal will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be someone who is neither an individual who was consulted in connection with the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Following our review of the appeal, we will provide you with a written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 45 days after the receipt of the appeal unless an extension is needed. An extension of 45 days will be allowed for making this decision if special circumstances are present. You will be given notice of any such extension before the end of the 45-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be written in an understandable manner and include the following:
- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement of your right to bring a civil action.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Michael S. Smith
President

Jennifer M. Ogren
Secretary

ACCELERATED DEATH BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Intact Services USA LLC

GROUP POLICY NUMBER: 64381-5GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

THE AMOUNT OF LIFE INSURANCE WILL BE REDUCED IF AN ACCELERATED DEATH BENEFIT IS PAID. THE RECEIPT OF ACCELERATED DEATH BENEFITS MAY BE A TAXABLE EVENT.YOU SHOULD SEEK ADDITIONAL INFORMATION ABOUT THE TAX STATUS OF THE PAYMENT FROM A PERSONAL TAX ADVISOR.

CONTENTS

SCHEDULE OF BENEFITS

Accelerated Death Benefit

You:	75% of the amount of Basic and Supplemental Life Insurance in force, or $500,000, whichever is less.
Your Spouse:	75% of the amount of Supplemental Spouse Life Insurance in force.
Your Children:	75% of the amount of Supplemental Children's Life Insurance in force

You must have at least $5,000 of life insurance coverage in force.

Your Spouse must have at least $5,000 of life insurance coverage in force.

Your Children must have at least $5,000 of life insurance coverage in force.

DEFINITIONS

Covered Person means:

- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider.
- Your Children who are covered under your Children's Life Insurance Rider.

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Institution means any hospital, convalescent hospital, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm, or aged persons.

Qualifying Event means either of the following:

- Terminal Illness.
- A medical condition that is reasonably expected to require continuous confinement in an Institution and the Covered Person is expected to remain there for the rest of his or her life.

Terminal Illness means a medical condition that is expected to result in the Covered Person's death within 12 months and from which there is no reasonable chance of recovery.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

This rider will not terminate while this rider is being continued under the terms of another rider.

Termination of this rider will not prejudice the payment of benefits for a Qualifying Event that occurred while this rider was in force.

CONVERSION

When this rider terminates, conversion of this rider is not available.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

ACCELERATED DEATH BENEFIT

Accelerated death benefit proceeds is the amount we pay to you, while a Covered Person is living, if the Covered Person has a Qualifying Event. The accelerated death benefit proceeds are paid only once per Covered Person. This payout is the only settlement option available prior to a Covered Person's death.

The benefit is the amount of the accelerated death benefit shown on the SCHEDULE OF BENEFITS in effect on the date you request accelerated death benefit proceeds. When you request proceeds, you may elect a benefit percentage according to the available amounts shown on the SCHEDULE OF BENEFITS.

CONDITIONS FOR THE ACCELERATED DEATH BENEFIT

To receive a benefit payment under this rider, all of the following conditions must be met:

- Any required life insurance Premium is paid through the date you request proceeds under this rider.
- You request proceeds in writing while the Covered Person is living and before the Covered Person attains age 65. If you are unable to request payment yourself, your legal representative may request it on your behalf.
- The Covered Person is insured for life insurance benefits under the Policy.
- The Covered Person is insured for the minimum amount of life insurance as shown on the SCHEDULE OF BENEFITS in order to be eligible for benefits under this rider.
- The benefit percentage elected will equal no less than $5,000.
- You provide to us written proof from a Doctor that the Covered Person has a Qualifying Event.
- You provide to us written consent for payment from any irrevocable beneficiary and, in community property states, from your spouse.

NOTICE OF CLAIM AND PROOF OF LOSS

You must send us written notice of claim while the Covered Person is living and within 90 days of the date the Qualifying Event is diagnosed. Failure to give notice within 90 days will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice of claim includes proof of loss. Proof of loss includes information from the Covered Person's Doctor, at your expense, regarding the Covered Person's medical condition. We may require additional information from the Employer in order to verify eligibility. Proof of loss, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s). A claim form is available from the Employer or us.

We have the right to request a second or third medical opinion, at our expense, in order to determine if the Covered Person is eligible under the terms of this rider. Any second medical opinion may include a physical examination by a

Doctor designated by us. In the case of conflicting medical opinions, eligibility will be determined by a third medical opinion that is provided by a Doctor who is mutually acceptable to the Covered Person and us.

When you request proceeds under this rider and upon payment of the benefit proceeds, you will be provided with a disclosure demonstrating the effect of the acceleration on the death benefit and Premium, and any other effects on coverage. This disclosure will also be provided to any assignee of record or irrevocable beneficiary of record.

BENEFIT PAYMENT

We pay the benefit proceeds to you immediately upon receipt of due written proof of loss. If you are not the current owner of coverage under the Certificate or riders on the date proceeds are requested under this rider, then while you are living the benefit proceeds are payable to the current owner.

For coverage continued by your Spouse after your death or divorce, any benefit proceeds under this rider are payable to your Spouse. If your Spouse is not the current owner of coverage under the Spouse Life Insurance Rider and Children's Life Insurance Rider on the date accelerated death benefit proceeds are requested, then the benefit proceeds are payable to the current owner.

Benefit proceeds received for Terminal Illness will be paid as a lump sum.

For a Qualifying Event other than Terminal Illness, you may elect to receive the benefit proceeds as a lump sum or in monthly installments. You may elect monthly installments equal to 1-20% of the full amount of the benefit payable under this rider. The minimum monthly installment is $500. Monthly installments are paid once every 30 days until the full accelerated benefit amount has been paid out. Each monthly installment paid will reduce the remaining death benefit by the same amount.

Any payment we make in good faith will discharge our liability to the extent of such payment.

If you or the Covered Person dies after you request proceeds under this rider but before any proceeds are received, then the accelerated death benefit claim will be cancelled and any death benefit will be payable under the terms of the Certificate and riders. If any monthly installments are remaining at the time of death, the remaining amount will be payable as a death benefit under the terms of the Certificate and riders.

EFFECTS ON COVERAGE

When we pay this benefit, coverage is affected in the following ways:

- The Covered Person's Life Insurance amount is reduced by the accelerated death benefit proceeds paid under this rider.
- The Covered Person's life insurance amount that may be converted is reduced by the accelerated death benefit proceeds paid under this rider.
- You will not be eligible to increase the Covered Person's Contributory life insurance amount.
- Premium is based upon the life insurance amount in force prior to any proceeds paid under this rider. Such Premium must be paid, unless waived under the Waiver of Premium Rider, to keep the life insurance coverage in force.
- Your remaining life insurance amount is subject to future BENEFIT REDUCTIONS, if any, as shown on the SCHEDULE OF BENEFITS in the Certificate or riders.
- You will not be able to reinstate the Covered Person's coverage to its full amount in the event of a recovery from a Qualifying Event.

Payment of accelerated death benefits for a Covered Person will not affect the amount of life insurance on other Covered Persons.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Michael S. Smith
President

Jennifer M. Ogren
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Intact Services USA LLC

GROUP POLICY NUMBER: 64381-5GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

DEFINITIONS

Covered Person means:

- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider.
- Your Children who are covered under your Children's Life Insurance Rider.

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

Normal Retirement Age means your retirement age according to the following table:

Your Year of Birth	Your Normal Retirement Age
before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 to 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
after 1959	67

Temporary Layoff means you are absent from Active Employment for a period of time for which continuation of life insurance is available under the Employer's written plan for temporary layoffs, and the layoff is not intended to be permanent.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform any other job for which you are fit by education, training or experience.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

CHANGE OF INSURANCE CARRIERS
The CHANGE OF INSURANCE CARRIERS provision in the Certificate is revised to include an Employee whose coverage was being continued under a similar continuation provision of the Employer's prior policy on the date the Employer changes insurance carriers to our Policy.

TERMINATION OF RIDER
This rider terminates on the earliest of the following:
- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS
This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:
- Employer-approved Leave of Absence, or
- Total Disability,or
- Temporary Layoff,

then life insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

FAMILY AND MEDICAL LEAVE
If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of life insurance during an FMLA or State FML Leave of Absence, then life insurance coverage for all Covered Persons may be continued until the end of the later of:
- The leave period permitted by FMLA.
- The leave period permitted by state FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

SICKNESS OR INJURY

If you are on a Leave of Absence due to your sickness or injury, including Total Disability, then life insurance coverage for all Covered Persons may be continued until the date which is 18 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

TEMPORARY LAYOFF

If you stop Active Employment due to a Temporary Layoff, then life insurance coverage for all Covered Persons may be continued until the last day of the month which is on or next follows the date which is 1 month after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before you stopped Active Employment.

OTHER LEAVE OF ABSENCE

If you are on a Leave of Absence for any other reason, then life insurance coverage for all Covered Persons may be continued until the last day of the month which is on or next follows the date which is 1 month after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy as an Active Employee.
- The date of your death.
- The date you become covered under another group life insurance policy as an employee or member.
- The date Premiums are waived under the Waiver of Premium Rider.
- The date the Policy terminates.
- The date coverage for all Active Employees under the Policy terminates.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, other than by waiver of Premium, insurance under the Policy will stay in force only if all of the following conditions are met:

- Life insurance is in force for Active Employees under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your Premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your Premium payments are resumed.

CONVERSION FOLLOWING TERMINATION OF CONTINUATION

When continuation under this rider ends other than for nonpayment of Premium or waiver of premium, and if the Covered Person is not otherwise eligible for insurance under the Policy, then conversion will be available as described in the CONVERSION provision of the Certificate and riders.

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during an FMLA or State FML Leave of Absence, and you return to Active Employment immediately following the end of the FMLA or State FML Leave of Absence and while coverage is in force for Active Employees under the Policy, then [your coverage] [coverage for all Covered Persons] may be reinstated effective the date you return to Active Employment. The amount(s) of coverage will be subject to the SCHEDULE OF BENEFITS in effect on the date you return to Active Employment. We will not apply a new Eligibility Waiting Period or require Evidence of Insurability for the same or lesser amount(s) of coverage.

If coverage is not continued during any other period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Active Employees under the Policy, then the terms of the Certificate and riders will apply.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) – FOR TOTAL DISABILITY CLAIMS ONLY

If we deny a claim in whole or in part (an "adverse benefit determination"), we will provide written notice of the adverse benefit determination to you as soon as possible, but no more than 45 days after receipt of the claim unless an extension is needed. An extension of 30 days will be allowed for processing the claim for matters beyond our control. You will be given notice of any such extension before the end of the initial 45-day period. If, before the end of the 30-day extension period, we are still unable to render a decision on the claim for matters beyond our control, a second extension of 30 days will be allowed for processing the claim. You will be given notice of any such second extension before the end of the first 30-day extension period. The notice(s) will state the circumstances requiring the extension and the date a decision is expected. The notice(s) will also specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. If additional information is needed, you will have 45 days to provide the specified information. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

A notice of an adverse benefit determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable you to receive the benefits sought and an explanation of why it is needed.
- A description of the claim review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

You may request a review of an adverse benefit determination (an "appeal") at any time during the 180 day period following receipt of the notice of the determination. We will consider an appeal upon written application of you or your duly authorized representative. As part of the appeal you also have the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to your claim. This includes the identification of any medical or vocational experts whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. You may, in the course of this appeal, review relevant documents and submit to us written comments, documents, records and other information relevant to your claim.

Our review of the appeal will be conducted by someone who is neither the individual who made the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. If the determination was based in whole or in part on a medical judgment, our review of the appeal will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be someone who is neither an individual who was consulted in connection with the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Following our review of the appeal, we will provide you with a written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 45 days after the receipt of the appeal unless an extension is needed. An extension of 45 days will be allowed for making this decision if special circumstances are present. You will be given notice of any such extension before the end of the 45-day period. The notice will state the

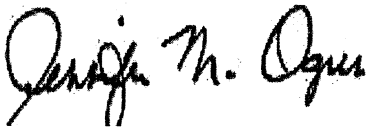
special circumstances involved and the date a decision is expected. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement of your right to bring a civil action.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Michael S. Smith
President



Jennifer M. Ogren
Secretary

CONTINUATION RIDER
for Minnesota residents

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Intact Services USA LLC

GROUP POLICY NUMBER: 64381-5GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

DEFINITIONS

Covered Person means:
- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider.
- Your Children who are covered under your Children's Life Insurance Rider.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

CHANGE OF INSURANCE CARRIERS
The CHANGE OF INSURANCE CARRIERS provision in the Certificate includes an Employee whose coverage was being continued under a similar continuation provision of the Employer's prior policy on the date the Employer changes insurance carriers to our Policy.

TERMINATION OF RIDER
This rider terminates on the date your life insurance terminates.

This rider will not terminate while coverage is being continued under the terms of this rider.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS
This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to

conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

CONTINUATION

If you stop Active Employment because your employment terminates or you retire, or your hours are reduced so that you are no longer in an eligible class for coverage under the Policy, then you may continue life insurance coverage for all Covered Persons for a limited period of time. Exception: If the Employer discharges you for gross misconduct, you will not be entitled to continue coverage under this rider.

Coverage continued under the terms of this rider includes benefits provided under all other riders that are in force on the date you become eligible for continuation under this rider. You may elect to continue Noncontributory coverage or Contributory coverage or both. You may elect to reduce Contributory coverage according to the SCHEDULE OF BENEFITS in the Certificate or riders.

The Employer will inform you of all of the following:
- Your right to elect continuation.
- The amount of Premium you must pay to continue coverage.
- The manner in which Premium must be paid to the Policyholder.
- The time by which Premium must be paid to the Policyholder to retain coverage.

You have 60 days in which to elect continuation. This election period begins on the later of the following:
- The date coverage would otherwise terminate.
- The date notice of the right to continue coverage is received.

If you do not make the election during that 60 days, you will have forfeited the right to continue coverage under this rider. Details are available from the Employer.

You must pay the Premiums for the continued coverage to the Policyholder on a monthly basis. The cost will not exceed 102% of the cost to the plan for coverage of Active Employees, regardless of whether those Premiums are paid by the Policyholder or Employees.

TERMINATION OF CONTINUATION

Continuation under this rider will terminate on the earliest of the following:
- The date you become covered under any other group life policy.
- The end of the 18 month period following the date you stopped Active Employment or began to work fewer hours than required for an eligible class of Employees covered under the Policy.
- The date of your death.
- The date the Policy terminates.
- The date coverage stops for all Active Employees under the Policy.

If you continue your insurance due to working fewer hours than required for an eligible class and then you stop Active Employment, no additional time period for continuation of insurance other than the original 18 months is available to you due to stopping Active Employment.

If you die while coverage is being continued under the terms of this rider, other Covered Persons may be eligible for portability or conversion. Refer to the riders for more information.

PORTABILITY AFTER TERMINATION OF CONTINUATION

At the end of the 18 month continuation period, you may be eligible to continue coverage by paying premiums directly to us. See the Portability Rider for more information. Any amounts of life insurance for which a conversion application has been received are not eligible for portability.

CONVERSION AFTER TERMINATION OF CONTINUATION

At the end of the 18 month continuation period, you may convert any amount of life insurance that stops at that time to an individual term life insurance policy without Evidence of Insurability. To convert life insurance, you must apply and pay the first premium to us within 31 days of the date the continuation under this rider terminates (the "conversion

period"). You may apply to convert the entire amount of life insurance that is terminating under the Policy, or a lesser amount. Premiums for the conversion policy will be based on our rates then in use, the amount of insurance, the Covered Person's class of risk, and the Covered Person's attained age at the beginning of the conversion period. The conversion policy will not include any additional benefits. When we accept the application and first premium, the conversion policy will become effective on the 32nd day after the date the continuation period ended.

During the conversion period, life insurance will continue under the terms of the Policy. If a Covered Person dies within the conversion period, any life insurance amount that was eligible for conversion will be payable as a death benefit under the Policy and any premiums paid for conversion will be refunded to the Beneficiary.

If you have made an absolute assignment of your insurance, only the current owner may apply for conversion.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Michael S. Smith
President

Jennifer M. Ogren
Secretary

PORTABILITY RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Intact Services USA LLC

GROUP POLICY NUMBER: 64381-5GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

DEFINITIONS

Covered Person means:
- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider.
- Your Children who are covered under your Children's Life Insurance Rider.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform any other job for which you are fit by education, training or experience.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER
This rider terminates on the earliest of the following:
- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

This rider will not terminate while your coverage is being continued under the terms of this rider.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS
This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to

conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

PORTABILITY

If there are any Covered Persons on portability under this rider when the Policy would otherwise terminate, the Policy will remain in force to cover those Covered Persons on portability until the date there are no Covered Persons on portability.

EMPLOYEE PORTABILITY

Portability means you can apply to continue coverage under the same Policy after it would otherwise terminate, if certain conditions are met. Continued coverage under this rider includes the following:

- Employee Basic Life Insurance under the Certificate
- Employee Supplemental Life Insurance under the Certificate
- Spouse Supplemental Life Insurance under the Spouse Life Insurance Rider
- Children's Supplemental Life Insurance under the Children's Life Insurance Rider
- Coverage under all riders except the Waiver of Premium Rider and any Continuation riders

CONDITIONS FOR EMPLOYEE PORTABILITY

All of the following conditions must be met:

- You must apply for a minimum of $5,000 in continued Employee coverage.
- If you apply for portability of Spouse coverage, you must apply for a minimum of $5,000 in continued Spouse coverage.
- If you apply for portability of Children's coverage, you must apply for a minimum of $5,000 in continued Children's coverage.
- You have not applied for conversion of life insurance on the same amounts.
- You apply for portability before the date you attain age 79.
- You did not stop Active Employment due to Total Disability.
- You are not on a leave of absence for your sickness or injury.
- You apply for portability within 31 days of the date your life insurance coverage would otherwise terminate due to any of the following:
  - You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Active Employees.
  - The Policyholder terminates coverage under the Policy for all Active Employees, and does not replace it with another life insurance plan.
  - You are no longer in an eligible class for coverage under the Policy.
  - Any other continuation provided under the Policy ends.

You will be given notice of your portability and conversion rights at least 15 days before the date any part of your life insurance ends. Your portability rights will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your portability rights extend beyond 60 days after the expiration of the conversion period.

Portability is not available for any of the following:

- Any amounts of life insurance for which a conversion application has been received by us.
- Coverage that reduces due to BENEFIT REDUCTIONS as described on the SCHEDULE OF BENEFITS in the Certificate or any riders.
- Coverage that reduces due to your change from one eligible class to another.
- Coverage that reduces due to a Policy change.
- Coverage that is being continued under the Waiver of Premium Rider.
- Coverage that ends due to termination under the Waiver of Premium Rider.
- Coverage that ends due to termination of a continuation for your sickness or injury.

You may apply for conversion of any terminating life insurance amounts that are not eligible for portability. See the CONVERSION provision of the Certificate and riders.

APPLICATION FOR EMPLOYEE PORTABILITY

You may apply for portability on the same amount of insurance that would otherwise terminate or a lesser amount according to the available amounts on the portability application. You must apply for portability of your insurance in order to continue Spouse and Children's insurance. The amount(s) that can be continued under this rider are subject to the following maximum(s):

- The lesser of 5 times your Basic Yearly Earnings or $750,000 total Employee Life Insurance
- $250,000 total Employee Life Insurance if you are age 60 or older
- $100,000 of Spouse Supplemental Life Insurance, not to exceed the amount of Employee Life ported
- $15,000 total Children's Life Insurance, not to exceed the total amount of Employee Life ported

You may apply for conversion of any terminating life insurance amounts that exceed the maximum amount(s) eligible for portability. See the CONVERSION provision of the Certificate and riders. You will not be eligible to increase the ported coverage amount(s). Ported coverage is subject to all the terms of the Policy including BENEFIT REDUCTIONS as described on the SCHEDULE OF BENEFITS in the Certificate or any riders.

If you die within 31 days of the date you become eligible for portability under this rider (the "conversion period"), any life insurance amount that you were entitled to convert will be payable according to the CONVERSION provision of the Certificate and riders. If your Spouse or Child dies during the conversion period, any Spouse or Children's life insurance amount that you were entitled to convert will be payable according to the CONVERSION provision of your Spouse Life Insurance Rider or Children's Life Insurance Rider. Any unearned Premiums paid for portability will be refunded to the Beneficiary.

You do not need to provide Evidence of Insurability in order to apply for portability. You may complete the Evidence of Insurability section of the application if you want to request a lower portability Premium rate. If we accept your application for portability but decline any Evidence of Insurability, you may either pay the standard portability Premium rate or apply for conversion of life insurance within 31 days of the date we provide you written notice of conversion. See the CONVERSION provision of the Certificate and riders. Your coverage must be ported under the terms of this rider in order for Spouse or Children's coverage to be ported.

Your application for portability must be approved by us. When we approve your application, ported coverage under this rider will be effective on the day after the conversion period ends. Premiums under this rider will be billed directly to you on a quarterly basis. Each quarterly Premium due will include a billing fee as indicated on the portability application or subsequent notice. Continued Premium payment is required to keep coverage in force. The initial Premium will be based on the portability Premium rates in effect at the time you apply for portability. We may change the portability Premium rates at any time upon 90 days written notice to you.

If you have made an absolute assignment of your insurance, only the current owner may apply for portability.

MISSTATEMENT OF EVIDENCE OF INSURABILITY FOR EMPLOYEE PORTABILITY

If your or your Spouse's Premium rates are based on Evidence of Insurability as provided on your application for portability, and you or your Spouse have misstated any information requested on the application for portability such that the lower Premium rates would not have been approved by us, then we will adjust your or your Spouse's Premium to the standard portability Premium rates. Any back Premium due as a result of this adjustment will be required. We will not adjust your or your Spouse's Premium after coverage has been continued under this rider for two years during your or your Spouse's lifetime.

GRACE PERIOD FOR EMPLOYEE PORTABILITY

You have a grace period of 31 days for the payment of any Premium due. During the grace period coverage will remain in force. If full Premium payment is not received by us by the due date, we will give written notification to you that if the Premium is not paid by the end of the grace period then all coverage will end on the last day of the grace period. If we fail to give such written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving written notice of such intent to you, and such notice will specify the date all coverage will terminate if the Premium remains unpaid. You are required to pay a pro rata Premium for any period coverage was in force during the grace period. Premium payment is required for any grace period, any extension of such period, and any period for which coverage was in effect and Premium was not paid.

TERMINATION OF EMPLOYEE PORTABILITY

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date you attain age 80.
- The date you die.
- The date we approve a claim under the Waiver of Premium Rider.

You may apply for conversion of any life insurance amount(s) that terminate when portability under this rider ends, other than for nonpayment of Premium or at your death. Your surviving Spouse and Children may apply for conversion of any Spouse and Children's life insurance amount(s) that terminate when you die. See the CONVERSION provision of the Certificate and riders.

Any unearned Premiums paid for ported coverage will be refunded.

PORTABILITY AT DEATH OR DIVORCE

If you die, your Spouse can apply to continue coverage under the same Policy if certain conditions are met. Continued coverage following your death includes the following:

- Spouse Supplemental Life Insurance under the Spouse Life Insurance Rider
- Children's Supplemental Life Insurance under the Children's Life Insurance Rider
- Spouse coverage under the Accelerated Death Benefit Rider
- Children's coverage under the Accelerated Death Benefit Rider

If you divorce, your Spouse can apply to continue coverage under the same Policy if certain conditions are met. Your Spouse's continued coverage following divorce includes the following:

- Spouse Supplemental Life Insurance under the Spouse Life Insurance Rider
- Spouse coverage under the Accelerated Death Benefit Rider

For purposes of this rider, "divorce" includes annulment.

CONDITIONS FOR PORTABILITY AT DEATH OR DIVORCE

All of the following conditions must be met:

- Your Spouse must have been insured under your Spouse Life Insurance Rider on the date of your death or divorce.
- Your Spouse must apply for portability before the date your Spouse attains age 60.
- Your Spouse must apply for portability within 31 days of your death or divorce.

Your Spouse will be given notice of portability and conversion rights when your Spouse's life insurance ends due to death or divorce. Your Spouse's portability rights will expire on the later of 16 days after your Spouse is given such notice or the end of the conversion period, but in no event will your Spouse's portability rights extend beyond 60 days after the expiration of the conversion period.

Children may be covered following your death only if they would have been eligible for coverage under the eligibility rules in force prior to your death.

Conversion is available for any terminating life insurance amount(s) that are not eligible for portability. See the CONVERSION provision of the riders. Any amounts of life insurance for which an application for conversion has been received by us are not eligible for portability under this rider.

APPLICATION FOR PORTABILITY AT DEATH OR DIVORCE

Your Spouse may apply for portability of the same amount of insurance that would otherwise terminate or a lesser amount according to the available amounts on the portability application. Your Spouse must apply for portability of Spouse insurance in order to continue Children's insurance. Your Spouse may only apply for portability of Children's Insurance in the event of your death. The amount(s) that can be continued under this provision are subject to the following maximum(s):

- $100,000 of Spouse Supplemental Life Insurance
- $15,000 of Children's Supplemental Life Insurance, not to exceed the amount of Spouse Supplemental Life ported

Conversion is available for any life insurance amounts that exceed the maximum amount(s) eligible for portability under this provision. See the CONVERSION provision of the riders. Your Spouse will not be eligible to increase the ported coverage amount. Ported coverage is subject to all the terms of the Policy, Certificate and any riders.

If your Spouse dies within 31 days of the date your Spouse becomes eligible for portability under this provision (the "conversion period"), any Spouse life insurance amount that was eligible for conversion will be payable according to the CONVERSION provision of the Spouse Life Insurance Rider. If your Child dies during the conversion period, any Children's life insurance amount that was eligible for conversion on that Child will be payable according to the CONVERSION provision of the Children's Life Insurance Rider. Any unearned Premiums paid for portability will be refunded to the Beneficiary.

Your Spouse does not need to provide Evidence of Insurability in order to apply for portability. Your Spouse may complete the Evidence of Insurability section of the application if your Spouse wants to request a lower portability Premium rate. If we accept your Spouse's application for portability but decline your Spouse's Evidence of Insurability, your Spouse may either pay the standard portability Premium rate or apply for conversion of life insurance within 31 days of the date we provide your Spouse written notice of conversion. See the CONVERSION provision of the riders. Spouse coverage must be ported under the terms of this rider in order for Children's coverage to be ported.

If we approve your Spouse's application for portability, your Spouse will become the owner of the Spouse coverage that was previously provided under your Spouse Life Insurance Rider. If Children's coverage is ported after your death, your Spouse will also become the owner of the Children's coverage that was previously provided under your Children's Life Insurance Rider. Ported coverage under this provision will be effective on the day after the conversion period ends. Premiums under this provision will be billed directly to your Spouse on a quarterly basis. Each quarterly Premium due will include a billing fee as indicated on the portability application or subsequent notice. Continued Premium payment is required to keep coverage in force. The initial Premium will be based on the portability Premium rates in effect at the time your Spouse applies for portability. We may change the portability Premium rates at any time upon 90 days written notice to your Spouse.

If you have made an absolute assignment of your insurance, the current owner's rights under the Policy will terminate on the date of your death. The current owner's rights regarding your Spouse's insurance will terminate on the date of your divorce. Your Spouse as the new owner under this provision may make an absolute assignment of insurance, as described in the ASSIGNMENT provision of the Certificate.

BENEFICIARY FOR PORTABILITY AT DEATH OR DIVORCE

For coverage continued under this provision, the Beneficiary is named by your Spouse to receive any proceeds payable at your Spouse's death. While your Spouse's coverage is in force under this provision, your Spouse may change the Beneficiary by Written request on a form that is acceptable to us. A Beneficiary designation form is available from us. An accepted designation will take effect as of the date it is Signed but will not affect any payment we make or action we take before receiving the Signed form. If your Spouse has made an absolute assignment of insurance, only the current owner may change the Beneficiary designation for proceeds payable at your Spouse's death.

If an irrevocable Beneficiary is named for proceeds payable at your Spouse's death, the Beneficiary designation can only be changed with the consent of the irrevocable Beneficiary.

There can be one or more Beneficiaries for proceeds payable at your Spouse's death. If two or more Beneficiaries are named and their shares are not specified in the Beneficiary designation, then the Beneficiaries will share any insurance proceeds equally. If a primary Beneficiary does not survive your Spouse, their share will be payable to the remaining primary Beneficiaries. One or more contingent Beneficiaries may be named to receive the proceeds in the event that all of the primary Beneficiaries named do not survive your Spouse.

Your Spouse is the Beneficiary for all other proceeds payable. This Beneficiary designation may not be changed. If your Spouse has made an absolute assignment of insurance, then during your Spouse's lifetime those proceeds are payable to the current owner.

PAYMENT OF PROCEEDS FOR PORTABILITY AT DEATH OR DIVORCE

For coverage continued under this provision, a Spouse death benefit is payable if your Spouse dies while the Spouse Life Insurance Rider is in force. Other benefits are payable if a covered loss occurs while coverage is in force, and

while your Spouse is living. See the CONVERSION provision of the Children's Life Insurance Rider for information about death benefits payable during the conversion period following your Spouse's death.

To be eligible to receive proceeds, the Beneficiary must be living on the date of your Spouse's or Child's death or loss under any rider. Exception: If your Child dies during the conversion period following your Spouse's death and your Spouse would otherwise have been the Beneficiary, we will pay the Child death benefit proceeds to your Spouse's estate.

If the Beneficiary is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to the Beneficiary's estate. If there is no eligible Beneficiary, we will pay the proceeds to your Spouse's estate.

MISSTATEMENT OF EVIDENCE OF INSURABILITY FOR PORTABILITY AT DEATH OR DIVORCE

If your Spouse's Premium rates are based on Evidence of Insurability as provided on your Spouse's application for portability, and your Spouse has misstated any information requested on the application for portability such that the lower Premium rates would not have been approved by us, then we will adjust your Spouse's Premium to the standard portability Premium rates. Any back Premium due as a result of this adjustment will be required. We will not adjust your Spouse's Premium after coverage has been continued under this rider for two years during your Spouse's lifetime.

GRACE PERIOD FOR PORTABILITY AT DEATH OR DIVORCE

Your Spouse has a grace period of 31 days for the payment of any Premium due. During the grace period coverage will remain in force. If full Premium payment is not received by us by the due date, we will give written notification to your Spouse that if the Premium is not paid by the end of the grace period then all coverage will end on the last day of the grace period. If we fail to give such written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving written notice of such intent to your Spouse, and such notice will specify the date all coverage will terminate if the Premium remains unpaid. Your Spouse is required to pay a pro rata Premium for any period coverage was in force during the grace period. Premium payment is required for any grace period, any extension of such period, and any period for which coverage was in effect and Premium was not paid.

TERMINATION OF PORTABILITY AT DEATH OR DIVORCE

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date your Spouse attains age 70.
- The date your Spouse dies.
- For each Child's coverage, the date the Child is no longer an eligible Child as defined by the Children's Life Insurance Rider. Coverage of a disabled Child ends when there is no longer evidence satisfactory to us that the incapacity is continuing.
- For Children's coverage, the date there are no longer any eligible Children covered under the Children's Life Insurance Rider.

If your Spouse is continuing coverage under this provision and then later your Spouse becomes eligible as an Active Employee under the Policy, then any amount(s) of coverage continued under this rider will be reduced by the amount(s) of coverage your Spouse has as an Active Employee. Any unearned Premiums paid for ported coverage will be refunded.

CONVERSION FOR TERMINATION OF PORTABILITY AT DEATH OR DIVORCE

Your Spouse may convert any life insurance amounts that stop when portability under this provision ends for any reason other than nonpayment of Premium, or your Spouse's death, or your Child reaching the termination age under the Children's Life Insurance Rider. Conversion is also available for any part of Spouse life insurance that reduces due to a Policy change. Conversion is also available for any part of Children's life insurance that reduces due to a Policy change. See the CONVERSION provision of the rider(s). If your Spouse has made an absolute assignment of insurance, only the current owner may apply for conversion under this paragraph.

Your Child may convert any Children's life insurance amount that stops under the Children's Life Insurance Rider due to your Child reaching the termination age under that rider, or when portability under this rider ends due to your Spouse's death. If a Child is too young to contract for life insurance after your Spouse's death, then a parent or a court-appointed guardian of the Child may apply for conversion of that Child's coverage. See the CONVERSION provision of the rider.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Michael S. Smith
President

Jennifer M. Ogren
Secretary

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440

Plan Name, Number and Name and Address of Policyholder:
Intact Services USA LLC
64381-5GAT2
Intact Services USA LLC
605 North Highway 169, Suite 800
Plymouth, Minnesota, 55441

Name, Address, and Telephone Number of the Plan Administrator:
Intact Services USA LLC
605 North Highway 169, Suite 800
Plymouth, Minnesota, 55441
952-852-2440

Identification Numbers
IRS Employer Identification Number: 26-3300055
Plan Number: 506

Agent for Legal Process: Plan Administrator

Trustees: None

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: Basic Insurance is paid by the Employer and Supplemental Insurance is paid by the Employee.

Plan Year: January 1 thru December 31

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of insurance.

Type of Plan: As described in the Certificate of insurance.

Benefits in Plan: As described in the Certificate of insurance.

Amendment or Termination of Plan: The Policyholder makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Policyholder reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR LIFE INSURANCE

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR WAIVER OF PREMIUM RIDER

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 45 days after receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice of any such extension. The notice will state the standards on which the entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, the additional information needed to resolve those issues, if any, and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision, internal rule, guideline or protocol which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 180-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) Prior to rendering an adverse decision on appeal, ReliaStar Life will provide notice to the claimant of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. ReliaStar Life Insurance Company of New York will also notify the claimant if it has new or additional rationale for an adverse appeal determination. ReliaStar Life Insurance Company of New York will then provide the claimant with a reasonable opportunity to review and respond to this new information before making its decision. The time period ReliaStar Life Insurance Company of New York has to make its determination will be tolled while it is waiting for the claimant's response.
8) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. If ReliaStar Life Insurance Company of New York sends an adverse benefit determination following its review of the appeal, the notice of the determination will be written in an understandable manner and include the following:
   a. The specific reason(s) for the adverse benefit determination.
   b. Reference to the specific provision on which the determination is based.
   c. 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.
   d. A statement of the claimant's right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
   e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of

charge.

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

This decision will be issued as soon as practicable from the date of appeal, but not longer than 45 days unless an extension is needed. An extension of 45 days will be allowed for making the decision for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice if this extension is necessary, stating the reason for the extension, the date a decision is expected, and the additional information needed from the claimant, if any. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.

9) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

Intact Services USA LLC provides this valuable benefit at no cost to you.

Employees working a minimum of 20 regularly scheduled hours

Short-Term Disability Plan

Protect your paycheck when you can't work.

Many medical conditions can keep you out of work. Short-term disability insurance helps you meet your financial obligations while you're recovering from an injury, illness, surgery, or childbirth. Intact Services USA LLC's short-term disability plan provides partial income replacement if you are unable to work due to a qualifying illness or injury.

AT A GLANCE:

- A cash benefit of 100% of your weekly salary for the first three weeks, followed by 66.67% thereafter, when you are out of work for up to 26 weeks due to injury, illness, surgery, or recovery from childbirth
- A partial cash benefit if you can only do part of your job or work part time
- A prompt, responsive claims process

ADDITIONAL DETAILS

Elimination Period: Benefits are payable after a period of seven calendar days due to injury or sickness.

For complete benefit descriptions, limitations, and exclusions, refer to the plan document.

Please see your Human Resources department or Benefits department for additional information.

ASO products are funded entirely by the employer. Lincoln Financial Group provides administrative and/or claims payment services only.

LCN-2681220-081319

Lincoln Financial Group®

Intact Services USA LLC

Benefits At-A-Glance

Employees working a minimum of 20 regularly scheduled hours per week

Core Plan (paid by Intact Services USA LLC)	
Monthly benefit amount	60% of your monthly salary, limited to $25,000 per month
Elimination period	After the end of your short-term disability or a period of 180 days of disability, whichever is greater
"Buy-Up" Option LTD (paid by you through payroll deduction)	
Monthly benefit amount	70% of your monthly salary, limited to $25,000 per month
Elimination period	After the end of your short-term disability or a period of 180 days of disability, whichever is greater

Elimination Period

- This is the number of days you must be disabled before you can collect disability benefits.

Maximum Coverage Period

- This is the total amount of time you can collect disability benefits (also known as the benefit duration).
- Mental illness and substance abuse benefits are limited to a combined period of 24 months
- Age at Disability — Maximum Benefit Period

  Less than age 60---------- Greater of Social Security Normal Retirement age or to age 65 (but not less than 5 years)

  60 ---------- 60 months
  61 ---------- 48 months
  62 ---------- 42 months
  63 ---------- 36 months
  64 ---------- 30 months
  65 ---------- 24 months
  66 ---------- 21 months
  67 ---------- 18 months
  68 ---------- 15 months
  69 and over ---------- 12 months

Supplemental Long-Term Disability Insurance

The Lincoln Long-term Disability Insurance Plan:

- Provides a cash benefit after you are out of work for 180 days or more due to injury, illness, or surgery
- Starts with a "core plan" that is paid for by Intact Services USA LLC
- Offers a simple "buy-up" option that lets you enhance your benefit at affordable group rates
- Features group rates for eligible Intact Services USA LLC employees
- Includes *EmployeeConnect*SM services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance

Additional Plan Information

Evidence of Insurance

- When you are first offered this coverage (and during approved open enrollment periods), you may be able to take advantage of this important coverage with no evidence of insurability (proof of health).

Pre-existing Condition

- If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

Benefit Exclusions & Reductions

Like any insurance, this long-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- Your disability is the result of cosmetic surgery, unless related to a disabling condition
- Your disability occurs while you are committing a felony or misdemeanor or participating in a riot

Your benefits may be reduced if you are eligible to receive benefits from:

- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' Compensation
- Salary continuance
- Sick leave

A complete list of benefit exclusions and reductions is included in the policy. State restrictions may apply to this plan.

Lincoln Financial Group®

LCN-2599341-061719

Supplemental Long-Term Disability Insurance
Calculate Your Premium

Use the employee buy-up long-term disability premium rate table provided below to calculate your cost and benefit. The following example calculates the monthly cost for an employee with annual earnings of $35,400.

Note: The maximum monthly covered earnings are equal to the maximum monthly benefit divided by the benefit percentage.

Calculation Example		Example	You
Step 1	Enter the monthly rate per $100 of monthly covered payroll.	$0.290	
Step 2	Enter your monthly earnings. *Divide your annual earnings by 12.*	$2,950	
Step 3	If your monthly earnings are greater than the **maximum monthly covered earnings** of $35,714, indicate $35,714. *Otherwise, indicate the amount from Step 2.*	$2,950	
Step 4	Calculate your monthly benefit. *Multiply Step 3 by 0.70.*	$2,065	
Step 5	Enter your monthly earnings in increments of $100 of monthly covered payroll. *To calculate, divide the amount in Step 3 by $100.*	20.65	
Step 6	Calculate your monthly cost. *Multiply Step 1 by Step 5*	$5.99	

Premium Rate
$0.290

This worksheet allows you to approximate your monthly contributions for buy-up long-term disability insurance coverage. Cost of insurance may change in the future due to age and/or coverage amount elected.

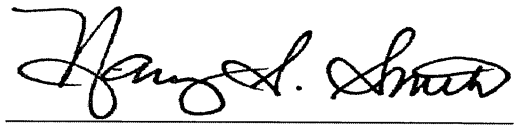
NOTICE OF CHANGE

In The Certificate Booklet
Issued to Employees of:

Intact Services USA LLC

This Notice is a summary of changes that have been made to your Booklet. These changes are effective on February 18, 2020. Keep this Notice with your Booklet.

LINCOLN LIFE ASSURANCE COMPANY OF BOSTON



Officer of the Company

AMENDMENT

to be attached to and made a part of
the Certificate for Group Plan No. GF3-810-253226-01
issued by

LINCOLN LIFE ASSURANCE COMPANY OF BOSTON
(Lincoln)

to

Intact Services USA LLC
(Sponsor)

Effective date of this Amendment: February 18, 2020

The attached pages reflect the following revisions: Sponsor's legal name has changed

Intact Services USA LLC
January 1, 2011

DISCLAIMER

Sponsor: **Intact Services USA LLC**

Policy Number(s): **GF3-810-253226-01**

Date Provided: **October 5, 2020**

The following certificate(s) are a true copy of the certificate(s) issued under the policy(ies).

LINCOLN LIFE ASSURANCE COMPANY OF BOSTON

Intact Services USA LLC

CERTIFICATE OF COVERAGE

Lincoln Life Assurance Company of Boston welcomes your employer as a client.

Sponsor: **Intact Services USA LLC**

Plan Number: **GF3-810-253226-01**

Effective Date: **January 1, 2011**

When this plan refers to "you" or "your" it means the Employee insured under this plan. This is your Disability Income certificate of coverage as long as you are eligible for insurance and remain insured.

A few words about this certificate of coverage...

It is written in plain English. A few terms and provisions are written as required by insurance law. **PLEASE READ IT CAREFULLY**. If you have any questions about any terms and provisions, please contact the Insurance Administrator at your work location or write to Lincoln. Lincoln will assist you in any way we can to help you understand your benefits.

Also, if the terms of your certificate of coverage and the policy differ, the policy will govern. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the policy.

Dennis R Glass

PRESIDENT

TABLE OF CONTENTS

SECTION 1 - SCHEDULE OF BENEFITS

ELIGIBILITY REQUIREMENTS FOR INSURANCE BENEFITS

What is the Minimum Hourly Requirement?

Employees working a minimum of 20 regularly scheduled hours per week

Who is Eligible for Long Term Disability Benefits?

Class 1: All Full-Time associates participating in the Core Plan, except leased associates, individuals classified by the Sponsor as temporary or independent contractors and represented associates

Class 2: All Full-Time associates participating in the Buy-up Plan, except leased associates, individuals classified by the Sponsor as temporary or independent contractors and represented associates

Note: Temporary and seasonal Employees and Employees who are not United States citizens or legal residents working in the United States are not covered under this policy.

What is the Eligibility Waiting Period?

1. If you are employed by the Sponsor on the policy effective date -
   None

2. If you begin employment for the Sponsor after the policy effective date -
   None

Are Employee Contributions Required?

Yes

LONG TERM DISABILITY COVERAGE

What is the Elimination Period?

The greater of:

a. the end of your Short Term Disability Benefits; or

b. 180 days

What is the Amount of Insurance Benefits?

Applicable to Class 1:

60.00% of Basic Monthly Earnings not to exceed a Maximum Monthly Benefit of $25,000.00 less Other Income Benefits and Other Income Earnings as outlined in Section 4.

Applicable to Class 2:

70.00% of Basic Monthly Earnings not to exceed a Maximum Monthly Benefit of $25,000.00 less Other Income Benefits and Other Income Earnings as outlined in Section 4.

What is the Maximum Basic Monthly Earnings on which the Benefit is Based?

Applicable to Class 1:	$41,667.00
Applicable to Class 2:	$35,714.00

What is the Own Occupation Duration?

24 Month Own Occupation

LONG TERM DISABILITY COVERAGE (Continued)

What is the Minimum Monthly Benefit?

The Minimum Monthly Benefit is $100.00 or 10.00% of your Gross Monthly Benefit, whichever is greater.

What is the Maximum Benefit Period?

Age at Disability	Maximum Benefit Period
Less than age 60	Greater of SSNRA* or to age 65 (but not less than 5 years)
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

* SSNRA means the Social Security Normal Retirement Age as figured by the 1983 amendment to the Social Security Act and any subsequent amendments and provides:

Year of Birth	Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and after	67

SECTION 2 - DEFINITIONS

In this section Lincoln defines some basic terms needed to understand this plan.

"**Active Employment**" means you must be actively at work for the Sponsor:

1. on a full-time basis and paid regular earnings;

2. for at least the minimum number of hours shown in the Schedule of Benefits; and either perform such work:

    a. at the Sponsor's usual place of business; or
    b. at a location to which the Sponsor's business requires you to travel.

You will be considered actively at work if you were actually at work on the day immediately preceding:

1. a weekend (except where one or both of these days are scheduled work days);
2. holidays (except when the holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. an excused leave of absence (except medical leave for your own disabling condition and lay-off); and
6. an emergency leave of absence (except emergency medical leave for your own disabling condition).

"**Administrative Office**" Lincoln Life Assurance Company of Boston, 100 Liberty Way, Suite 100, Dover, New Hampshire 03820-4695.

"**Annual Enrollment Period**" or "**Enrollment Period**" means the period before each plan anniversary so designated by the Sponsor and Lincoln during which you may enroll for coverage under this plan.

SECTION 2 - DEFINITIONS
(Continued)

"Any Occupation" means any occupation that you are or become reasonably fitted by training, education, experience, age, physical and mental capacity.

"Appropriate Available Treatment" means care or services which are:

1. generally acknowledged by Physicians to cure, correct, limit, treat or manage the disabling condition;
2. accessible within your geographical region;
3. provided by a Physician who is licensed and qualified in a discipline suitable to treat the disabling Injury or Sickness;
4. in accordance with generally accepted medical standards of practice.

"Basic Monthly Earnings" means the Covered Person's monthly rate of earnings from the Sponsor in effect immediately prior to the date Disability or Partial Disability begins: however, such earnings will not include commissions, overtime pay, extra compensation and bonuses, other than the target bonus.

"**Disability**" or "**Disabled**" means:

1. For persons other than pilots, co-pilots, and crewmembers of an aircraft:

   i. that during the Elimination Period and the next 24 months of Disability you, as a result of Injury or Sickness, are unable to perform the Material and Substantial Duties of your Own Occupation; and

   ii. thereafter, you are unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation.

2. With respect to Covered Persons employed as pilots, co-pilots and crewmembers of an aircraft:

   as of a result of Injury or Sickness you are unable to perform the Material and Substantial Duties of Any Occupation.

"**Disability Benefits under a Retirement Plan**" means money which:

1. is payable under a Retirement Plan due to Disability as defined in that plan; and

2. does not reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the plan if the Disability had not occurred. (If the payment does cause such a reduction, it will be deemed a Retirement Benefit as defined in this plan.)

SECTION 2 - DEFINITIONS
(Continued)

"**Domestic Partner**" means an unmarried person of the same or opposite sex with whom you share a committed relationship, are jointly responsible for each other's welfare and financial obligations, at least 18 years of age and mentally competent to consent to a contract, not related by blood to a degree that could prohibit legal marriage in the state where you legally reside, maintain the same residence(s) and are not married to or legally separated from anyone else. A Domestic Partner certification must be completed and filed with the Sponsor before the partner can be designated as an Eligible Survivor.

"**Eligibility Date**" means the date you become eligible for insurance under this plan. The Eligibility Requirements are shown in the Schedule of Benefits.

"**Eligible Survivor**" means your spouse or Domestic Partner, if living, otherwise your children under age 25.

"**Eligibility Waiting Period**" means the continuous length of time you must be in Active Employment in an eligible class to reach your Eligibility Date.

"**Elimination Period**" means a period of consecutive days of Disability or Partial Disability for which no benefit is payable. The Elimination Period is shown in the Schedule of Benefits and begins on the first day of Disability.

If you return to work for any thirty or fewer days during the Elimination Period and cannot continue, Lincoln will count only those days you are Disabled or Partially Disabled to satisfy the Elimination Period.

"**Employee**" means a person in Active Employment with the Sponsor.

"**Enrollment Form**" is the document completed by you, if required, when enrolling for coverage. This form must be satisfactory to Lincoln.

"**Evidence of Insurability**" means a statement of proof of your medical history upon which acceptance for insurance will be determined by Lincoln.

"**Extended Treatment Plan**" means continued care that is consistent with the American Psychiatric Association's standard principles of Treatment, and is in lieu of confinement in a Hospital or Institution. It must be approved in writing by a Physician.

"**Family and Medical Leave**" means a leave of absence for the birth, adoption or foster care of a child, or for the care of your child, spouse or parent or for your own serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 (FMLA) and any amendments, or by applicable state law.

"**Family Status Change**" means any one of the following events that may occur:

1. your marriage or divorce;
2. your filing or rescinding of a Domestic Partner certification;
3. the birth of a child to you;
4. the adoption of a child by you;
5. the death of your spouse or Domestic Partner or child;
6. the commencement or termination of employment of your spouse or Domestic Partner;
7. the change from part-time employment to full-time employment by you or your spouse or Domestic Partner;
8. the change from full-time employment to part-time employment by you or your spouse or Domestic Partner;
9. the taking of unpaid leave of absence by you or your spouse or Domestic Partner.

"**Gross Monthly Benefit**" means your Monthly Benefit before any reduction for Other Income Benefits and Other Income Earnings.

"**Hospital**" or "**Institution**" means a facility licensed to provide Treatment for the condition causing your Disability.

"**Initial Enrollment Period**" means one of the following periods during which you may first enroll for coverage under this plan:

1. if you are eligible for insurance on the plan effective date, a period before the plan effective date set by the Sponsor and Lincoln.

2. if you become eligible for insurance after the plan effective date, the period which ends 31 days after your Eligibility Date.

"**Injury**" means bodily impairment resulting directly from an accident and independently of all other causes. For the purpose of determining benefits under this plan:

1. any Disability which begins more than 60 days after an Injury will be considered a Sickness; and

2. any Injury which occurs before you are covered under this plan, but which accounts for a medical condition that arises while you are covered under this plan will be treated as a Sickness.

"**Last Monthly Benefit**" means the gross Monthly Benefit payable to you prior to your death without any reduction for earnings received from employment.

"**Material and Substantial Duties**" means responsibilities that are normally required to perform your Own Occupation, or any other occupation, and cannot be reasonably eliminated or modified.

SECTION 2 - DEFINITIONS
(Continued)

"**Mental Illness**" means a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) regardless of the underlying cause of the Mental Illness. If the DSM is discontinued, Lincoln will use the replacement chosen or published by the American Psychiatric Association.

"**Monthly Benefit**" means the monthly amount payable by Lincoln to you if you are Disabled or Partially Disabled.

"**Non-Verifiable Symptoms**" means your subjective complaints to a Physician which cannot be diagnosed using tests, procedures or clinical examinations typically accepted in the practice of medicine. Such symptoms may include, but are not limited to, dizziness, fatigue, headache, loss of energy, numbness, pain, ringing in the ear, and stiffness.

"**Own Occupation**" means your occupation that you were performing when your Disability or Partial Disability began. For the purposes of determining Disability under this plan, Lincoln will consider your occupation as it is normally performed in the national economy.

"**Partial Disability**" **or** "**Partially Disabled**" means you, as a result of Injury or Sickness, are able to:

1. perform one or more, but not all, of the Material and Substantial Duties of your Own Occupation or Any Occupation on an Active Employment or a part-time basis; or

2. perform all of the Material and Substantial Duties of your Own Occupation or Any Occupation on a part-time basis; and

3. earn between 20.00% and 80.00% of your Basic Monthly Earnings.

"**Physician**" means a person who:

1. is licensed to practice medicine and is practicing within the terms of his license; or

2. is a licensed practitioner of the healing arts in a category specifically favored under the health insurance laws of the state where the Treatment is received and is practicing within the terms of his license.

It does not include you, any family member or domestic partner.

"**Proof**" means the evidence in support of a claim for benefits and includes, but is not limited to, the following:

1. a claim form completed and signed (or otherwise formally submitted) by you claiming benefits;

2. an attending Physician's statement completed and signed (or otherwise formally submitted) by your attending Physician; and

3. the provision by the attending Physician of standard diagnosis, chart notes, lab findings, test results, x-rays and/or other forms of objective medical evidence in support of a claim for benefits.

Proof must be submitted in a form or format satisfactory to Lincoln.

"**Regular Attendance**" means your personal visits to a Physician which are medically necessary according to generally accepted medical standards to effectively manage and treat your Disability or Partial Disability.

"**Retirement Benefit under a Retirement Plan**" means money which:

1. is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;

2. does not represent contributions made by you (payments which represent your contributions are deemed to be received over your expected remaining life regardless of when such payments are actually received); and

3. is payable upon:

   a. early or normal retirement; or
   b. Disability, if the payment does reduce the amount of money which would have been paid under the plan at the normal retirement age.

SECTION 2 - DEFINITIONS
(Continued)

"**Retirement Plan**" means a plan which provides retirement benefits to you and which is not funded wholly by your contributions. The term shall not include a profit-sharing plan, informal salary continuation plan, registered retirement savings plan, stock ownership plan, 401(K) or a non-qualified plan of deferred compensation.

"**Schedule of Benefits**" means the section of this policy which shows, among other things, the Eligibility Requirements, Eligibility Waiting Period, Elimination Period, Amount of Insurance, Minimum Benefit, and Maximum Benefit Period.

"**Sickness**" means illness, disease, pregnancy or complications of pregnancy.

"**Sponsor**" means the entity to whom this policy is issued.

"**Sponsor's Retirement Plan**" is deemed to include any Retirement Plan:

1. which is part of any Federal, State, Municipal or Association retirement system; or

2. for which you are eligible as a result of employment with the Sponsor.

"**Substance Abuse**" means alcohol and/or drug abuse, addiction or dependency.

"**Treatment**" means consulting, receiving care or services provided by or under the direction of a Physician including diagnostic measures, being prescribed drugs and/or medicines, whether you choose to take them or not, and taking drugs and/or medicines.

SECTION 3 - ELIGIBILITY AND EFFECTIVE DATES

Who is Eligible for Benefits?

The eligibility requirements for insurance benefits are shown in the Schedule of Benefits.

What is Your Eligibility Date for Insurance Benefits?

If you are in an eligible class you will qualify for insurance on the later of:

1. this plan's effective date; or

2. the day after you complete the Eligibility Waiting Period shown in the Schedule of Benefits.

What Happens During the Initial Enrollment Period?

You may enroll in any one coverage or coverage option shown in the Schedule of Benefits. If you do not choose any coverage or coverage option, enrollment will automatically default to Option 1/ the Core Plan. If your Initial Enrollment Period takes place during or after the Annual Enrollment Period, but before the plan anniversary, your coverage option will apply for (a) the rest of the plan year in which you first become eligible; and (b) the next plan year.

What Happens During the Annual Enrollment Period?

You may keep your coverage at the same level or make one of the following changes in coverage for the next plan year:

1. a decrease in coverage;

2. an increase in coverage by one level without Evidence of Insurability.

SECTION 3 - ELIGIBILITY AND EFFECTIVE DATES
(Continued)

What Happens when You Experience a Family Status Change?

You may keep your coverage at the same level or make one of the following changes in coverage:

1. a decrease in coverage;

2. an increase in coverage without Evidence of Insurability.

You must apply for the change in coverage within 31 Days of the date of the Family Status Change. Such change in coverage must be due to or consistent with the reason that the change in coverage was permitted. A change in coverage is consistent with a Family Status Change only if it is necessary or appropriate as the result of the Family Status Change.

What is Your Effective Date of Insurance?

Your insurance will be effective at 12:01 A.M. Standard Time in the governing jurisdiction on the day determined as follows, but only if your application or enrollment for insurance is made with Lincoln through the Sponsor in a form or format satisfactory to Lincoln.

1. For Coverage Applied for During Initial Enrollment Periods:

   a. you will be insured for contributory coverage on the date you make application for insurance if you enroll on or before the 31st day after your Eligibility Date; or
   b. if you do not enroll for contributory coverage on or before the 31st day after your Eligibility Date, or you terminated your insurance while continuing to be eligible you must submit an application and Evidence of Insurability to Lincoln for approval, at your expense. You will be insured on the date Lincoln gives its approval.

SECTION 3 - ELIGIBILITY AND EFFECTIVE DATES
(Continued)

What is Your Effective Date of Insurance? (Continued)

2. For Contributory Coverage Applied for During Annual Enrollment Periods

   You will be insured for the selected contributory coverage on the later of these dates:

   a. the first day of the next policy anniversary; or
   b. the date Lincoln gives its approval, if you:

      i. increase your coverage option; or
      ii. terminated your insurance while continuing to be eligible.

   In the case of i. and ii. above, you must submit an application and Evidence of Insurability to Lincoln for approval. This will be at your expense.

3. For Coverage Applied for Due to a Family Status Change

   You will be insured for the selected coverage on the later of the following dates, provided you apply or enroll for the change in coverage before the end of the 31st Day following the Family Status Change:

   a. the date of the Family Status Change;
   b. the date you apply or enroll for the change in coverage.

When will Your Effective Date for Insurance be Delayed?

Your effective date of any initial, increased or additional insurance will be delayed if you are not in Active Employment because of Injury or Sickness. The initial, increased or additional insurance will begin on the date you return to Active Employment.

SECTION 3 - ELIGIBILITY AND EFFECTIVE DATES
(Continued)

What Happens to Your Coverage During a Family and Medical Leave?

Your coverage may be continued under this plan for an approved family or medical leave of absence for up to 12 weeks following the date coverage would have terminated, subject to the following:

1. the authorized leave is in writing;

2. the required premium is paid;

3. your benefit level, or the amount of earnings upon which your benefit may be based, will be that in effect on the date before the leave begins; and

4. continuation of coverage will cease immediately if any one of the following events should occur:

    a. you return to work;
    b. this plan terminates;
    c. you are no longer in an eligible class;
    d. nonpayment of premium when due by the Sponsor or you;
    e. your employment terminates.

What Happens if You are Rehired?

If you are a former Employee and you are re-hired by the Sponsor within 12 months of your termination date:

1. all past periods of Active Employment with the Sponsor will be used in determining your Eligibility Date; and

2. if you are re-hired by the Sponsor you will be insured for the same coverage that was in effect for you on the date your employment terminated and no change in that coverage may be made during the rest of that plan year, unless you experience a Family Status Change. You may make changes in your coverage options at the next Annual Enrollment Period.

If you are a former Employee and you are re-hired by the Sponsor more than 12 months after your termination date, you are considered to be a new Employee when determining your Eligibility Date.

Leave of Absence

The Sponsor may continue your coverage(s) by paying the required premiums, if you are given a leave of absence.

Your coverage will not continue beyond the end of the policy month following the policy month in which the leave of absence begins. In continuing such coverage under this provision, the Sponsor agrees to treat all covered Employees equally.

Lay-off

The Sponsor may continue your coverage(s) by paying the required premiums, if you are temporarily laid off.

Your coverage will not continue beyond the end of the policy month in which the lay-off begins. In continuing such coverage under this provision, the Sponsor agrees to treat all covered Employees equally.

When will Your Coverage be Continued if You Leave the Group or Your Employment Ends because of a Plant Closing or Partial Closing? (Applicable to Massachusetts Residents only)

If you leave the group covered by this policy, you will remain insured for a period of 31 days, unless during such period you are entitled to similar benefits.

In addition, if you leave the group covered by this policy because your employment is terminated due to plant closing or covered partial closing, you will remain insured under this policy for a period of 90 days, unless during such period you are entitled to similar benefits.

What Happens if There is a Transfer of Insurance Carriers?

In order to prevent loss of coverage for you because of transfer of insurance carriers, this plan will provide coverage for you as follows:

If You are not in Active Employment Due to Injury or Sickness

Subject to premium payments, this plan will cover you if:

1. at the time of transfer you were covered under the prior carrier's plan; and

2. you are not in Active Employment due to Injury or Sickness on the effective date of this plan.

Benefits will be determined based on the lesser of:

1. the amount of the Disability benefit that would have been payable under the prior plan and subject to any applicable plan limitations; or

2. the amount of Disability benefits payable under this plan. If benefits are payable under the prior plan for the Disability, no benefits are payable under this plan.

If You are Disabled Due to a Pre-Existing Condition

If you were insured under the prior carrier's plan at the time of transfer and were in Active Employment and insured under this plan on its effective date, benefits may be payable for a Disability due to a Pre-Existing Condition.

If you can satisfy this plan's Pre-Existing Condition Exclusion, the benefit will be determined according to this plan.

If you cannot satisfy this plan's Pre-Existing Condition Exclusion, then:

1. Lincoln will apply the Pre-Existing Condition Exclusion of the prior carrier's plan; and

2. if you would have satisfied the prior carrier's pre-existing condition exclusion, giving consideration towards continuous time coverage under this plan and the prior carrier's plan, the benefit will be determined according to this plan. However, the Maximum Monthly Benefit amount payable under this plan shall not exceed the maximum monthly benefit payable under the prior carrier's plan.

No benefit will be paid if you cannot satisfy the Pre-Existing Condition Exclusions of either plan.

SECTION 4 - DISABILITY INCOME BENEFITS

LONG TERM DISABILITY COVERAGE

Disability Benefit

When is Your Disability Benefit Payable?

When Lincoln receives Proof that you are Disabled due to Injury or Sickness and require the Regular Attendance of a Physician, Lincoln will pay you a Monthly Benefit after the end of the Elimination Period, subject to any other provisions of this plan. The benefit will be paid for the period of Disability if you give to Lincoln Proof of continued:

1. Disability;

2. Regular Attendance of a Physician; and

3. Appropriate Available Treatment.

The Proof must be given upon Lincoln's request and at your expense. In determining whether you are Disabled, Lincoln will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, paycuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining Disability, the Injury must occur and Disability must begin while you are insured for this coverage.

The Monthly Benefit will not:

1. exceed your Amount of Insurance; or

2. be paid for longer than the Maximum Benefit Period.

The Amount of Insurance and the Maximum Benefit Period are shown in the Schedule of Benefits.

Amount of Disability Monthly Benefit

To figure the amount of your Monthly Benefit:

1. Take the lesser of:

   a. your Basic Monthly Earnings multiplied by the benefit percentage shown in the Schedule of Benefits; or

   b. the Maximum Monthly Benefit shown in the Schedule of Benefits; and then

2. Deduct Other Income Benefits and Other Income Earnings, (shown in the Other Income Benefits and Other Income Earnings provision of this policy), from this amount.

The Monthly Benefit payable will not be less than the Minimum Monthly Benefit shown in the Schedule of Benefits. However, if an overpayment is due to Lincoln, the Minimum Monthly Benefit otherwise payable under this provision will be applied toward satisfying the overpayment.

LONG TERM DISABILITY COVERAGE (Continued)

Partial Disability

When is Your Partial Disability Benefit Payable?

When Lincoln receives Proof that you are Partially Disabled and have experienced a loss of earnings due to Injury or Sickness and require the Regular Attendance of a Physician, you may be eligible to receive a Monthly Benefit, subject to any other provisions of this plan. To be eligible to receive Partial Disability benefits, you may be employed in your Own Occupation or another occupation, must satisfy the Elimination Period and must be earning between 20.00% and 80.00% of your Basic Monthly Earnings.

A Monthly Benefit will be paid for the period of Partial Disability if you give to Lincoln Proof of continued:

1. Partial Disability;
2. Regular Attendance of a Physician; and
3. Appropriate Available Treatment.

The Proof must be given upon Lincoln's request and at your expense. In determining whether you are Partially Disabled, Lincoln will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, paycuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining Partial Disability, the Injury must occur and Partial Disability must begin while you are insured for this coverage.

How is Your Loss of Earnings Partial Disability Benefit Figured using the Loss of Earnings with Work Incentive Monthly Calculation?

For the first 12 Months, the work incentive benefit will be an amount equal to your Basic Monthly Earnings multiplied by the benefit percentage shown in the Schedule of Benefits, without any reductions from earnings. The work incentive benefit will only be reduced, if the Monthly Benefit payable plus any earnings exceed 100% of your Basic Monthly Earnings. If the combined total is more, the Monthly Benefit will be reduced by the excess amount so that the Monthly Benefit plus your earnings does not exceed 100% of your Basic Monthly Earnings.

LONG TERM DISABILITY COVERAGE (Continued)

Partial Disability (Continued)

How is Your Loss of Earnings Partial Disability Benefit Figured using the Loss of Earnings with Work Incentive Monthly Calculation? (Continued)

Thereafter, the Monthly Benefit will be calculated as follows:

1. Your Basic Monthly Earnings minus your earnings received while you are Partially Disabled. This figure represents the amount of lost earnings.

2. Multiply the amount of lost earnings by 75%; and then

3. deduct Other Income Benefits (shown in the Other Income Benefits and Other Income Earnings provision of this plan) from this amount.

The Monthly Benefit payable will not be less than the Minimum Monthly Benefit shown in the Schedule of Benefits. However, if an overpayment is due to Lincoln, the Minimum Monthly Benefit otherwise payable under this provision will be applied toward satisfying the overpayment.

LONG TERM DISABILITY COVERAGE (Continued)

Mental Illness and/or Substance Abuse Limitation

What Limitations will Apply for Mental Illness and/or Substance Abuse?

The benefit for Disability due to Mental Illness and/or Substance Abuse will not exceed a combined period of 24 months of Monthly Benefit payments while the Covered Person is insured under this policy.

If the Covered Person is in a Hospital or Institution for Mental Illness and/or Substance Abuse at the end of the combined period of 24 months, the Monthly Benefit will be paid during the confinement.

If the Covered Person is not confined in a Hospital or Institution for Mental Illness and/or Substance Abuse, but is fully participating in an Extended Treatment Plan for the condition that caused Disability, the Monthly Benefit will be payable to a Covered Person for up to a combined period of 36 months.

In no event will the Monthly Benefit be payable beyond the Maximum Benefit Period shown in the Schedule of Benefits.

LONG TERM DISABILITY COVERAGE (Continued)

Rehabilitation Incentive Benefit

When is Your Rehabilitation Incentive Benefit Payable?

Lincoln will pay an increased Monthly Benefit while you are fully participating in a Rehabilitation Program. Lincoln must first approve the Rehabilitation Program in writing before you can be considered for this benefit. If Lincoln does not approve a Rehabilitation Program, the regular Disability benefit will be payable provided you are Disabled under the terms of this plan. To be eligible for a Rehabilitation Incentive Benefit, you must:

1. be Disabled and receiving benefits under this plan; and

2. be fully participating in a Rehabilitation Program approved by Lincoln.

What is Your Increased Monthly Benefit?

If you are eligible for a Rehabilitation Incentive Benefit, the benefit percentage, shown in the Schedule of Benefits, will be increased by 10.00%. The increased benefit will begin on the first day of the month after Lincoln receives written Proof of your full participation in the Rehabilitation Program.

What is Your Decreased Monthly Benefit?

If you, at any time, decline to fully participate in an approved Rehabilitation Program recommended by Lincoln, the benefit percentage shown in the Schedule of Benefits will be reduced by 20.00% beginning on the first day of the month following your declination to fully participate in the approved Rehabilitation Program. If Lincoln recommends rehabilitation, benefits will be paid at the reduced amount from the date recommendation is made until Lincoln receives your written agreement to fully participate in the Rehabilitation Program.

When will Your Rehabilitation Incentive Benefit be Discontinued?

The Rehabilitation Incentive Benefit will cease:

1. when you are no longer fully participating in a Rehabilitation Program approved by Lincoln;

2. in accordance with the provision[s] entitled "When will Your Long Term Disability Benefit Be Discontinued?"; or

3. when the Rehabilitation Program ends.

LONG TERM DISABILITY COVERAGE (Continued)

Rehabilitation Incentive Benefit (Continued)

For the purpose of this provision, "**Rehabilitation Program**" means a comprehensive individually tailored, goal oriented program to return you, if you are Disabled, to gainful employment. The services offered may include, but are not limited to, the following:

1. physical therapy;
2. occupational therapy;
3. work hardening programs;
4. functional capacity evaluations;
5. psychological and vocational counseling;
6. rehabilitative employment; and
7. vocational rehabilitation services.

LONG TERM DISABILITY COVERAGE (Continued)

Three month Survivor Benefit

What Happens to Your Benefit if You Die?

Lincoln will pay a lump sum benefit to the Eligible Survivor when Proof is received that you died:

1. after Disability had continued for 180 or more consecutive days; and

2. while receiving a Monthly Benefit.

The lump sum benefit will be an amount equal to three times your Last Monthly Benefit.

If the survivor benefit is payable to your children, payment will be made in equal shares to the children, including step children and legally adopted children. However, if any of said children are minors or incapacitated, payment will be made on their behalf to the court appointed guardian of the children's property. This payment will be valid and effective against all claims by others representing or claiming to represent the children.

If an overpayment is due to Lincoln at the time of your death, the benefit payable under this provision will be applied toward satisfying the overpayment.

LONG TERM DISABILITY COVERAGE (Continued)

Workplace Modification Benefit

When is Your Workplace Modification Benefit Payable?

If you are Disabled or Partially Disabled and receiving a benefit from Lincoln, a benefit may be payable to the Sponsor as part of your benefit for modifications to the workplace to accommodate your return to work or to assist you in remaining at work.

Lincoln will reimburse the Sponsor for up to 100% of reasonable costs the Sponsor incurs for the modification, up to the greater of:

1. $1,000.00; or

2. the equivalent of 2 months of your Monthly Benefit.

To qualify for this benefit:

1. the Disability or Partial Disability must prevent you from performing some or all of the Material and Substantial Duties of your occupation; and

2. any proposed modifications must be approved in writing and signed by you, the Sponsor and Lincoln; and

3. the Sponsor must agree to make the modifications to the workplace to reasonably accommodate your return to work or to assist you in remaining at work.

The Sponsor's costs for the approved modifications will be reimbursed after:

1. the proposed modifications have been made; and

2. written proof of the expenses incurred by the Sponsor has been provided to Lincoln; and

3. Lincoln has received proof that you have returned to and/or remain at work.

LONG TERM DISABILITY COVERAGE (Continued)

Other Income Benefits and Other Income Earnings

What are Your Other Income Benefits and Other Income Earnings?

Other Income Benefits means:

1. The amount for which you are eligible under:

   a. Workers' or Workmen's Compensation Laws;
   b. Occupational Disease Law;
   c. Title 46, United States Code Section 688 (The Jones Act);
   d. any work loss provision in mandatory "No-Fault" auto insurance;
   e. Railroad Retirement Act;
   f. any governmental compulsory benefit act or law; or
   g. any other act or law of like intent.

2. The amount of any Disability benefits which you are eligible to receive under:

   a. any other group insurance plan of the Sponsor;
   b. any governmental retirement system as a result of your employment with the Sponsor; or
   c. any individual insurance plan where the premium is wholly or partially paid by the Sponsor. However, Lincoln will only reduce the Monthly Benefit if your Monthly Benefit under this plan, plus any benefits that you are eligible to receive under such individual insurance plan exceed 100% of your Basic Monthly Earnings. If this sum exceeds 100% of Basic Monthly Earnings, your Monthly Benefit under this plan will be reduced by such excess amount.

3. The amount of benefits you receive under the Sponsor's Retirement Plan as follows:

   a. the amount of any Disability Benefits under a Retirement Plan, or Retirement Benefits under a Retirement Plan you voluntarily elect to receive as retirement payment under the Sponsor's Retirement Plan; and
   b. the amount you receive as retirement payments when you reach the later of age 62, or normal retirement age as defined in the Sponsor's plan.

4. The amount of Disability and/or Retirement Benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act, which:

   a. you receive or are eligible to receive; and
   b. your spouse, child or children receive or are eligible to receive because of your Disability; or
   c. your spouse, child or children receive or are eligible to receive because of your eligibility for retirement benefits.

5. Any amount you receive from any unemployment benefits.

LONG TERM DISABILITY COVERAGE (Continued)

Other Income Benefits and Other Income Earnings (Continued)

What are Your Other Income Benefits and Other Income Earnings? (Continued)

Other Income Earnings means:

1. the amount of earnings you earn or receive from any form of employment including severance; and

2. any amount you receive from any formal or informal sick leave or salary continuation plan(s).

Other Income Benefits, except retirement benefits, must be payable as a result of the same Disability for which Lincoln pays a benefit. The sum of Other Income Benefits and Other Income Earnings will be deducted in accordance with the provisions of this policy.

LONG TERM DISABILITY COVERAGE (Continued)

Estimation of Benefits

How will Your Benefits be Estimated?

Lincoln will reduce your Disability or Partial Disability benefits by the amount of Other Income Benefits that we estimate are payable to you and your dependents.

Your Disability benefit will not be reduced by the estimated amount of Other Income Benefits if you:

1. provide satisfactory proof of application for Other Income Benefits;

2. sign a reimbursement agreement under which, in part, you agree to repay Lincoln for any overpayment resulting from the award or receipt of Other Income Benefits;

3. if applicable, provide satisfactory proof that all appeals for Other Income Benefits have been made on a timely basis to the highest administrative level unless Lincoln determines that further appeals are not likely to succeed; and

4. if applicable, submit satisfactory proof that Other Income Benefits have been denied at the highest administrative level unless Lincoln determines that further appeals are not likely to succeed.

Lincoln will not estimate or reduce for any benefits under the Sponsor's pension or retirement benefit plan according to applicable law, until you actually receive them.

In the event that Lincoln overestimates the amount payable to you from any plans referred to in the Other Income Benefits and Other Income Earnings provision of this plan, Lincoln will reimburse you for such amount upon receipt of written proof of the amount of Other Income Benefits awarded (whether by compromise, settlement, award or judgement) or denied (after appeal through the highest administrative level).

When May Lincoln Provide Social Security Assistance?

Lincoln may help you in applying for Social Security Disability Income Benefits. In order to be eligible for assistance you must be receiving a Monthly Benefit from Lincoln. Such assistance will be provided only if Lincoln determines that assistance would be beneficial.

LONG TERM DISABILITY COVERAGE (Continued)

What Happens if You Receive a Lump Sum Payment?

Other Income Benefits from a compromise, settlement, award or judgement which are paid to you in a lump sum and are meant to compensate you for any one or more of the following:

1. loss of past or future wages;
2. impaired earnings capacity;
3. lessened ability to compete in the open labor market;
4. any degree of permanent impairment; and
5. any degree of loss of bodily function or capacity;

will be prorated on a monthly basis as follows:

1. over the period of time such benefits would have been paid if not in a lump sum; or

2. if such period of time cannot be determined, the lesser of:

   a. the remainder of the Maximum Benefit Period; or
   b. 5 years.

What Happens if You Receive any Cost of Living Increases?

After the first deduction for each of the Other Income Benefits, the Monthly Benefit will not be further reduced due to any cost of living increases payable under the Other Income Benefits and Other Income Earnings provision of this plan. This provision does not apply to increases received from any form of employment.

What Happens if Your Benefit Period is Less than a Month?

For any period for which a Long Term Disability benefit is payable that does not extend through a full month, the benefit will be paid on a prorated basis. The rate will be 1/30th for each day for such period of Disability.

When will Your Long Term Disability Benefits be Discontinued?

The Monthly Benefit will cease on the earliest of:

1. the date you fail to provide Proof of continued Disability or Partial Disability and Regular Attendance of a Physician;

2. the date you fail to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;

LONG TERM DISABILITY COVERAGE (Continued)

When will Your Long Term Disability Benefits be Discontinued? (Continued)

The Monthly Benefit will cease on the earliest of: (Continued)

3. the date you refuse to be examined or evaluated at reasonable intervals;

4. the date you refuse to receive Appropriate Available Treatment;

5. the date you refuse a job with the Sponsor where workplace modifications or accommodations were made to allow you to perform the Material and Substantial Duties of the job;

6. the date you are able to work in your Own Occupation on a part-time basis, but choose not to;

7. the date your current Partial Disability earnings exceed 80.00% of your Basic Monthly Earnings;

   Because your current earnings may fluctuate, Lincoln will average earnings over three consecutive months rather than immediately terminating your benefit once 80.00% of Basic Monthly Earnings has been exceeded.

8. the date you do not apply for and/or appeal for Social Security Disability Income Benefits upon advisement and instruction from your assigned Lincoln case manager;

9. the date you are no longer Disabled according to this plan;

10. the end of the Maximum Benefit Period; or

11. the date you die.

LONG TERM DISABILITY COVERAGE (Continued)

Successive Periods of Disability

What Happens if You Return to Work and Become Disabled Again?

With respect to this plan, "**Successive Periods of Disability**" means a Disability which is related or due to the same cause(s) as a prior Disability for which a Monthly Benefit was payable.

A Successive Period of Disability will be treated as part of the prior Disability if, after receiving Disability benefits under this plan, you:

1. return to your Own Occupation on an Active Employment basis for less than twenty six continuous weeks; and

2. perform all the Material and Substantial Duties of your Own Occupation.

To qualify for the Successive Periods of Disability benefit, you must experience more than a 20% loss of Basic Monthly Earnings.

Benefit payments will be subject to the terms of this plan for the prior Disability.

If you return to your Own Occupation on an Active Employment basis for twenty six continuous weeks or more, the Successive Period of Disability will be treated as a new period of Disability. You must complete another Elimination Period.

If you become eligible for coverage under any other group long term disability coverage, this Successive Periods of Disability provision will cease to apply to you.

SECTION 5 - EXCLUSIONS

GENERAL EXCLUSIONS

What Disabilities are Not Covered?

This plan will not cover any Disability due to:

1. war, declared or undeclared, or any act of war;
2. intentionally self-inflicted injuries, while sane or insane;
3. active Participation in a Riot;
4. the committing of or attempting to commit a felony or misdemeanor;
5. cosmetic surgery unless such surgery is in connection with an Injury or Sickness sustained while you are covered under this plan; or
6. a gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change.

No benefit will be payable during any period of incarceration.

With respect to this provision, **Participation** shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in your defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including, but not limited to police officers and fire fighters.

With respect to this provision, **Riot** shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

SECTION 5 - EXCLUSIONS

GENERAL EXCLUSIONS

What Disabilities are Not Covered?

This plan will not cover any Disability due to:

1. war, declared or undeclared, or any act of war;
2. intentionally self-inflicted injuries, while sane or insane;
3. active Participation in a Riot;
4. the committing of or attempting to commit a felony or misdemeanor;
5. cosmetic surgery unless such surgery is in connection with an Injury or Sickness sustained while you are covered under this plan;
6. a gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change; or
7. Non-Verifiable Symptoms.

No benefit will be payable during any period of incarceration.

With respect to this provision, **Participation** shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in your defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including, but not limited to police officers and fire fighters.

With respect to this provision, **Riot** shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

SECTION 5 - EXCLUSIONS
(Continued)

LONG TERM DISABILITY COVERAGE

Pre-Existing Condition Exclusion(s)

What Other Disabilities are Not Covered?

This plan will not cover any Disability or Partial Disability:

1. which is caused or contributed to by, or results from, a Pre-Existing Condition; and

2. which begins in the first 12 months immediately after your effective date of coverage.

"**Pre-Existing Condition**" means a condition resulting from an Injury or Sickness for which you were diagnosed or received Treatment within three months prior to your effective date of coverage.

SECTION 6 - TERMINATION PROVISIONS

When will Your Insurance End?

You will cease to be insured on the earliest of the following dates:

1. the date this plan terminates, but without prejudice to any claim originating prior to the time of termination;

2. the date you are no longer in an eligible class;

3. the date your class is no longer included for insurance;

4. the last day for which any required Employee contribution has been made;

5. the date employment terminates. Cessation of Active Employment will be deemed termination of employment, except the insurance will be continued for an Employee absent due to Disability during:

   a. the Elimination Period; and
   b. any period during which premium is being waived.

6. the date you cease active work due to a labor dispute, including any strike, work slowdown, or lockout.

Lincoln reserves the right to review and terminate all classes insured under this plan if any class(es) cease(s) to be covered.

SECTION 7 - GENERAL PROVISIONS

Is Assignment Allowed?

No assignment of any present or future right or benefit under this policy will be allowed.

How will Lincoln Conform With State Statutes?

Any provision of this plan which, on its effective date, is in conflict with the statutes of the governing jurisdiction of this plan is hereby amended to conform to the minimum requirements of such statute.

What are Lincoln's Examination Rights?

Lincoln, at its own expense, may have the right and opportunity to have the claimant, whose Injury or Sickness is the basis of a claim, examined or evaluated at reasonable intervals deemed necessary by Lincoln. This right may be used as often as reasonably required.

Who has the Authority for Interpretation of this Plan?

Lincoln shall possess the authority, in its sole discretion, to construe the terms of this plan and to determine benefit eligibility hereunder. Lincoln's decisions regarding construction of the terms of this plan and benefit eligibility shall be conclusive and binding.

When can this Plan be Contested?

The validity of this plan shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of this plan shall not be contested on the basis of a statement made relating to insurability by you after such insurance has been in force for two years during your lifetime, and shall not be contested unless the statement is contained in a written instrument signed by you.

When can Legal Proceedings Begin?

A claimant or the claimant's authorized representative cannot begin any legal action:

1. until 60 days after Proof of claim has been given; or

2. more than three years after the time Proof of claim is required.

What Happens if Your Age is Misstated?

If your age has been misstated, an equitable adjustment will be made in the premium. If the amount of the benefit is dependent upon your age, the amount of the benefit will be the amount you would have been entitled to if your correct age were known.

A refund of premium will not be made for a period more than 12 months before the date Lincoln is advised of the error.

SECTION 7 - GENERAL PROVISIONS
(Continued)

When Must Lincoln be Notified of a Claim?

1. Notice of claim must be given to Lincoln within 30 days of the date of the loss on which the claim is based. If that is not possible, Lincoln must be notified as soon as it is reasonably possible to do so. Such notice of claim must be received in a form or format satisfactory to Lincoln.

2. When written notice of claim is applicable and has been received by Lincoln, you will be sent claim forms. If the forms are not received within 15 days after written notice of claim is sent, you can send to Lincoln written Proof of claim without waiting for the forms.

When Must Lincoln Receive Proof of Claim?

1. Satisfactory Proof of loss must be given to Lincoln no later than 30 days after the end of the Elimination Period.

2. Failure to furnish such Proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to furnish such Proof within such time. Such Proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one year from the time Proof is otherwise required.

3. Proof of continued loss, continued Disability or Partial Disability, when applicable, and Regular Attendance of a Physician must be given to Lincoln within 30 days of the request for such Proof.

Lincoln reserves the right to determine if your Proof of loss is satisfactory.

Who are Claims Paid To?

The benefit is payable to you. But, if a benefit is payable to your estate, or if you are a minor, or you are not competent, Lincoln has the right to pay up to $2,000 to any of your relatives or any other person whom Lincoln considers entitled thereto by reason of having incurred expense for the maintenance, medical attendance or burial. If Lincoln in good faith pays the benefit in such a manner, any such payment shall fulfill Lincoln's responsibility for the amount paid.

What are Lincoln's Rights of Recovery?

Lincoln has the right to recover any overpayment of benefits caused by, but not limited to, the following:

1. fraud;
2. any error made by Lincoln in processing a claim; or
3. your receipt of any Other Income Benefits.

Lincoln may recover an overpayment by, but not limited to, the following:

1. requesting a lump sum payment of the overpaid amount;
2. reducing any benefits payable under this policy;
3. taking any appropriate collection activity available including any legal action needed; and
4. placing a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any Other Income Benefits, whether on a periodic or lump sum basis.

It is required that full reimbursement be made to Lincoln.

SECTION 7 - GENERAL PROVISIONS
(Continued)

How will Statements Made In Your Application Affect Your Coverage?

In the absence of fraud, all statements made in any application are considered representations and not warranties (absolute guarantees). No representation by:

1. the Sponsor in applying for this plan will make it void unless the representation is contained in the signed Application; or

2. you in enrolling for insurance under this plan will be used to reduce or deny a claim unless a copy of the Enrollment Form, signed by you if required, is or has been given to you.

What are Lincoln's Rights of Subrogation and Reimbursement?

When your Injury or Sickness appears to be someone else's fault, benefits otherwise payable under this policy for loss of time as a result of that Injury or Sickness will not be paid unless you or your legal representative agree(s):

1. to repay Lincoln for such benefits to the extent they are for losses for which compensation is paid to you by or on behalf of the person at fault;

2. to allow Lincoln a lien on such compensation and to hold such compensation in trust for Lincoln; and

3. to execute and give to Lincoln any instruments needed to secure the rights under 1. and 2. above.

Further, when Lincoln has paid benefits to or on your behalf, Lincoln will be subrogated to all rights of recovery that you have against the person at fault. These subrogation rights will extend only to recovery of the amount Lincoln has paid. You must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to Lincoln.

How does the Policy Affect Workers' Compensation?

This plan and the coverages provided are not in lieu of, nor will they affect any requirements for coverage under any Workers' Compensation Law or other similar law.

SUMMARY PLAN DESCRIPTION

Name of Plan: The Intact Services USA LLC Group Long Term Disability Income Plan

Plan benefits are provided under the terms of the Group Disability Income Policy No. GF3-810-253226-01 hereinafter referred to as "the policy", issued by Lincoln Life Assurance Company of Boston, hereinafter referred to as "Lincoln," to the Employer hereinafter referred to as "Sponsor".

Participants Included: See Schedule of Benefits

Name and Address of Sponsor:

Intact Services USA LLC
150 Royall Street
Canton, MA 02021

Who Pays For the Plan: Premiums are paid by the Sponsor.

The cost of the Plan is funded by both Employer and Employee contributions.

Plan Identification Number:

a. Sponsor IRS Identification No.: 26-3300555

b. Plan No.: 506

Type of Plan: Group Disability Income

Plan Year: January 1st-December 31st

Plan Administrator, Name, Address and Telephone No:

Intact Services USA LLC
605 North Highway 169, Suite 800
Plymouth, MN 55441

Agent for Service of Legal Process on the Plan:

same as above

Type of Administration: Insurer Administration

Funding Arrangement of the Plan: Benefits of the Plan are insured.

Amendment of the Sponsor's Plan:

The Plan Sponsor reserves the right to modify, amend or terminate in whole or in part, any or all provisions of the Plan. Amendments to the Plan are to be made by a written resolution adopted in accordance with the established procedures of the Board of Directors. Amendments may be adopted with retroactive effect to the extent permitted by ERISA and the Code.

Amendment of Lincoln's Policy:

The policy may be changed in whole or in part by mutual agreement of the Sponsor and Lincoln. Only an Officer of Lincoln can approve a change. The approval must be in writing and endorsed on or attached to the policy. No consent of any participant or any other person referred to in the policy(ies) shall be required to modify, amend, or change the policy(ies).

NOTE: If you cease active employment, see your benefits administrator to determine what arrangements, if any, may be made to continue your coverage beyond the date you cease active employment.

When May The Policy Terminate?

1. If the Sponsor fails to pay any premium within the grace period, the policy will automatically terminate at 12:00 midnight of the last day of the grace period. The "grace period" is the 31 days following a premium due date during which premium payment may be paid.

2. The Sponsor may terminate the policy by advance written notice delivered to Lincoln at least 31 days prior to the termination date. But the policy will not terminate during any period for which premium has been paid.

3. Lincoln may terminate the policy on any premium due date by giving written notice to the Sponsor at least 31 days in advance if:

    a. The number of employees insured is less than 10;

    b. less than 25.00% of the Employees eligible for any contributory insurance are insured for it; or

    c. the Sponsor fails:

        i. to furnish promptly any information which Lincoln may reasonably require; or
        ii. to perform any other obligations pertaining to this policy.

4. Termination may take effect on any earlier date when both the Sponsor and Lincoln agree.

No consent of any participant or any other person referred to in the policy(ies) shall be required to terminate the policy(ies).

Termination of Coverage Option(s)

Participation Requirements

Lincoln may terminate coverage or any coverage option afforded hereunder on any premium due date by giving written notice to the Sponsor at least 31 days in advance:

What Are Your Rights In The Event Of Policy Termination?

Termination of the policy under any conditions will not prejudice any payable claim which occurs while the policy is in force.

What Are Your Rights Under ERISA?

1. As a participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

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

    b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

2. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan.

3. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

4. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

6. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

What Are Your Rights Under ERISA? (Continued)

7. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

8. If you have any questions about your Plan, you should contact the Plan Administrator.

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

What is the Time Frame For Claim Decisions?

If your claim is denied, Lincoln will notify you of the adverse decision within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if Lincoln: (1) determines the extension is necessary because of matters beyond the Plan's control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date. If, before the end of the first 30-day extension, Lincoln determines, due to matters beyond the Plan's control, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days, provided Lincoln notifies you, before the end of the first 30-day extension period, why the extension is needed and the expected decision date.

The notice of extension shall explain: (1) the standards on which benefit entitlement is based, (2) the unresolved issues that prevent a claim decision, and (3) the additional information needed. You have at least 45 days to provide the information.

The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date Lincoln sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

What If Your Claim Is Denied?

Lincoln's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those specific Plan provisions on which the denial is based;

2. A description of any additional material or information necessary to perfect the claim and an explanation of why that material or information is necessary;

3. A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring a civil action under ERISA following an adverse decision on appeal;

4. Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;

6. If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration;

7. A statement that you are entitled, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim; and

8. Notice in a culturally and linguistically appropriate manner.

What Do You Do To Appeal A Claim Denial?

You, or your authorized representative, may appeal a denied claim within 180 days after you receive Lincoln's notice of denial. You have the right to:

1. Submit to Lincoln, for review, written comments, documents, records, and other information relating to the claim;

2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;

3. A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision;

4. A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person's subordinate;

5. If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual;

6. The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision; and

7. A review and reasonable opportunity to respond to any new or additional evidence considered, relied upon, or generated, or any new or additional rationale in support of an adverse decision, before an adverse decision is rendered.

What Do You Do To Appeal A Claim Denial? (Continued)

Lincoln will make a full and fair review of your appeal and may require additional documents as it deems necessary in making such a review. A final decision on the review will be made within a reasonable period of time but not later than 45 days following receipt of the written request for review unless Lincoln determines that special circumstances require an extension. In such case, a written notice will be sent to you before the end of the initial 45-day period. The extension notice shall indicate the special circumstances and the date by which Lincoln expects to render the appeal decision. The extension cannot exceed a period of 45 days from the end of the initial period.

The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

Lincoln's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

2. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim;

3. A statement describing any voluntary appeal procedures offered by Lincoln and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA, including any applicable contractual limitations period that applies to your right to bring such an action and the calendar date on which the contractual limitations period expires;

4. Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;

6. If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration; and

7. Notice in a culturally and linguistically appropriate manner.

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

Lincoln Financial Group® Privacy Practices Notice

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. We do not sell your personal information to third parties. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. You do not need to take any action because of this Notice, but you do have certain rights as described below.

Information We May Collect And Use

We collect personal information about you to help us identify you as our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; to analyze in order to enhance our products and services; or to tell you about our products or services we believe you may want and use; and as otherwise permitted by law. The type of personal information we collect depends on the products or services you request and may include the following:

- **Information from you:** When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history.
- **Information about your transactions:** We maintain information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment and claims history.
- **Information from outside our family of companies**: If you are purchasing insurance products, we may collect information from consumer reporting agencies such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information, such as medical information from other individuals or businesses.
- **Information from your employer**: If your employer purchases group products from us, we may obtain information about you from your employer in order to enroll you in the plan.

How We Use Your Personal Information

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you have requested; provide customer service; to analyze in order to enhance our products and services; and inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, regulatory authorities and law enforcement officials, and to other non-affiliated or affiliated parties as permitted by law. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

Security of Information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are required to complete privacy training annually.

Your Rights Regarding Your Personal Information

Access: We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you request a copy of the information, we may charge you a fee for copying and mailing costs. In very limited circumstances, your request may be denied. You may then request that the denial be reviewed.

Accuracy of Information: If you feel the personal information we have about you is inaccurate or incomplete, you may ask us to amend the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years. If your requested change is denied, we will provide you with reasons for the denial. You may write to request the denial be reviewed. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request.

Accounting of Disclosures: If applicable, you may request an accounting of disclosures made of your medical information, except for disclosures:

- For purposes of payment activities or company operations;
- To the individual who is the subject of the personal information or to that individual's personal representative;
- To persons involved in your health care;
- For notification for disaster relief purposes;
- For national security or intelligence purposes;
- To law enforcement officials or correctional institutions;
- Included in a limited data set; or
- For which an authorization is required.

You may request an accounting of disclosures for a time period of less than six years from the date of your request.

Basis for Adverse Underwriting Decision: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate, or terminate your coverage.

Your state may provide for additional privacy protections under applicable laws. We will protect your information in accordance with these additional protections.

If you have questions about your personal information, please provide your full name, address and telephone number and either email your question to our Data Subject Access Request Team at DSAR@lfg.com or mail to:

Lincoln Financial Group
Attn: Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Distributors, Inc.
Lincoln Financial Group Trust Company
Lincoln Investment Advisors Corporation
Lincoln Life & Annuity Company of New York
Lincoln Life Assurance Company of Boston
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company

GROUP VOLUNTARY ACCIDENT SUMMARY PLAN DESCRIPTION

FOR

EMPLOYEES OF INTACT SERVICES USA LLC

THIS INSURANCE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY.

IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.

OneBeacon America Insurance Company
1 Beacon Lane
Canton, MA 02021-1030

POLICYHOLDER: **Intact Services USA LLC**

POLICY NUMBER: **212-000-009**

COVERED SUBSIDIARIES OR AFFILIATED COMPANIES **Atlantic Specialty Insurance Company**
A.W.G. Dewar, Inc.

The insurance evidenced by this Certificate provides Accident insurance only. It does not provide Coverage for sickness. This Certificate describes the main features of the Policy, but the Policy is the only contract under which benefit payments are made. If there is an inconsistency between the Certificate and the Policy, the Policy will govern.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT
CERTIFICATE OF INSURANCE

Table of Contents

SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

PRIMARY INSURED PERSON – CERTIFICATE HOLDER.

Class	Description
1	All **Active** employees of the **Policyholder** working a minimum of 20 hours per week who have submitted completed enrollment materials.

Effective Date. A. If **You** are hired prior to January 1, 2008:
January 1, 2008, provided the completed enrollment material is received by the **Policyholder** on or prior thereto.

B. If **You** are hired on or after January 1, 2008:
on **Your** first day **Active** work provided **Your** completed enrollment material is received by the **Policyholder** on or prior thereto.

If **You** are not **Actively at Work** on **Your** Effective Date of coverage, coverage will begin on **Your** first full day of **Active** work following **Your** Effective Date.

Termination Date. Your coverage terminates at the end of the period for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. **You** cease to be eligible for coverage;
3. **You** fail to pay the required premium, if **You** are so required;
4. **You** retire.

If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, or are on a list of grandfathered employees on LTD as on file with **Us** and the **Policyholder**, **Your** insurance under the **Policy** will continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of the **Policy** with the exception of number 2. above.

PRIMARY INSURED PERSON'S DEPENDENTS.

Eligibility. Individuals who enroll may elect to cover their eligible **Dependents**. An eligible **Dependent** includes **Your Spouse** and **Your Dependent Child(ren)**, and **Your Spouse's Dependent Child(ren)**. **Your Spouse** will not be eligible as a **Dependent** if he or she is also a **Primary Insured Person** under the **Policy**. If **You** and **Your Spouse** or former **Spouse** are both **Primary Insured Persons** under the **Policy**, only one may select a **Plan** covering **Your** mutual **Dependents**.

Effective Date. Dependent coverage begins on the later of:

1. the date **Your** coverage begins, provided **You** requested **Dependent Coverage** on **Your** enrollment materials;
2. the date **You** request to add coverage for **Your** eligible **Dependents** in the applicable benefit materials; or
3. the date he or she becomes an eligible **Dependent**.

Termination Date. Coverage terminates at the end of the period for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. **Your Dependent** ceases to be eligible for insurance;
3. **Your** coverage terminates, except in such situations where the written policy of the **Policyholder** allows **You** to continue coverage for **Your Covered Dependents**;
4. **You** fail to pay the required premium, if **You** are so required; or
5. for **Your Covered Spouse**, he or she reaches age 70.

If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, or are is on a list of grandfathered employees on LTD as on file with **Us** and the **Policyholder**, insurance for **Your Covered Dependents** under the **Policy** may continue, provided the required premiums are paid. This extension of coverage **is** subject to all of the termination provisions of the **Policy** with the exception of number 2. above.

SECTION II – SCHEDULE

HAZARDS

The following are the **Hazards** for which insurance applies:

Class 1 including their **Covered Dependents**, if any:	24 Hour **Accident** Protection, Business and Pleasure, Excluding Corporate Owned or Leased Aircraft

Additional Coverages

Class 1 and their **Covered Dependents**, if any:	Exposure and Disappearance Coverage

BENEFITS

A. Principal Sum

The following are the **Principal Sums** for each Class:

Class 1 **You** may purchase an amount of **Principal Sum** from a minimum of one (1) times **Your Base Annual Earnings*** to a maximum of six (6) times **Your Base Annual Earnings***, rounded up to the next highest $1,000, to a maximum amount of $500,000.

***Base Annual Earnings** means **Your** base annual pay excluding overtime, bonuses, commissions and special compensation.

The following are the **Principal Sums** for **Covered Dependents**:

The **Principal Sum** for **Covered Dependents** will be a percentage of **Your Principal Sum:**

Plan Selected	**% Spouse**	**% Child(ren)**
Spouse only:	60%	0
Dependent Child(ren) only:	0	20%
Spouse and **Dependent Child(ren)**	50%	15%

Maximum of $25,000 **Accidental Death Benefit** for **Dependent Child(ren)**.

Principal Sum Reduction

At age 70, for **You** only, the **Principal Sum** will be reduced based on **Your** previous **Principal Sum** on the January 1st after **Your** attainment of the ages specified below:

Age at Date of Loss	**Percent of Principal Sum**
70-74	65%
75-79	45%
80-84	30%
85 & Over	15%

B. Accidental Death Benefit

This benefit applies to Class 1 and their **Covered Dependents**, if any.

C. Accidental Dismemberment and Covered Loss of Use Benefit

This benefit applies to Class 1 and their **Covered Dependents**, if any.

D. Coma Benefit

This benefit applies to Class 1 and their **Covered Dependents**, if any.

E. Additional Benefits

Class I:	Additional Dismemberment Benefit for Children
	Continuation of Coverage Benefit
	Rehabilitation Benefit
	Spouse Vocational Training Benefit
Class 1 and their **Covered Dependents**, if any:	Day Care Benefit
	Higher Education Benefit
	Seat Belt Benefit
	Travel Assistance

SECTION III – HAZARDS

24 HOUR ACCIDENT PROTECTION, BUSINESS AND PLEASURE EXCLUDING CORPORATE OWNED OR LEASED AIRCRAFT

The **Policy** insures against the following **Hazards:**

A **Covered Injury** sustained by **You** anywhere in the world, subject to the terms, conditions, exclusions and limitations under the **Policy**.

Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while **You** are a passenger riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
   - **a.** medical certificate; and
   - **b.** pilot certificate with a proper rating to pilot such aircraft.
2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

Hazard Exclusions:

Coverage is not provided:

1. If **You** are the pilot, operator, member of the crew or cabin attendant of any aircraft.
2. Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   - **a.** any aircraft other than those expressly stated in this **Hazard**;
   - **b.** any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder**;
   - **c.** any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured Person** or a member of an **Insured Person's** family or household;

d. any aircraft operated by the **Policyholder** or one of the **Policyholder's** employees including members of an employee's family or household;

e. any aircraft engaged in a **Specialized Aviation Activity**;

f. any conveyance used for tests or experimental purposes, or in a race or speed test.

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.

SECTION IV – ADDITIONAL COVERAGES

EXPOSURE AND DISAPPEARANCE COVERAGE

If **You** are exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which **You** are riding disappears, is wrecked, or sinks, and **You** are not found within 365 days of the event, **We** will presume that **You** lost **Your** life as a result of **Injury**. If travel in such conveyance was covered under the terms of the **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that **You** survived the event.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

We will pay the applicable **Principal Sum**, if an **Insured Person** sustains a loss of life as a result of a **Covered Injury**, and the death occurs within 365 days of the **Covered Injury**.

This benefit is subject to the limitations in Section VII Limitations.

ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT

We will pay the benefit amount shown below, if an **Injury** to an **Insured Person** results in any of the following **Covered Losses**, provided the **Covered Loss** occurs within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person sustaining the **Covered Loss**.

Covered Loss of	**Benefit**
• Both Hands or Both Feet	**Principal Sum**
• One Hand and One Foot	**Principal Sum**
• One Hand or One Foot plus the loss of Sight of One Eye	**Principal Sum**
• Sight of Both Eyes	**Principal Sum**
• Speech and Hearing	**Principal Sum**
• Speech or Hearing	50% of **Principal Sum**
• One Hand; One Foot; or Sight of One Eye	50% of **Principal Sum**
• Thumb and Index Finger of the same Hand	25% of **Principal Sum**

Covered Loss of Use of	**Benefit**
• Both Arms and Both Legs	**Principal Sum**
• Both Arms or Both Legs or a Combination of an Arm and a Leg	75% of **Principal Sum**

- One Arm or One Leg — 50% of **Principal Sum**
- Both Hands or Both Feet or a Combination of a Hand and a Foot — 50% of **Principal Sum**
- One Hand or One Foot — 25% of **Principal Sum**

A reduced benefit will be payable equal to 50% of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after 365 days, the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.

For purposes of this benefit:

- **Covered Loss** means:
  - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
  - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - **c.** Total and permanent loss of sight;
  - **d.** Total and permanent loss of speech;
  - **e.** Total and permanent loss of hearing.
- **Covered Loss of Use** means total paralysis of an arm, leg, hand, or foot, which has continued for 12 consecutive months and is determined by **Our** competent medical authority to be permanent, complete and irreversible.

This benefit is subject to the limitations in Section VII Limitations.

COMA BENEFIT

We will pay a **Coma Benefit,** if an **Insured Person** sustains an **Injury** resulting in a **Covered Loss** within 365 days of a **Covered Accident**, and such **Injury** causes the **Insured Person** to be in a **Coma** for at least thirty-one (31) consecutive days.

The **Coma Benefit** is equal to 1% of the **Insured Person's Principal Sum**, and will be paid each month the **Insured Person** remains in a **Coma** following the initial thirty-one (31) day period. The **Coma Benefit** will end on the earliest of the following:

1. the **Insured Person** is no longer in a **Coma** which directly resulted from the **Injury**;

2. the **Insured Person** has received a **Coma Benefit** for 100 months.

Brief periods of consciousness of no more than one (1) day in duration will not effect the **Insured Person's** eligibility for, or continuation of, benefits.

Coma will be determined by **Our** duly licensed **Physician**.

This benefit is subject to the limitations in Section VII Limitations.

SECTION VI – ADDITIONAL BENEFITS

ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN

We will pay **You** a benefit that will be equal to an additional 100% of the benefit amount provided by the **Accidental Dismemberment Benefit** that is payable under the **Accidental Dismemberment Benefit**, if **You** select a **Plan** covering **Your** eligible **Dependent Child(ren),** and **Your Covered Dependent Child** sustains an **Injury** resulting in a **Covered Loss**.

CONTINUATION OF COVERAGE BENEFIT

All **Coverages** under the **Policy** that were in force on the date of the indicated **Covered Loss**, with respect to **Insured Persons** other than **You**, will be continued automatically for 365 days after the date of the **Covered Loss** at no additional

cost, if **You** select a **Plan** covering **Your Dependents,** and **You** sustain an **Injury** resulting in a **Covered Loss,** which is payable under the **Accidental Death Benefit**.

DAY CARE BENEFIT

We will pay an additional benefit for Day Care expenses, if **You** select a **Plan** covering **Your Dependents** and **You** or **Your Covered Spouse** sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to the individual who incurs the expense on behalf of each **Covered Dependent Child** if:

1. on the date of the **Accident**, the **Covered Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within ninety (90) days from the date of **Covered Loss**; and
2. the **Covered Dependent Child** is under age 13.

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the Day Care;
2. 3% of the **Principal Sum** of the **Insured Person** who sustained the **Covered Loss**; or
3. $3,000.

If both **You** and **Your Covered Spouse** sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Day Care Benefit** will be based on **Your Principal Sum**.

The **Day Care Benefit** will be paid annually for up to[four (4) consecutive years, if:

1. the **Covered Dependent Child** is under age thirteen (13) at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the **Covered Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

HIGHER EDUCATION BENEFIT

We will pay an additional benefit for Higher Education expenses, if **You** select a **Plan** covering **Your Dependents** and **You** or **Your Covered Spouse** sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit.** This benefit will be paid to the individual who incurs the expense on behalf of each **Covered Dependent Child** if:

1. on the date of the **Accident**, the **Covered Dependent Child** was enrolled as a full-time student in an accredited college, university or trade school; or
2. the **Covered Dependent Child** was at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The **Higher Education Benefit** will be equal to the lesser of:

1. 5% of the **Principal Sum** of the **Insured Person** who sustained the **Covered Loss**; or
2. $5,000.

If both **You** and **Your Covered Spouse** sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Higher Education Benefit** will be based on **Your Principal Sum**.

The **Higher Education Benefit** will be paid annually for up to four (4) consecutive years, if:

1. the **Covered Dependent Child** continues his or her Higher Education; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the **Covered Dependent Child** remains enrolled in an institution of higher learning on a full-time basis.

If, at the time of the **Accident**, a **Plan** covering **Your Dependents** was selected, but there are no **Covered Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of $1,000 to the designated beneficiary.

REHABILITATION BENEFIT

We will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training**, if **You** sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit.** The benefit will be in an amount equal to the lesser of:

1. the actual expenses that are incurred within two (2) years from the date of the **Accident** for the **Rehabilitation Training**;
2. $10,000; or
3. 10% of **Your Principal Sum**.

Rehabilitation Training means a treatment program that:

1. is prescribed by a licensed **Physician** acting within the scope of his or her license that is approved by **Us** prior to the provision of services;
2. is required due to **Your Injury**; and
3. prepares **You** for an occupation that **You** would not have engaged in except for the **Injury**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

SEAT BELT BENEFIT

We will pay an additional benefit equal to 10% of the applicable **Principal Sum** up to a maximum of $10,000, if an **Insured Person** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, provided that the **Insured Person** was:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of the **Insured Person's** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

We will not pay a **Seat Belt Benefit** if the **Insured Person** is the operator of a private passenger automobile at the time he or she incurs such **Covered Injury** and is either:

1. under the influence of alcohol;
   a. An **Insured Person** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Insured Person's** intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.

SPOUSE VOCATIONAL TRAINING BENEFIT

We will pay the actual cost of any professional or trade-training program in which **Your Covered Spouse** enrolls, if **You** select a **Plan** covering **Your Spouse**, and **You** sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit.** This benefit will be paid to **Your Covered Spouse**, provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;
2. the actual cost is incurred within thirty (30) months from **Your** death; and
3. the professional or trade training program is licensed by the state.

The maximum amount payable under this benefit will be the lesser of 2% of **Your Principal Sum** or $3,000.

TRAVEL ASSISTANCE

Travel Assistance will be available to the following **Insured Persons** when they are traveling 100 miles or more from their **Principal Residence**: **You** and **Your Spouse** and/or **Child(ren)**, if covered under the **Policy**. The transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. Under the **Policy**, **Travel Assistance** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**.

For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider.

Assisted Repatriation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to his or her **Principal Residence,** or to his or her residence in the country where he or she is currently assigned (at his or her option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered.

Post-Recovery Repatriation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending **Physician**. The upgrade will be subject to **Our** sole discretion.

Return of Remains
If an **Insured Person** dies while on a **Covered Trip**, **We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable.

Visit to Hospital
If an **Insured Person** is scheduled to be hospitalized for more than seven (7) consecutive days while on a **Covered Trip, We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Insured Person** to visit the **Insured Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable.

Return of Child
If an **Insured Person** is traveling with a **Child(ren),** who is under nineteen (19) years of age or a **Child(ren)** who prior to age nineteen (19) became incapable of self-sustaining employment by reason of mental retardation or physical

handicap and remains chiefly dependent upon the **Insured Person** for support and maintenance, while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Insured Person**, such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Insured Person**, and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable.

Return of Companion
If an **Insured Person** is traveling with a companion while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person** the **Insured Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable.

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section VIII General Exclusions of this **Certificate**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from the deliberate ingestion of a poison, fume, noxious chemical substance; or the use of a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions;
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Insured Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Insured Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation; or
7. **We** did not pre-authorize the transportation and/or services.

- **TRAVEL ASSISTANCE DEFINITIONS**

For purposes of **Travel Assistance** only, the following definitions apply:

Covered Trip means when an **Insured Person** is traveling more than 100 miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

Illness or **Ill** means a sickness or disease which impairs normal functions of the body.

Principal Residence means the legal domicile of the **Insured Person**.

Western Medical Standards means generally accepted medical standards comparable to those in the United States, or Canada or Western Europe.

For the purpose of **Travel Assistance**, if there are any differences in the definition of a term between **Travel Assistance** and the **Policy**, the definition in **Travel Assistance** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

Right of Recovery
We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder** or **Insured Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured Person** that were covered under **Travel Assistance**. **We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance**.

Reservation of Rights
We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services or in any country for which a travel warning has been issued by the Department of State of the United States of America.

Scope
Illness, as covered under **Travel Assistance**, is solely covered under **Travel Assistance**, and in no way supersedes or modifies the other **Coverages** provided under the **Policy**. All other **Coverages** provided under the **Policy** are available only as a result of a **Covered Injury**.

To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call 1-866-670-6693 from the U.S. or Canada; and collect from anywhere else in the world at +1-973-630-6693.

SECTION VII – LIMITATIONS

Limitation on Multiple Covered Losses.

We will pay only one benefit, the largest benefit, if an **Insured Person** sustains more than one loss as a result of the same **Accident**.

Limitation on Multiple Benefits.

The most **We** will pay for the following benefits, in total, is the **Insured Person's Principal Sum,** if the **Insured Person** can recover benefits under more than one of these: **Accidental Death Benefit**, **Accidental Dismemberment and Covered Loss of Use Benefit**, and **Coma Benefit** as a result of the same **Accident**.

Limitation on Multiple Hazards.

We will pay only one benefit, the largest benefit, if **an Insured Person** sustains a **Covered Loss** that is covered under more than one **Hazard**.

SECTION VIII – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

- suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
- war or any act of war, whether declared or undeclared;
- involvement in any type of active military service. (For purposes of this exclusion, orders to active military service for sixty (60) days or less will not be considered involvement in active military service.);
- illness or disease; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease;
- participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot;
- travel or flight in any aircraft except to the extent stated in the **Hazards** Section.

SECTION IX – CLAIMS PROVISIONS

Notice. You or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within twenty (20) days of such **Covered Loss**. The notice must name **You**, the **Insured Person** who sustained the **Injury**, and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 1-866-538-2233. The notice must be sent to the Claims Department, OneBeacon America Insurance Company, P.O. Box 1009, Morristown, NJ 07962-1009, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. We will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss**.

Proof of Covered Loss. Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss,** and the proof was provided as soon as reasonably possible.

Time of Payment. We will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

Recipient of Payment.

1. **Your** Loss of Life. **Covered Losses** resulting from **Your** death are paid to **Your** named beneficiary at the time of death. If there is no beneficiary named or **Your** named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:
   a. **Your Spouse**;
   b. **Your** child(ren);
   c. **Your** parents;
   d. **Your** brothers and sisters;
   e. **Your** estate.
2. **Your Covered Dependent's** Loss of Life. **Covered Losses** for the death of **Your Covered Dependent** will be paid to **You**. If **You** pre-decease or die at the same time as **Your Covered Dependent**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.
3. All Other Claims. Benefits are to be paid to **You**.

Physical Examination and Autopsy. We have the right to examine the **Insured Person** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

Choice of Service Provider. The **Insured Person** has the sole right to choose his or her duly licensed **Physician** and hospital.

Right to Recover Overpayments. In addition to any rights of recovery or reimbursement provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under the **Policy** to the extent of the overpayment.

Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the **Insured Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

SECTION X – GENERAL PROVISIONS

Beneficiaries. You have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time unless **You** have assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.

Change or Waiver. A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

Clerical Error. A clerical error or omission will not increase or continue **Your Coverage**, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity with Statute. Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

Assignment of Interest. A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.

Incontestability. The validity of the **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.

SECTION XI – DEFINITIONS

- **Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.
- **Active** or **Actively at Work** describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered actively at work provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.
- **Chartered Aircraft** means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than ten (10) consecutive days and/or for no more than fifteen (15) days in a one (1) year period.
- **Controlled** by, as used in the **Hazards** Section, means the **Policyholder** has the right to use a block of aircraft flight time for 25 or more hours in a one (1) year period or for 100 hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled** by the **Policyholder**.

- **Coverage(s)** means the event or events described in the **Hazards** Section and Additional Coverages Section of this **Certificate** to which benefits and additional benefits apply. The **Hazards** and Additional Coverages are listed in the Schedule.
- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Insured Person** is insured under the **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.
- **Dependent** means **Your Spouse** and **Dependent Child(ren)**, as defined in this Section. The **Dependent** will only be a **Covered Dependent** if **You** select a **Plan** covering **Your Dependents**.
- **Dependent Child(ren)**, if used in this **Certificate**, means **Your** unmarried **Child(ren)**, and those unmarried **Child(ren)** of **Your Spouse** who rely on **You** for more than 50% of their support through the end of the month in which such **Child(ren)** has attained age 26 (twenty-six), or who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap. The **Dependent Child(ren)** will only be **Covered Dependent Child(ren)** if **You** select a **Plan** covering **Your Dependent Child(ren)**.
- **Injured, Injury or Injuries** means bodily harm or bodily damage.
- **Insured Person** means any person who has insurance under the terms of the **Policy**. It includes **You**, and **Your Spouse** and/or **Dependent Child(ren)** if **You** select a **Plan** covering **Your Spouse** and/or **Dependent Child(ren)**.
- **Owned Aircraft** means an aircraft in which the **Policyholder** or a related company has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.
- **Physician** means a person who is licensed to practice medicine in the jurisdiction in which the medical service or treatment is performed and is acting within the scope of his or her license.
- **Plan** means the plan design as described in the Schedule**.**
- **Policy** means the Group **Accident** Insurance **Policy**.
- **Policyholder** means the group named on the front page of the **Policy**.
- **Primary Insured Person** means an individual who is eligible for coverage under the **Policy** as provided in the Eligibility of **Primary Insured Persons** part of Section I and who completes the enrollment material. The **Primary Insured Person** is the Certificate Holder.
- **Specialized Aviation Activity** means an aircraft while it is being used for one or more of the following activities:

  acrobatic or stunt flying
  aerial photography
  banner towing
  bird or fowl herding
  crop dusting
  crop seeding
  crop spraying
  endurance tests
  exploration
  fire fighting
  hanggliding
  hunting
  parachuting or skydiving
  pipe line inspection
  power line inspection
  racing
  skywriting
  test or experimental purpose

  flight on a rocket-propelled or rocket launched aircraft

  flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted
- **Spouse**, if used in the **Policy**, means **Your** legally married **Spouse** under age 70. **Your Spouse** will only be a **Covered Spouse** if **You** select a **Plan** covering **Your** eligible **Spouse**.

- **Under lease**, as used in the **Hazards** Section**,** means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than ten (10) consecutive days and/or for more than fifteen (15) days in a one (1) year period. A **Chartered Aircraft** will not be considered **Under lease**.
- **We**, **Us** and **Our** refers to OneBeacon America Insurance Company.
- **You** and **Your** refers to the **Primary Insured Person**.

In Witness Whereof, We have caused the Policy to be executed and attested.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Michael Miller, President & CEO
OneBeacon America Insurance Company

ONEBEACON AMERICA INSURANCE COMPANY

ATLANTIC SPECIALTY INSURANCE COMPANY

CERTIFICATE OF ASSUMPTION

EFFECTIVE OCTOBER 1, 2012

Policy #212-000-009

Policyholder: OneBeacon Services, LLC

You are hereby notified that, for all purposes on and after the Effective Date specified above, Atlantic Specialty Insurance Company ("Atlantic Specialty") has assumed liability for your policy of insurance originally issued by OneBeacon America Insurance Company ("OneBeacon America").

On and after the Effective Date, Atlantic Specialty has assumed all rights and duties under your policy and all references in the policy to OneBeacon America are hereby changed to Atlantic Specialty. All correspondence and inquiries such as policy changes and notices of claims should continue to be submitted to the current addresses under the company name of Atlantic Specialty Insurance Company.

This Certificate of Assumption forms a part of and should be attached to the insurance policy issued to you by OneBeacon America.

IN WITNESS WHEREOF, Atlantic Specialty Insurance Company has caused this Certificate of Assumption to be duly signed and issued.

Secretary

President

ERISA
SUMMARY PLAN DESCRIPTION
INFORMATION

The plan described in this Certificate, together with the following information, constitutes the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 as amended.

The Plan Sponsor is:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441
The Employer Identification Number (EIN) is:	26-3300555
The Plan Number is:	502
The Plan Administrator is:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441
The Claims Fiduciary is:	Intact Services USA LLC
The agent for the service of legal process is:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441 800-527-1255

The benefits of the Plan are provided under Policy No. 212-000-009 underwritten by OneBeacon America Insurance Company located in Canton, MA with administrative offices in Morristown, NJ.

The plan is financed through contributions made by: The Employees of Intact Services USA LLC

Plan Year Ends: December 31

For a description of the eligibility requirements of the plan, the amount and type of benefits available, the circumstances under which benefits under the plan are not available or may terminate, please refer to this Certificate.

Plan Termination: The right is reserved in the plan for the Plan Administrator to terminate, suspend, withdraw, or amend the plan in whole or in part at any time, subject to the applicable provisions of the Policy.

CLAIM PROCEDURES

Filing a Claim for Benefits

When you are reasonably sure that you are eligible to receive benefits under this plan, you may request a claim form from the Plan Administrator. All claims submitted to the Insurer must be on forms provided by the Insurer (unless forms are not currently available), in which case you, your beneficiary or a legally authorized representative may simply supply the appropriate party with a written statement outlining proof and extent of loss. Complete the claim form according to directions and return the claim form to the Plan Administrator.

From the date your notice of claim is returned, the insurance company has 90 days in which to review the claim to determine whether or not benefits are payable in accordance with the terms and provisions of the Group Policy. Under special circumstances the insurance company may require an extension of the 90 day period in which case you will receive written notice from the insurance company, prior to the end of the initial 90 days, informing you of the need for an extension. This extension period allows the insurance company an additional 90 days to review your claim. During this period the insurance company may require a medical examination, at its own expense, or additional information in order to make a determination on your claim. If additional information is required you will receive a request, in writing, specifying the nature of the information needed and an explanation as to why it is needed. If a medical examination is necessary, you will be given the time of appointment and the doctor's name and location. It is important to keep any appointments made since rescheduling exams will delay the claim process.

If you are not notified of the claim status within 90 days and you have not been notified that the extension period has been applied, you may request a review of your claim by following the procedure outlined under "Claim Review Procedure."

Once your claim has been approved, you will receive the appropriate benefit from the insurance company.

What if your Benefits are denied?

If your claim for benefits is denied in whole or in part, you will receive written notice of such denial within the 90 day period stated above (or 180 days if the extension period is required).

Each written notice of denial shall set forth:

1. the specific reason(s) for the denial of the claim;
2. a specific reference to the provision(s) of the Group Policy upon which the denial is based;
3. a description of any additional information or material needed and why; and
4. notice of your rights to have the denial reviewed by the insurance company, and to bring suit under ERISA if the review also results in an adverse benefit determination.

Claim Review Procedure

If you receive a written notice of denial, you or your duly authorized representative may request a review of the claim by giving written notice to the insurance company. This request for a review must be made to the insurance company within 60 days of the receipt of denial by the insurance company. If such request is not made within 60 days you will be deemed to have waived your right to a review.

Once the insurance company receives a request for a review, a prompt review of the claim must take place. You or your authorized representative have the right to review documents that might have a bearing on the claim, including the documents which establish and control the plan, and to submit issues and comments that you feel might affect the outcome of the review.

Upon completion of a full and complete review, the insurance company will notify you in writing of the results, citing plan provisions that control the decision. The insurance company has 60 days to notify you of its decision unless special circumstances require an extension of time. If an extension is required, the insurance company shall notify you of the need for an extension before the end of the initial 60-day period for completing the review procedure. This means that the insurance company will have an additional 60 days to notify you of the decision on your denied claim.

What If Your Benefits Continue To Be Denied?

If your claim for benefits continues to be denied, you will receive written notice of such continued denial within the 60-day period stated above (or 120 days if an extension period is required).

The written notice of denial shall set forth:

1. the specific reason(s) for the continued denial on review of the claim;
2. reference to the specific plan provision(s) on which the denial on review is based;
3. a statement regarding your right to access and receive copies of relevant documents, records and other information upon request, without charge; and
4. notice of your rights to pursue other voluntary dispute resolution alternatives, if available, and to bring suit under ERISA.

Statement of ERISA Rights

Your Rights under ERISA: Your Employer intends to comply fully with the Employee Retirement Income Security Act of 1974 and the regulations under the Act as it understands them. The Act provides for certain rights and protections for each participant of the Plan. As a participant in this Group Insurance Plan you may:

1. Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Our Policy Regarding Your Privacy

In order to provide the insurance products and services that respond to our customers' diverse needs, OneBeacon Insurance Group collects certain personal information. OneBeacon Insurance Group does not disclose any nonpublic personal information to any affiliated or nonaffiliated third party for marketing purposes. At OneBeacon Insurance Group, maintaining the confidentiality of our customers' personal information is of the highest importance. OneBeacon Insurance Group personal information-handling practices are governed by this privacy policy and are further regulated by law. This notice describes those practices and how they preserve your privacy in a way that permits OneBeacon Insurance Group to provide you with the products and service you demand.

Collection of Personal Information

We get most of our information directly from you. The application you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. Depending on the nature of your insurance transaction, we may need additional information about you or other potential insureds from outside sources such as motor vehicle records, loss information reports, credit reports, court records or other public records. For property insurance, we may send someone to inspect your property and verify information about its value and condition, and a photo of the property may be taken.

We also may obtain information from third parties such as other insurance companies or consumer reporting agencies. A consumer report from such an agency may contain information as to credit worthiness and credit standing. If we order any kind of consumer report, upon request, we will tell you how to get a copy of the report. The agency preparing a consumer report for us may keep the information collected about you as permitted by law, and it may be disclosed to other persons.

Disclosure of Personal Information

Information which has been collected about you will be contained in either our policy records or in your producer's files. We review it in evaluating your request for insurance coverage and in determining your rates. We will also use information in our policy records for purposes related to issuing and servicing insurance policies and settling claims. OneBeacon Insurance Group may disclose personal information to others in order to service, process or administer business such as underwriting and claims operations. In this context, OneBeacon Insurance Group may disclose **(i)** information we receive from you on applications and other forms, including information such as assets, income, and identifying information such as name, address and social security number; **(ii)** transaction information such as information about balances, payment history and parties to the transaction; and **(iii)** information from consumer reporting agencies such as a consumer's credit worthiness and credit history.

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report, we will tell you as required by state law and the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report.

Parties to Whom Information May be Disclosed

OneBeacon Insurance Group will not disclose information about you to others without your written consent unless the disclosure is necessary to conduct our business. By law, OneBeacon Insurance Group is permitted to share information about you without prior permission under certain circumstances to certain persons and organizations such as:

- Your producer.
- Parties who perform a business, professional or insurance function for our company, including our reinsurance companies.
- Claim adjusters, appraisers, investigators and attorneys who need the information to investigate, defend or settle a claim involving you.
- Insurance support organizations which are established to collect information for the purpose of detecting and preventing insurance crimes and fraudulent claims.
- Insurance regulatory agencies in connection with the regulation of our business.
- Law enforcement or other governmental authorities to protect our legal interest, or in cases of suspected fraud or illegal activities.
- Authorized persons as ordered by subpoena, warrant or other court order or as required by law.
- Lien holder, mortgagee, assignee, lessor, or other person shown on our records or our producer’s as having a legal or beneficial interest in a policy of insurance.
- Parties acting in a fiduciary or representative capacity to you (attorneys, accountants and auditors).
- Insurance rate advisory organizations.
- Parties enforcing OneBeacon Insurance Group rights in connection with the settlement of a debt, the transfer of interests or an audit.
- Parties administering transactions as requested or authorized by you.

Right of Access to Personal Information

You have the right to know what kind of information we keep in our files about you, to have reasonable access to it and to receive a copy. Write to us if you have questions about the information. Provide your complete name, address, type of policy and policy number that was issued or applied for with us. Mail your request to: Privacy Administrator, Post Office Box 254, Canton, MA, 02021-0254. Certain types of information generally collected when evaluating claims or possible lawsuits need not be disclosed to you.

Within thirty (30) business days of receipt of your request, we will inform you in writing of the nature and substance of retrievable recorded personal information about you in our files. You may review this information in person or receive a copy by mail. We will also identify the person or organization to which we have disclosed this information within the past two (2) years. In addition, you will be given the name and address of any consumer reporting agency which prepared a report about you so that you can contact them for a copy.

After you have reviewed the personal information about you in our file, you can write to us if you believe it should be corrected, amended or deleted. We will consider your request, and within thirty (30) days either change the information or tell you that we did not and state the reason. If we do not make changes, you will have the right to insert in our file a concise statement containing what you believe to be the correct, relevant or fair information, and explaining which information on file you believe to be improper. We will notify persons designated by you to whom we have previously disclosed the information of the change or your statement. Subsequent disclosures we make also will include your statement.

Confidentiality and Security of Personal Information

Our company maintains appropriate standards and procedures to prevent unauthorized access to your information. OneBeacon Insurance Group limits employee access to personally identifiable information to those with a business reason for knowing such information. We educate our employees so that they will understand the importance of confidentiality of personal information and take appropriate measures to enforce privacy responsibilities.

Treatment of Personal Information of Former Customers

OneBeacon Insurance Group follows this personal information privacy policy even when a customer relationship no longer exists.

If you have additional questions about the privacy of your personal information or about your insurance needs in general, please contact your producer.

Effective July 1, 2001

GROUP BUSINESS TRAVEL ACCIDENT SUMMARY PLAN DESCRIPTION

FOR

EMPLOYEES OF INTACT SERVICES USA LLC

THIS INSURANCE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY.

IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.

OneBeacon America Insurance Company
1 Beacon Lane
Canton, MA 02021-1030

POLICYHOLDER: **Intact Services USA LLC**

POLICY NUMBER: **212-000-015**

COVERED SUBSIDIARIES OR AFFILIATED COMPANIES:

Atlantic Specialty Insurance Company
A.W.G. Dewar, Inc.
Intact Insurance Group USA LLC
International Bond & Marine
The Guarantee Company of North America

The insurance evidenced by this Certificate provides Accident insurance only. It does not provide Coverage for sickness. This Certificate describes the main features of the Policy, but the Policy is the only contract under which benefit payments are made. If there is an inconsistency between the Certificate and the Policy, the Policy will govern.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT

CERTIFICATE OF INSURANCE

Table of Contents

SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

PRIMARY INSURED PERSON - CERTIFICATE HOLDER.

Class	Description
1	All **Active** employees of the **Policyholder**

If **You** sustain an **Injury** resulting in a **Covered Loss**, and **You** are covered under more than one Class, only one benefit will be paid, the largest benefit.

Effective Date. A. If **You** are hired prior to January 1, 2008:
Your first day of **Active** work following the effective date of the **Policy**

B. If **You** are hired on or after January 1, 2008:
Your first day of **Active** work following **Your** date of hire

If **You** are not **Actively at Work** on **Your** Effective Date of coverage, coverage will begin on **Your** first full day of **Active** work following **Your** Effective Date.

Termination Date. Your coverage terminates at the end of the period for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. **You** cease to be eligible for coverage;
3. **You** fail to pay the required premium, if **You** are so required; or
4. **You** retire.

SECTION II – SCHEDULE

HAZARDS

The following are the **Hazards** for which insurance applies:

Class I	24 Hour **Accident** Protection, While on a Business Trip, Excluding Corporate **Owned** or **Leased** Aircraft

Additional Coverages

Class 1	Exposure and Disappearance Coverage Family Traveling with Employee on Business and/or Relocation Trips Coverage

BENEFITS

A. Principal Sum

The following are the **Principal Sums** for each Class:

Class 1	Five (5) times the employee's **Base Annual Earnings*** rounded up to the next highest $1,000, to a maximum of $1,750,000

***Base Annual Earnings** means the employee's base annual pay excluding overtime, bonuses, commissions and special compensation.

Principal Sum Reduction

At age 70, **Your Principal Sum** will be reduced based on **Your** previous **Principal Sum** on the January 1st after **Your** attainment of the ages specified below:

Age at Date of Loss	Percent of Principal Sum
70-74	65%
75-79	45%
80-84	30%
85 & Over	15%

Aggregate Limit of Liability

The **Aggregate Limit of Liability** per **Covered Accident** is $7,500,000.

B. Accidental Death Benefit

This benefit applies to Class 1.

C. Accidental Dismemberment and Covered Loss of Use Benefit

This benefit applies to Class 1.

D. Coma Benefit

This benefit applies to Class 1.

E. Additional Benefits

Class 1 Seat Belt Benefit

Travel Assistance Benefit

SECTION III – HAZARDS

24 HOUR ACCIDENT PROTECTION WHILE ON BUSINESS TRIP, EXLUDING CORPORATE OWNED OR LEASED AIRCRAFT

The **Policy** insures against the following **Hazards:**

A **Covered Injury** sustained by **You** anywhere in the world while on the **Business of the Policyholder**, subject to the terms, conditions, limitations and exclusions under the **Policy**.

Coverage, subject to limitations and exclusions, is provided between:

1. the later of the time **You** leave the place where **You** normally work or live; and
2. the earlier of the time **You** return to the place where **You** normally work or live.

Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while **You** are a passenger, riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
   a. medical certificate; and
   b. pilot certificate with a proper rating to pilot such aircraft.

2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

Hazard Exclusions:

Coverage is not provided:

1. If **You** are the pilot, operator, member of the crew or cabin attendant of any aircraft.
2. For an assignment by the **Policyholder** or relocation that exceeds sixty (60) days in duration. Note: If an assignment exceeds sixty (60) days in duration, the location of the assignment will be considered the place of permanent assignment, and **You** will then have **Coverage** when traveling elsewhere on the **Business of the Policyholder**.
3. Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   a. any aircraft other than those expressly stated in this **Hazard**;
   b. any aircraft **Owned** or **Controlled** by, or **Under lease** to the **Policyholder**.
   c. any aircraft **Owned** or **Controlled** by, or **Under lease** to a **Primary Insured Person** or a member of a **Primary Insured Person's** family or household;
   d. any aircraft operated by the **Policyholder** or one of the **Policyholder's** employees including members of an employee's family or household;
   e. any aircraft engaged in a **Specialized Aviation Activity**;
   f. any conveyance used for tests or experimental purposes, or in a race or speed test.

Hazard Definitions:

- **Business of the Policyholder** means an assignment by or at the direction of the **Policyholder** to further the business of the **Policyholder**. It does not include an **Accident** occurring during usual travel to and from work; bona fide leaves of absence or vacation. It does include **Personal Deviations/Side Trips**.
- **Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while on the **Business of the Policyholder**, but unrelated to furthering the **Business of the Policyholder** that: 1) is incidental to the business trip; 2) would not have been taken if not for the business trip; 3) is taken during the course of the business trip; and 4) is limited to 72 hours.

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.

SECTION IV – ADDITIONAL COVERAGES

EXPOSURE AND DISAPPEARANCE COVERAGE

If **You** are exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which **You** are riding disappears, is wrecked, or sinks, and **You** are not found within 365 days of the event, **We** will presume that **You** lost **Your** life as a result of **Injury**. If travel in such conveyance was covered under the terms of this **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that [**You**] [the **Insured Person**] survived the event.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

FAMILY TRAVELING WITH EMPLOYEE ON BUSINESS AND/OR RELOCATION TRIPS COVERAGE

Your Spouse and/or **Dependent Child(ren)** will also be considered a **Primary Insured Person** when they are traveling on a business and/or relocation trip with **You** that is approved by and at the expense of the **Policyholder**. Their coverage will be limited to the **Accidental Death Benefit** and the **Accidental Dismemberment and Covered Loss of Use Benefit** as stated in the **Policy**, when the eligibility for such **Benefit** results from the **Hazards** covered by the **Policy**.

This **Coverage** for **Your Spouse** and/or **Dependent Child(ren)** ends upon arrival at the destination of the **Policyholder's** last reimbursed trip.

The **Principal Sum** for **Your Spouse** and each **Dependent Child** will be as follows:

Spouse: $50,000

Dependent Child(ren): $25,000

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

We will pay the applicable **Principal Sum**, if **You** sustain a loss of life as a result of a **Covered Injury**, and the death occurs within 365 days of the **Covered Injury**.

This benefit is subject to the limitations in Section VII Limitations.

ACCIDENTAL DISMEMBERMENT AND LOSS OF USE BENEFIT

We will pay the benefit amount shown below, if an **Injury** to **You** results in any of the following **Covered Losses**, provided the **Covered Loss** occurs within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person sustaining the **Covered Loss**.

Covered Loss of	**Benefit**
• Both Hands or Both Feet	**Principal Sum**
• One Hand and One Foot	**Principal Sum**
• One Hand or One Foot plus the loss of Sight of One Eye	**Principal Sum**
• Sight of Both Eyes	**Principal Sum**
• Speech and Hearing	**Principal Sum**
• Speech or Hearing	50% of **Principal Sum**
• One Hand; One Foot; or Sight of One Eye	50% of **Principal Sum**
• Thumb and Index Finger of the same Hand	25% of **Principal Sum**

Covered Loss of Use of	**Benefit**
• Both Arms and Both Legs	**Principal Sum**
• Both Arms or Both Legs or a Combination of an Arm and a Leg	75% of **Principal Sum**
• One Arm or One Leg	50% of **Principal Sum**
• Both Hands or Both Feet or a Combination of a Hand and a Foot	50% of **Principal Sum**
• One Hand or One Foot	25% of **Principal Sum**

A reduced benefit will be payable equal to 50% of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after 365 days, the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.

For purposes of this benefit:

- **Covered Loss** means:
  - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
  - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - **c.** Total and permanent loss of sight;

d. Total and permanent loss of speech;

e. Total and permanent loss of hearing.

- **Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which [has continued for 12 consecutive months and is determined by **Our** competent medical authority to be permanent, complete and irreversible.

This benefit is subject to the limitations in Section VII Limitations.

COMA BENEFIT

We will pay a **Coma Benefit,** if **You** sustain an **Injury** resulting in a **Covered Loss** within 365 days of a **Covered Accident**, and such **Injury** causes **You** to be in a **Coma** for at least thirty-one (31) consecutive days.

The **Coma Benefit** is equal to 1% of **Your Principal Sum**, and will be paid each month **You** remain in a **Coma** following the initial thirty-one (31) day period. The **Coma Benefit** will end on the earliest of the following:

1. **You** are no longer in a **Coma** which directly resulted from the **Injury**;

2. **You** have received a **Coma Benefit** for 100 months.

Brief periods of consciousness of no more than one (1) day in duration will not effect **Your** eligibility for, or continuation of, benefits.

Coma will be determined by **Our** duly licensed **Physician**.

This benefit is subject to the limitations in Section VII Limitations.

SECTION VI – ADDITIONAL BENEFITS

SEAT BELT BENEFIT

We will pay an additional benefit equal to 10% of the applicable **Principal Sum** up to a maximum of $25,000, if **You** sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, provided that **You** were:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and

2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of **Your** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or

2. by other reasonable proof, acceptable to **Us**.

We will not pay a **Seat Belt Benefit** if **You** are the operator of a private passenger automobile at the time he or she incurs such **Covered Injury** and are either:

1. under the influence of alcohol;

a. **You** will be conclusively presumed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.

b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication. Or,

2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.

TRAVEL ASSISTANCE

Travel Assistance will be available to the following **Insured Persons** when they are traveling 100 miles or more from their **Principal Residence**: **You** and **Your Spouse** and/or **Child(ren)**, if **Your Spouse** and/or **Child(ren)** are with **You** while **You** are covered under the **Policy**. **Your Spouse** or **Child(ren)** will not be covered while making a trip without **You**. The

transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. Under the **Policy**, **Travel Assistance** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**.

For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider.

Assisted Repatriation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to his or her **Principal Residence,** or to his or her residence in the country where he or she is currently assigned (at his or her option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered.

Post-Recovery Repatriation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending **Physician**. The upgrade will be subject to **Our** sole discretion.

Return of Remains
If an **Insured Person** dies while on a **Covered Trip**, **We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable.

Visit to Hospital
If an **Insured Person** is scheduled to be hospitalized for more than seven (7) consecutive days while on a **Covered Trip, We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Insured Person** to visit the **Insured Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable.

Return of Child
If an **Insured Person** is traveling with a **Child(ren),** who is under nineteen (19) years of age or a **Child(ren)** who prior to age [nineteen (19)] became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Insured Person** for support and maintenance, while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Insured Person,** such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Insured Person,** and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable.

Return of Companion

If an **Insured Person** is traveling with a companion while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Insured Person** the **Insured Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable.

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section VIII General Exclusions of this **Certificate**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from the deliberate ingestion of a poison, fume, noxious chemical substance; or the use of a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions;
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Insured Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Insured Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services.

- **TRAVEL ASSISTANCE DEFINITIONS**

For purposes of **Travel Assistance** only, the following definitions apply:

Covered Trip means when an **Insured Person** is traveling more than 100 miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

Illness or **Ill** means a sickness or disease which impairs normal functions of the body.

Principal Residence means the legal domicile of the **Insured Person**.

Western Medical Standards means generally accepted medical standards comparable to those in the United States, or Canada or Western Europe.

For the purpose of **Travel Assistance**, if there are any differences in the definition of a term between **Travel Assistance** and the **Policy,** the definition in **Travel Assistance** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

Right of Recovery
We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder** or **Insured Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured Person** that were covered under **Travel Assistance. We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance**.

Reservation of Rights
We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services.

Scope

Illness, as covered under **Travel Assistance**, is solely covered under **Travel Assistance,** and in no way supersedes or modifies the other **Coverages** provided under the **Policy**. All other **Coverages** provided under the **Policy** are available only as a result of a **Covered Injury**.

To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call 1-866-670-6693 from the U.S. or Canada; and collect from anywhere else in the world at +1-973-630-6693.

SECTION VII – LIMITATIONS

Limitation on Multiple Covered Losses.

We will pay only one benefit, the largest benefit, if **You** sustain more than one loss as a result of the same **Accident.**

Limitation on Multiple Benefits.

The most **We** will pay for the following benefits, in total, is **Your Principal Sum,** if **You** can recover benefits under more than one of these: **Accidental Death Benefit**, **Accidental Dismemberment and Covered Loss of Use Benefit,** and **Coma Benefit** as a result of the same **Accident**.

Limitation on Multiple Hazards.

We will pay only one benefit, the largest benefit, if **You** sustain a **Covered Loss** that is covered under more than one **Hazard**.

Aggregate Limit.

We will not pay more than the **Aggregate Limit of Liability** stated in the Schedule.

SECTION VIII – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

- suicide or any attempt at suicide or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**;
- war or any act of war, whether declared or undeclared;
- involvement in any type of active military service. (For purposes of this exclusion, orders to active military service for sixty (60) days or less will not be considered involvement in active military service.);
- illness or disease; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease;
- participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot;
- travel or flight in any aircraft except to the extent stated in the **Hazards** Section.

SECTION IX – CLAIMS PROVISIONS

Notice. You or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within twenty (20) days of such **Covered Loss**. The notice must name **You**, the **Insured Person** who sustained the **Injury**, and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 1-866-583-2233. The notice must be sent to the Claims Department, OneBeacon America Insurance Company, 44 Whippany Road, Morristown, NJ 07962-1009, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. We will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss.**

Proof of Covered Loss. Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss,** and the proof was provided as soon as reasonably possible.

Time of Payment. We will pay claims for all **Covered Losses**, other than **Covered Losses** for which this **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

Recipient of Payment.

1. **Your** Loss of Life. **Covered Losses** resulting from **Your** death are paid to **Your** named beneficiary at the time of death. If there is no beneficiary named or **Your** named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:
   a. **Your Spouse**;
   b. **Your** child(ren);
   c. **Your** parents;
   d. **Your** brothers and sisters;
   e. **Your** estate.
2. All Other Claims. Benefits are to be paid to **You**.

Physical Examination and Autopsy. We have the right to examine [**You**] [the **Insured Person**] when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

Choice of Service Provider. You have the sole right to choose his or her duly licensed **Physician** and hospital.

Right to Recover Overpayments. In addition to any rights of recovery or reimbursement provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under the **Policy** to the extent of the overpayment.

Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where **You** live makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

SECTION X – GENERAL PROVISIONS

Beneficiaries. You have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time unless **You** have assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us.**

Change or Waiver. A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

Clerical Error. A clerical error or omission will not increase or continue **Your Coverage**, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity with Statute. Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

Assignment of Interest. A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.

Incontestability. The validity of the **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.

SECTION XI – DEFINITIONS

- **Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.
- **Active** or **Actively at Work** describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered actively at work provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.
- **Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the **Policy.** For purposes of the Aggregate Limit of Liability provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause occurring within a one (1) day period and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each **Insured Person**, **We** will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.
- **Chartered Aircraft** means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than ten (10) consecutive days and/or for no more than fifteen (15) days in a one (1) year period.
- **Controlled** by, as used in the **Hazards** Section, means the **Policyholder** has the right to use a block of aircraft flight time for 25 or more hours in a one (1) year period or for 100 hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled** by the **Policyholder**.
- **Coverage(s)** means the event or events described in the **Hazards** Section and Additional Coverages Section of this **Certificate** to which benefits and additional benefits apply. The **Hazards** and Additional Coverages are listed in the Schedule.

- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Insured Person** is insured under this **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury,** and for which benefits are payable under the **Policy**.
- **Dependent** means **Your Spouse** and **Dependent Child(ren),** as defined in this Section.
- **Dependent Child(ren)**, if used in this **Certificate**, means **Your** unmarried **Child(ren)**, and those unmarried **Child(ren)** of **Your Spouse** who rely on **You** for more than 50% of their support, through the end of the month in which such Child(ren) has attained age 26 (twenty-six), or who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap.
- **Injured, Injury or Injuries** means bodily harm or bodily damage.
- **Insured Person** means any person who has insurance under the terms of the **Policy**. It includes **You**.
- **Owned Aircraft** means an aircraft in which the **Policyholder** or a related company has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.
- **Physician** means a person who is licensed to practice medicine in the jurisdiction in which the medical service or treatment is performed and is acting within the scope of his or her license.
- **Plan** means the plan design as described in the Schedule**.**
- **Policy** means the Group **Accident** Insurance **Policy**.
- **Policyholder** means the group named on the front page of the **Policy**.
- **Primary Insured Person** means an individual who has an employment relationship with the **Policyholder** and is eligible for coverage under the **Policy** as provided in the Eligibility of **Primary Insured Persons** part of Section I. The **Primary Insured Person** is the Certificate Holder.
- **Specialized Aviation Activity** means an aircraft while it is being used for one or more of the following activities:

  acrobatic or stunt flying
  aerial photography
  banner towing
  bird or fowl herding
  crop dusting
  crop seeding
  crop spraying
  endurance tests
  exploration
  fire fighting
  flight on a rocket-propelled or rocket launched aircraft
  hanggliding
  hunting
  parachuting or skydiving
  pipe line inspection
  power line inspection
  racing
  skywriting
  test or experimental purpose

  flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted;
- **Spouse**, if used in the **Policy**, means **Your** legally married **Spouse**.
- **Under lease**, as used in the **Hazards** Section**,** means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than ten (10) consecutive days and/or for more than fifteen (15) days in a one (1) year period. A **Chartered Aircraft** will not be considered **Under lease**.
- **We, Us** and **Our** refers to OneBeacon America Insurance Company.
- **You** and **Your** refers to the **Primary Insured Person**.

In Witness Whereof, We have caused the Policy to be executed and attested, and, if required by state law, the Policy shall not be valid unless countersigned by Our authorized representative.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Michael Miller, President & CEO
OneBeacon America Insurance Company

ONEBEACON AMERICA INSURANCE COMPANY

ATLANTIC SPECIALTY INSURANCE COMPANY

CERTIFICATE OF ASSUMPTION

EFFECTIVE OCTOBER 1, 2012

Policy #212-000-015

Policyholder: OneBeacon Services, LLC

You are hereby notified that, for all purposes on and after the Effective Date specified above, Atlantic Specialty Insurance Company ("Atlantic Specialty") has assumed liability for your policy of insurance originally issued by OneBeacon America Insurance Company ("OneBeacon America").

On and after the Effective Date, Atlantic Specialty has assumed all rights and duties under your policy and all references in the policy to OneBeacon America are hereby changed to Atlantic Specialty. All correspondence and inquiries such as policy changes and notices of claims should continue to be submitted to the current addresses under the company name of Atlantic Specialty Insurance Company.

This Certificate of Assumption forms a part of and should be attached to the insurance policy issued to you by OneBeacon America.

IN WITNESS WHEREOF, Atlantic Specialty Insurance Company has caused this Certificate of Assumption to be duly signed and issued.

Secretary

President

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ERISA
SUMMARY PLAN DESCRIPTION
INFORMATION

The plan described in this Certificate, together with the following information, constitutes the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 as amended.

The Plan Sponsor is:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441
The Employer Identification Number (EIN) is:	26-3300555
The Plan Number is:	509
The Plan Administrator is:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441
The Claims Fiduciary is:	Intact Services USA LLC
The agent for the service of legal process is:	Intact Services USA LLC 605 North Highway 169, Suite 800 Plymouth, MN 55441 800-527-1255

The benefits of the Plan are provided under Policy No. 212-000-015 underwritten by OneBeacon America Insurance Company located in Canton, MA with administrative offices in Morristown, NJ.

The plan is financed through contributions made by: The Employees of Intact Services USA LLC

Plan Year Ends: December 31

For a description of the eligibility requirements of the plan, the amount and type of benefits available, the circumstances under which benefits under the plan are not available or may terminate, please refer to this Certificate.

Plan Termination: The right is reserved in the plan for the Plan Administrator to terminate, suspend, withdraw, or amend the plan in whole or in part at any time, subject to the applicable provisions of the Policy.

ERISA SPD

CLAIM PROCEDURES

Filing a Claim for Benefits

When you are reasonably sure that you are eligible to receive benefits under this plan, you may request a claim form from the Plan Administrator. All claims submitted to the Insurer must be on forms provided by the Insurer (unless forms are not currently available), in which case you, your beneficiary or a legally authorized representative may simply supply the appropriate party with a written statement outlining proof and extent of loss. Complete the claim form according to directions and return the claim form to the Plan Administrator.

From the date your notice of claim is returned, the insurance company has 90 days in which to review the claim to determine whether or not benefits are payable in accordance with the terms and provisions of the Group Policy. Under special circumstances the insurance company may require an extension of the 90 day period in which case you will receive written notice from the insurance company, prior to the end of the initial 90 days, informing you of the need for an extension. This extension period allows the insurance company an additional 90 days to review your claim. During this period the insurance company may require a medical examination, at its own expense, or additional information in order to make a determination on your claim. If additional information is required you will receive a request, in writing, specifying the nature of the information needed and an explanation as to why it is needed. If a medical examination is necessary, you will be given the time of appointment and the doctor's name and location. It is important to keep any appointments made since rescheduling exams will delay the claim process.

If you are not notified of the claim status within 90 days and you have not been notified that the extension period has been applied, you may request a review of your claim by following the procedure outlined under "Claim Review Procedure."

Once your claim has been approved, you will receive the appropriate benefit from the insurance company.

What if your Benefits are denied?

If your claim for benefits is denied in whole or in part, you will receive written notice of such denial within the 90 day period stated above (or 180 days if the extension period is required).

Each written notice of denial shall set forth:

1. the specific reason(s) for the denial of the claim;
2. a specific reference to the provision(s) of the Group Policy upon which the denial is based;
3. a description of any additional information or material needed and why; and
4. notice of your rights to have the denial reviewed by the insurance company, and to bring suit under ERISA if the review also results in an adverse benefit determination.

Claim Review Procedure

If you receive a written notice of denial, you or your duly authorized representative may request a review of the claim by giving written notice to the insurance company. This request for a review must be made to the insurance company within 60 days of the receipt of denial by the insurance company. If such request is not made within 60 days you will be deemed to have waived your right to a review.

Once the insurance company receives a request for a review, a prompt review of the claim must take place. You or your authorized representative have the right to review documents that might have a bearing on the claim, including the documents which establish and control the plan, and to submit issues and comments that you feel might affect the outcome of the review.

Upon completion of a full and complete review, the insurance company will notify you in writing of the results, citing plan provisions that control the decision. The insurance company has 60 days to notify you of its decision unless special circumstances require an extension of time. If an extension is required, the insurance company shall notify you of the need for an extension before the end of the initial 60-day period for completing the review procedure. This means that the insurance company will have an additional 60 days to notify you of the decision on your denied claim.

What If Your Benefits Continue To Be Denied?

If your claim for benefits continues to be denied, you will receive written notice of such continued denial within the 60-day period stated above (or 120 days if an extension period is required).

The written notice of denial shall set forth:

1. the specific reason(s) for the continued denial on review of the claim;
2. reference to the specific plan provision(s) on which the denial on review is based;
3. a statement regarding your right to access and receive copies of relevant documents, records and other information upon request, without charge; and
4. notice of your rights to pursue other voluntary dispute resolution alternatives, if available, and to bring suit under ERISA.

Statement of ERISA Rights

Your Rights under ERISA: Your Employer intends to comply fully with the Employee Retirement Income Security Act of 1974 and the regulations under the Act as it understands them. The Act provides for certain rights and protections for each participant of the Plan. As a participant in this Group Insurance Plan you may:

1. Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Our Policy Regarding Your Privacy

In order to provide the insurance products and services that respond to our customers' diverse needs, OneBeacon Insurance Group collects certain personal information. OneBeacon Insurance Group does not disclose any nonpublic personal information to any affiliated or nonaffiliated third party for marketing purposes. At OneBeacon Insurance Group, maintaining the confidentiality of our customers' personal information is of the highest importance. OneBeacon Insurance Group personal information-handling practices are governed by this privacy policy and are further

regulated by law. This notice describes those practices and how they preserve your privacy in a way that permits OneBeacon Insurance Group to provide you with the products and service you demand.

Collection of Personal Information

We get most of our information directly from you. The application you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. Depending on the nature of your insurance transaction, we may need additional information about you or other potential insureds from outside sources such as motor vehicle records, loss information reports, credit reports, court records or other public records. For property insurance, we may send someone to inspect your property and verify information about its value and condition, and a photo of the property may be taken.

We also may obtain information from third parties such as other insurance companies or consumer reporting agencies. A consumer report from such an agency may contain information as to credit worthiness and credit standing. If we order any kind of consumer report, upon request, we will tell you how to get a copy of the report. The agency preparing a consumer report for us may keep the information collected about you as permitted by law, and it may be disclosed to other persons.

Disclosure of Personal Information

Information which has been collected about you will be contained in either our policy records or in your producer's files. We review it in evaluating your request for insurance coverage and in determining your rates. We will also use information in our policy records for purposes related to issuing and servicing insurance policies and settling claims. OneBeacon Insurance Group may disclose personal information to others in order to service, process or administer business such as underwriting and claims operations. In this context, OneBeacon Insurance Group may disclose **(i)** information we receive from you on applications and other forms, including information such as assets, income, and identifying information such as name, address and social security number; **(ii)** transaction information such as information about balances, payment history and parties to the transaction; and **(iii)** information from consumer reporting agencies such as a consumer's credit worthiness and credit history.

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report, we will tell you as required by state law and the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report.

Parties to Whom Information May be Disclosed

OneBeacon Insurance Group will not disclose information about you to others without your written consent unless the disclosure is necessary to conduct our business. By law, OneBeacon Insurance Group is permitted to share information about you without prior permission under certain circumstances to certain persons and organizations such as:

- Your producer.
- Parties who perform a business, professional or insurance function for our company, including our reinsurance companies.
- Claim adjusters, appraisers, investigators and attorneys who need the information to investigate, defend or settle a claim involving you.
- Insurance support organizations which are established to collect information for the purpose of detecting and preventing insurance crimes and fraudulent claims.
- Insurance regulatory agencies in connection with the regulation of our business.
- Law enforcement or other governmental authorities to protect our legal interest, or in cases of suspected fraud or illegal activities.
- Authorized persons as ordered by subpoena, warrant or other court order or as required by law.
- Lien holder, mortgagee, assignee, lessor, or other person shown on our records or our producer’s as having a legal or beneficial interest in a policy of insurance.
- Parties acting in a fiduciary or representative capacity to you (attorneys, accountants and auditors).
- Insurance rate advisory organizations.
- Parties enforcing OneBeacon Insurance Group rights in connection with the settlement of a debt, the transfer of interests or an audit.
- Parties administering transactions as requested or authorized by you.

Right of Access to Personal Information

You have the right to know what kind of information we keep in our files about you, to have reasonable access to it and to receive a copy. Write to us if you have questions about the information. Provide your complete name, address, type of policy and policy number that was issued or applied for with us. Mail your request to: Privacy Administrator, Post Office Box 254, Canton, MA, 02021-0254. Certain types of information generally collected when evaluating claims or possible lawsuits need not be disclosed to you.

Within thirty (30) business days of receipt of your request, we will inform you in writing of the nature and substance of retrievable recorded personal information about you in our files. You may review this information in person or receive a copy by mail. We will also identify the person

or organization to which we have disclosed this information within the past two (2) years. In addition, you will be given the name and address of any consumer reporting agency which prepared a report about you so that you can contact them for a copy.

After you have reviewed the personal information about you in our file, you can write to us if you believe it should be corrected, amended or deleted. We will consider your request, and within thirty (30) days either change the information or tell you that we did not and state the reason. If we do not make changes, you will have the right to insert in our file a concise statement containing what you believe to be the correct, relevant or fair information, and explaining which information on file you believe to be improper. We will notify persons designated by you to whom we have previously disclosed the information of the change or your statement. Subsequent disclosures we make also will include your statement.

Confidentiality and Security of Personal Information

Our company maintains appropriate standards and procedures to prevent unauthorized access to your information. OneBeacon Insurance Group limits employee access to personally identifiable information to those with a business reason for knowing such information. We educate our employees so that they will understand the importance of confidentiality of personal information and take appropriate measures to enforce privacy responsibilities.

Treatment of Personal Information of Former Customers

OneBeacon Insurance Group follows this personal information privacy policy even when a customer relationship no longer exists.

If you have additional questions about the privacy of your personal information or about your insurance needs in general, please contact your producer.

Effective July 1, 2001

GROUP LEGAL PROGRAM

UltimateAdvisor®

These days, life is full of legal issues. Some you plan for — like creating a will or buying a home — and others are more unexpected — like fighting a traffic ticket or getting your deposit back from a difficult landlord.

Legal insurance makes it affordable to get the professional legal help you need. As a legal plan member, you benefit from a wide range of coverage and services to help address a wide range of situations in life that come with legal or financial challenges. For example:

- There's a charge that's not yours on your credit card bill.
- You're thinking of adopting a child.
- You have a legal dispute with a neighbor.
- Your child is in trouble with the law.

These situations happen every day…to people just like you. But now, with a legal plan, you'll have the **peace of mind** that comes from having an attorney on your side. Plus, when you work a network attorney, the attorney fees are 100% paid in full – with no co-pays – for most covered legal matters. This can save you hundreds, if not thousands of dollars, as attorney fees currently average $368 per hour.

You'll have access to a nationwide network of attorneys who can:

- Work with you in person, over the phone or online to consult with you on legal issues.
- Review or prepare personal documents.
- Make follow-up calls or write letters on your behalf.
- Represent you.

* Average attorney rates in the United States of $368 per hour for attorneys with 11 to 15 years of experience, Survey of Law Firm Economics, The National Law Journal and ALM Legal Intelligence, October 2018.

Enrollment in this plan is for the entire calendar year. If you enroll in UltimateAdvisor, your per pay period cost of coverage will be paid on an after-tax basis.

To start using the UltimateAdvisor legal insurance plan:

- Visit www.ARAGlegal.com/myinfo and type in access code 15621one for detailed information on plan benefits and how to use the plan.
- Talk to an ARAG Customer Care specialist at 800-247-4184 for information about plan-specific benefits or for help getting connected with a network attorney. Specialists are available from 7:00 a.m. to 7:00 p.m. Central time, Monday through Friday.
- Email an ARAG Customer Care specialist for assistance or questions at service@ARAGLegal.com.

How to obtain in-office legal services and court representation

Network Attorney Services

There are network attorneys throughout your state. To obtain a list of network attorneys you can:

1. Call 800-247-4184 and a Customer Service Specialist will assist you by:
    - Describing how the plan benefits work and what types of situations are covered. Providing you a listing of network attorneys specific to your need.
    - Providing a Case Confirmation Number that outlines your coverage.

2. Visit our Web site at www.ARAGlegal.com/myinfo and log on as a member and search using the Attorney Finder.

Simply call an attorney for an appointment. When you call, identify yourself as a member of your group's legal plan. If you have a Case Confirmation Number, you should provide it to the attorney. If not, the attorney may call us to confirm your coverage and then proceed to provide services. If you choose a network attorney to provide covered legal services, the network attorney will bill us directly for his/her attorney fees.

- Network Attorney Guarantee- If there is not a network attorney located within 30 miles of your home, ARAG guarantees you will receive in-network benefits. ARAG will work with you to arrange for you to receive covered legal services through an attorney in your area.

Non-Network Attorney Services

If you choose a non-network attorney, we will pay your attorney fees for covered legal services according to the non-network attorney indemnity benefits schedule. Instructions for submitting a claim are printed on the claim form. For a form, call 800-247-4184. Or you can download a form from our Web site www.ARAGlegal.com/myinfo and log on as a member.

UltimateAdvisor - Covered Services

	Network Provider
Learning Center	
Access the Learning Center for an extensive online library of easy-to-read articles, guidebooks and videos created to help you: • Learn more about dealing with common legal and financial matters, like estate planning, identity theft and consumer protection. • Understand how the legal insurance plan works and the coverages, services and resources it provides.	Paid-in-full
Do-It-Yourself Legal Documents	
You have online access to state-specific documents authored and reviewed by attorneys for accuracy and state-specific compliance in all 50 states.	Paid-in-full
Identity Theft Services	
Identity Theft Services helps you protect your privacy, identity, reputation and your property. Services include: • Legal Advice and Representation: You can work with an attorney in-person or via telephone for legal advice and representation. Most covered legal matters – including IRS Audit Protection, IRS Collection Defense and Debt Collection – are 100% paid-in-full when you work with a Network Attorney (coverage may vary by plan). • Prevention and Recovery Tools: You have access to several online tools to help you prevent and recover from identity theft. These tools include an Identity Theft Tracking Sheet, Personal Information Organizer, Identity Theft Prevention and Victim Action Guidebooks and more. • Assisted Identity Restoration: Identity Theft Case Specialists are available to help you assess your situation and identify your objectives. They'll assist you with tracking activities and progress until the conclusion of each case.	Paid-in-full

	Network Provider
Telephone Legal Services	
Toll free telephone advice on how the law relates to your personal legal matter and which action may be taken.	Paid-in-full
Follow-up correspondence and telephone calls to third parties regarding your personal legal matter.	Paid-in-full
Specific document preparation and review.	Paid-in-full
You will receive legal assistance for the preparation or review of a Standard Will or Codicil.	Paid-in-full
Immigration Services	

You have access to network attorneys over the phone for:
• Legal advice and consultation on:
  ○ Immigration processes and guidelines.
  ○ Filing and processing of applications and petitions.
  ○ Laws and regulations governing various types of immigration benefits; including asylum, adjustment of status, business visas, and employment authorizations.
  ○ Deportation and removal proceedings.
• Document review of any immigration forms.
• Document preparation of affidavits and powers of attorney.
• Preparation for immigration hearings.
	Paid-in-full

For additional immigration services, network attorneys provide a reduced rate of at least 25% off their normal rates for any representation-based immigration services. Network attorneys will bill you directly.	At least a 25% reduced rate
Reduced Fee Legal Services	
If your legal matter is not fully covered under your insurance policy and is not listed under the "Exclusions" in your Service Plan, you are eligible to work with a network attorney and receive a reduced fee that will be at least 25% off the attorney's normal hourly rate. The initial consultation for each legal matter will be provided at no cost. If you retained the services of a network attorney prior to the effective date of your legal insurance membership, the reduced fee benefit is not available. Payment of attorney fees is handled directly between the plan member and the network attorney. Access to a network attorney is subject to availability. You are encouraged to contact ARAG to determine proximity to a network attorney within legal practice areas. For matters that include a cap on the number of hours ARAG will pay a network attorney, and where your legal matter will exceed the cap set, the network attorney will bill you directly at reduced rates of at least 25% off his or her normal rates for the remaining hours. You pay the attorney directly.	At least a 25% reduced rate
For Telephone Advice, if your matter cannot be resolved over the phone and is not fully covered under your insurance policy and not excluded under the "Exclusions" in your Service Plan, you are eligible to work with a network attorney and receive a reduced fee that will be at least 25% off the attorney's normal hourly rate. Payment of attorney fees is handled directly between the plan member and the network attorney.	At least a 25% reduced rate

	Network Provider
Reduced Contingency Fees	
If your legal matter is not fully covered under your insurance policy and is not listed under the "Exclusions" in your Service Plan, you are eligible to work with a network attorney for a legal matter the network attorney deems to be appropriately handled through the use of a contingency fee. The network attorney will represent you under a contingent fee arrangement where the contingent fee will not exceed 25% of the net recovery if successfully resolved before or after trial, or will not exceed 30% of the net recovery if successfully resolved on or after an appeal. The initial consultation for each legal matter will be provided at no cost. If you retained the services of a network attorney prior to the effective date of your legal insurance membership, the reduced contingency fee benefit is not available.	Reduced Rate

In-Office Legal Services

In-Office Legal Services	Network Attorney	Non-Network Attorney
Name Change		
Legal services for you to legally change your name.	Paid-in-full	$240*
Uncontested Adoption		
Legal services in an uncontested adoption for you to become an adoptive parent(s). In international adoptions, where a foreign attorney is necessary, you are eligible to receive indemnity reimbursement in addition to the benefits available in the United States.	Paid-in-full	$400*
Contested Adoption		
Legal services in a contested adoption for you to become an adoptive parent(s). In international adoptions, where a foreign attorney is necessary, you are eligible to receive indemnity reimbursement in addition to the benefits available in the United States.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$800* $1,800** $100,000***
Uncontested Guardianship/Conservatorship		
Legal services in an uncontested guardianship/conservatorship for you to appoint or be appointed as a guardian/conservator.	Paid-in-full	$480*
Contested Guardianship/Conservatorship		
Legal services in a contested guardianship/conservatorship for you to appoint or be appointed as a guardian/conservator.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$720* $1,800** $100,000***

In-Office Legal Services	**Network Attorney**	**Non-Network Attorney**
Elder Law – Member Support		
Initial advice for you on the impact of your parent's/grandparent's personal legal matter on you.	Paid-in-full	$25
Legal services for you for the preparation and review of a deed where they are the grantee.	Paid in full	$40 per document
Legal services for you for the preparation and review of a promissory note where they are the payee.	Paid in full	$40 per document
Legal services for you for the review of your parent's/grandparent's personal legal documents, including estate planning documents where you have been named as an agent or executor/personal representative.	Paid in full	$40 per document
Mental Incompetency or Infirmity Proceedings		
Legal services for you in defense of mental incompetency or infirmity proceedings.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$960* $1,800** $100,000***
Credit Records Correction		
Legal services for you related to correcting inaccuracies or misrepresentations on your credit record.	Paid-in-full	$160*
Small Claims Court - Exclusion #4 as it relates specifically to plaintiff matters does not apply to this benefit		
Legal services for you to bring a claim in Small Claims Court (or similar court of limited civil jurisdiction). This benefit does not include representation in court.	Paid-in-full	$320*
Legal services for you to defend an action in Small Claims Court (or similar court of limited civil jurisdiction) including representation in court where allowed by law.	Paid-in-full	$400*
Consumer Protection		
Legal services for a member as a plaintiff or defendant regarding written, verbal or implied contracts or warranties relating to consumer goods or services and/or residential contractor disputes (excluding insurance disputes).		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$800* $1,800** $100,000***
Insurance Disputes		
Legal services for you as a plaintiff or defendant relating to disputes with your insurance carrier.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$800* $1,800** $100,000***

In-Office Legal Services	Network Attorney	Non-Network Attorney
Defense of Debt Collection		
Legal services for a member as the defendant in a legal dispute related to consumer goods or services (excluding foreclosure, garnishment, mechanic's lien and student loan debt collection).		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
Bankruptcy		
Legal services for you up to and including filing of a Chapter 7 bankruptcy final report.	Paid in full	$880*
Legal services for you up to and including confirmation of a Chapter 13 bankruptcy. This benefit does not include the ongoing maintenance of a Chapter 13 repayment plan.	Paid in full	$1,200*
Legal services for you to file an amendment/modification to a Chapter 7 post-discharge or a Chapter 13 post-confirmation bankruptcy.	Paid in full	$240*
Foreclosure – Primary Residence		
Legal services for you regarding written notice of foreclosure related to your primary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
Foreclosure – Secondary Residence		
Legal services for you regarding written notice of foreclosure related to your secondary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
Defense of Garnishment		
Legal services for you in a legal dispute for a garnishment against you to collect a judgment related to goods or services. Exclusion #3 as it relates to post judgment garnishment is waived for this benefit.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
Mechanic's Lien		
Legal services for you to remove a mechanic's lien.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***

In-Office Legal Services	Network Attorney	Non-Network Attorney
Student Loan Debt Collection		
Legal services for you as the defendant in a legal dispute related to your student loan.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
Personal Property Protection		
Legal services for you as a plaintiff or defendant regarding contracts or obligations for the transfer of your personal property or your personal property rights.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$320* $1,800** $100,000***
Purchase of Real Estate		
Legal services for you for the purchase of your primary residence for the review and preparation of documents including contract for purchase and attendance at closing.	Paid-in-full	$320*
Sale of Real Estate		
Legal services for you for the sale of your primary residence for the review and preparation of documents including contract for purchase and attendance at closing.	Paid-in-full	$320*
Purchase/Sale – Secondary Residence		
Legal services for you for the purchase or sale of your secondary residence for the review and preparation of documents including the contract for purchase or sale and attendance at closing.	Paid-in-full	$320*
Refinancing - Primary Residence		
Advice and review of relevant documents regarding refinancing of your primary residence.	Paid-in-full	$160*
Refinancing - Secondary Residence		
Advice and review of relevant documents regarding refinancing of your secondary residence.	Paid-in-full	$160*
Home Equity Loan – Primary Residence		
Legal services for you for the preparation and review of home equity loans for your primary residence.	Paid-in-full	$160*
Home Equity Loan – Secondary Residence		
Legal services for you for the preparation and review of home equity loans for your secondary residence.	Paid-in-full	$160*
Document Review		
Legal services for you for the review of your personal legal documents.	Paid in full	$40 per document

In-Office Legal Services	Network Attorney	Non-Network Attorney
Document Preparation		
Legal services for you for the preparation of Deeds, Mortgages, Promissory Notes, Affidavits, Lease Contracts, Demand Letters, Installment Contracts, Bill of Sale, HIPAA Authorization and Certification of Trust.	Paid in full	$40 per document
Property Tax – Primary Residence		
Legal services for you in an administrative action brought by you to reduce the property tax assessment on your primary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$400* $1,800** $100,000***
Property Tax – Secondary Residence		
Legal services for you in an administrative action brought by you to reduce the property tax assessment on your secondary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$400* $1,800** $100,000***
Real Estate Disputes		
Legal services for you as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase or sale of your primary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$1,200* $1,800** $100,000***
Real Estate Disputes - Secondary Residence		
Legal services for you as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase or sale of your secondary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$1,200* $1,800** $100,000***
Easement – Primary Residence		
Legal services for you in an administrative action regarding an easement on your primary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$400* $1,800** $100,000***
Easement – Secondary Residence		
Legal services for you in an administrative action regarding an easement on your secondary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$400* $1,800** $100,000***

In-Office Legal Services	Network Attorney	Non-Network Attorney
Building Codes – Primary Residence		
Legal services for you in an administrative action for permit or code violations relating to the renovation and/or improvement of your existing primary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$400* $1,800** $100,000***
Building Codes – Secondary Residence		
Legal services for you in an administrative action for permit or code violations relating to the renovation and/or improvement of your existing secondary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$400* $1,800** $100,000***
Zoning and Variances – Primary Residence		
Legal services for you in an administrative action related to a zoning change, variance or an eminent domain proceeding involving your primary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$400* $1,800** $100,000***
Zoning and Variances – Secondary Residence		
Legal services for you in an administrative action related to a zoning change, variance or an eminent domain proceeding involving your secondary residence.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$400* $1,800** $100,000***
Neighbor Disputes		
Legal services for you with a neighbor as a plaintiff or defendant in a dispute related to your primary residence, including boundary or property title disputes.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$720* $1,800** $100,000***
Neighbor Disputes - Secondary Residence		
Legal services for you with a neighbor as a plaintiff or defendant in a dispute related to your secondary residence, including boundary or property title disputes.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$720* $1,800** $100,000***

In-Office Legal Services	Network Attorney	Non-Network Attorney
Tenant Matters		
Legal services for you as a plaintiff or defendant with your landlord as a tenant of your primary residence, including but not limited to, eviction and security deposit disputes.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$320* $1,800** $100,000***
Defense of Civil Damage Claims		
Legal services for you in defense against civil damage(s) claims, except claims involving the ownership or use of a motorized vehicle, claims which are covered by other insurance, or claims related to a felony charge.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$800* $1,800** $100,000***
IRS Audit Protection		
Legal services for a member involving Internal Revenue Service (IRS) audits related to personal tax return where the initial written notice is received after effective date. This benefit does not include audits related to the member's failure to: ▪ File a personal tax return, or ▪ Pay the taxes owed as indicated on the personal tax return that was filed.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
IRS Collection Defense		
Legal services for you in defense against collection actions by the Internal Revenue Service (IRS) related to errors on personal tax return where the initial written notice is received after your effective date. This benefit does not include collection actions related to the member's failure to: ▪ File a personal tax return, or ▪ Pay the taxes owed as indicated on the personal tax return that was filed.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
State and Local Tax Audit		
Legal services for you involving state and/or local tax authority audits related to your personal state tax return or personal local taxes where the initial written notice is received after your effective date. ▪ File a personal tax return, or ▪ Pay the taxes owed as indicated on the personal tax return that was filed.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***

In-Office Legal Services	**Network Attorney**	**Non-Network Attorney**
State and Local Tax Collection Defense		
Legal services for you in defense against collection actions by state and/or local tax authority related to errors on your personal state tax return or personal local taxes where the initial written notice is received after your effective date. ▪ File a personal tax return, or ▪ Pay the taxes owed as indicated on the personal tax return that was filed.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
Social Security/Veterans/Medicare		
Legal services for you in an administrative legal dispute arising out of Social Security, Veterans, Medicare or Medicaid benefits.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$400* $1,800** $100,000***
Wills and Durable Powers of Attorney		
Individual will or spousal will(s). (Does not include any tax planning service done in connection with the will.)	Paid-in-full	$320 single document $400 spousal documents
Codicil- amendment to a will	Paid-in-full	$40 single document $80 spousal documents
Living Will/Health Care Directive	Paid-in-full	$40 single document $80 spousal documents
Power of Attorney/Financial Power of Attorney	Paid-in-full	$40 single document $80 spousal documents
Irrevocable Trusts		
Legal services for you for the preparation of a stand-alone irrevocable trust.	Paid-in-full	$320* single document $400* spousal documents
Revocable Trusts		
Legal services for you for the preparation of a stand-alone revocable living trust.	Paid-in-full	$320* single document $400* spousal document
Estate Administration & Estate Closing (Probate)		
Legal services for you in administering an estate where you have been named the executor	Paid-in-full (up to 9 hours per insured event)	$720*
Hospital Visitation Authorization		
Legal services for you for the preparation of a hospital visitation authorization.	Paid in full	$40 per document
Funeral Directive		
Legal services for you for the preparation of a funeral directive.	Paid in full	$40 per document

In-Office Legal Services	Network Attorney	Non-Network Attorney
Prenuptial Agreements		
Legal services for you for the preparation of a premarital or antenuptial agreement.	Paid in full	$320*
Protection from Domestic Violence – Named Insured		
Legal services for the named insured to obtain a protective order related to domestic violence.	Paid-in-full	$320*
Protection from Domestic Violence –Insured		
Legal services for you to obtain a protective order related to domestic violence when the opposing party is not an insured under the same Certificate.	Paid-in-full	$320*
Restraining Order – Named Insured		
Legal services for the named insured to obtain a restraining order.	Paid-in-full	$320*
Restraining Order – Insured		
Legal services for you to obtain a restraining order when the opposing party is not an insured under the same Certificate.	Paid-in-full	$320*
Postnuptial Agreements		
Legal services for the named insured for the preparation of a postnuptial agreement.	Paid in full	$320*
Domestic Partnership Agreements		
Legal services for you for the preparation of a domestic partnership agreement.	Paid in full	$320*
Gender Identifier Change		
Legal services for you to change your gender identifier on government issued documents.	Paid in full	$240*
Uncontested Divorce		
Legal services for the named insured in an uncontested divorce, a legal separation and/or annulment of marriage.	Paid in full	$640*
Contested Divorce – 20 hours		
Legal services for the named insured in a contested divorce, a legal separation and/or annulment of marriage.	Paid-in-full (up to 20 hours per insured event)	$1,600*
Habeas Corpus		
Legal services for you in habeas corpus proceedings.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***

In-Office Legal Services	Network Attorney	Non-Network Attorney
School Administrative Hearing		
Legal services for you in an administrative public or private formal school proceeding regarding disabilities, special education and student policy violations.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
Juvenile Court Proceedings		
Legal services for an insured child charged with a crime (except those involving traffic matters or felony charges) when the court proceedings are held in juvenile court. If the matter is removed from juvenile court, coverage under this benefit will cease as of the date of the removal.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
Parental Responsibilities		
Legal services for you in juvenile court proceedings (except those involving traffic matters) where a state has brought an action regarding your parental responsibilities for an insured child.		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
Minor Traffic Offenses - Broad (excluding DWI- related)		
Legal services for you in the defense of a traffic offense, the conviction of which would not result in the suspension or revocation of your driving privileges. (Does not include driving while impaired or under the influence of drugs or alcohol or any non-moving offense.)	Paid-in-full	$240*
Driving Privilege Protection (excluding DWI-related)		
Legal services for you in the defense of a traffic offense where conviction of the offense will directly result in the suspension or revocation of your driving privileges. (Does not include driving while impaired or under the influence of drugs or alcohol or a related offense.)		
Advice, negotiations and office work prior to trial Trial for three (3) days or less Trial starting on day four (4) until completion	Paid-in-full Paid-in-full Paid-in-full	$480* $1,800** $100,000***
Driving Privilege Restoration (excluding DWI-related)		
Legal services for you in an administrative proceeding for the restoration of your suspended or revoked driving privileges. (Does not include driving while impaired or under the influence of drugs or alcohol or a related offense.)	Paid-in-full	$240*

* Non-Network Attorney Indemnity Benefits are up to the stated amount

** Trial Indemnity Benefits are ($300 per ½ day of Trial time) up to the stated amount

*** Trial Indemnity Benefits are ($400 per ½ day of Trial time) up to the stated amount

Exclusions

The plan does not cover:

- Matters against ARAG, the policyholder, your employer and/or an insured against the interests of the named insured under the same Certificate.
- Legal services arising out of a business interest, investment interests, employment matters, employee benefits, your role as an officer or director of an organization, and patents or copyrights.
- Legal services in class actions, punitive damages, personal injury, malpractice, court appeals, or post judgements (settlement agreement signed by all parties, final bidding arbitration, judgment issued by a court).
- Legal services deemed by us to be frivolous or lacking merit, or in actions where you are the plaintiff and the amount we pay for your legal services exceeds the amount in dispute or in our reasonable belief you are not actively and reasonably pursuing resolution in your case.

Plan services do not include:

- Matters against us, the named plan member or the plan sponsor.
- Matters arising out of business interest, investment interests, employment matters, employee benefits, your role as an officer or director of an organization, and patents or copyrights.
- Matters deemed by us to be frivolous or lacking merit.
- Matters outside the jurisdiction of the United States of America.

Pre-existing Conditions

ARAG's general definition of a pre-existing matter is when the earliest of the following actions takes place prior to the effective date of the policy:

- Written notice of a legal dispute is sent or filed by the plan member or received by the plan member.
- A ticket or citation is issued.
- An attorney is hired.

As long as a matter is not specifically excluded, in-network assistance for a pre-existing legal matter is available via the telephone and 25 percent reduced fee benefit*; paid-in-full office visit or representation coverage is <u>not</u> available.

*So long as the network attorney was not retained prior to the member’s enrollment in the plan.

Notice of Claim, Proof of Expense Incurred and Payment of Claim

You or your representative must submit a written notice of claim to us within one year after the insured event. A claim form and itemized billing are required within one hundred eighty (180) days after legal services for which you seek payment are completed.

You are responsible for verifying your legal matter is covered under your legal plan with us prior to receiving legal services. You will be responsible for payment to the attorney at their usual and customary rate if your matter is not covered.

You must give us all information we request with respect to the circumstances of an insured event or service provided. We have the right to withhold benefits if the requested information is not provided to us.

Waiver of Premium

Death Benefit - This waiver of premium will cover the surviving spouse or domestic partner and insured dependents for one year from the date the named insured passed away. After that year, the spouse, domestic partner or insured dependent can roll their membership to the conversion plan.

Military Leave - Should a named insured be deployed for a period of more than thirty (30) consecutive days for the purposes of military service or of responding to a declared national emergency, coverage for the spouse and the insured dependents will continue, without the payment of premium, for the length of the named insured's absence and for so long as the named insured remains eligible for benefits through the policyholder.

Conversion

You may continue this insurance when you no longer qualify as an employee or as a member of the group to which this policy is issued. You must notify ARAG within 90 days of this disqualifying event to make arrangements for premium payment. Any questions regarding the ARAG conversion plan, please contact ARAG at 800-247-4184.

Disclaimer Language

This information is for illustrative purposes only and is not a contract. This information is intended to provide a general review of the plan described. Please remember that only the insurance policy can give actual terms, coverages, amounts, conditions and exclusions.

Plan Administrator

If you have any questions or concerns, please contact the plan administrator at ARAG®, 500 Grand Avenue, Suite 100, Des Moines, IA, 50309 or at 1-800-247-4184.

Underwriter Information

Insurance products are underwritten by ARAG® Insurance Company of Des Moines, Iowa or GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance of West Des Moines Iowa. Additional services may be provided by ARAG LLC or ARAG Services LLC. Some products are only available through membership in the ARAG Association LC.

BlueCross BlueShield Minnesota

EMPLOYEE ASSISTANCE PROGRAM (EAP)

THRIVE IN YOUR WHOLE LIFE

No matter what challenge you're trying to navigate, the employee assistance program can help.

intact INSURANCE

A helping hand

When you need a place to turn, the employee assistance program (EAP) from Beacon Wellbeing is the place to start. Experienced Master's level counselors are available to listen to your concerns, assess the situation and help you explore your options.

YOU'VE GOT SUPPORT

With Beacon Wellbeing you can take on all of life's challenges including:

- Child and elder care services
- Financial matters
- Legal concerns and counseling
- Education-related resources
- Marriage and relationships
- Mental and behavioral health support
- Work-related concerns

Any member of your household can call or access the secure online Beacon Wellbeing site to communicate confidentially with a counselor. Depending upon your plan, you may have access to virtual or in-person support.* A comprehensive library full of articles, videos, audio files and other helpful resources are also available online.

Call to connect with an EAP counselor today.

Confidential help is just a call or click away, anytime.

Call **1-800-432-5155** or TTY **711** to speak with an experienced counselor today. Or visit **bcbsmn3.mybeaconwellbeing.com** for additional resources.

*Check with your employer to see if this option is available.

Achieve Solutions and Beacon Wellbeing are part of Beacon Health Options, Inc., an independent company providing behavioral health services.

INTACT SERVICES USA LLC

Flexible Spending Plan

Medical FSA Summary

INTRODUCTION

INTACT SERVICES USA LLC's Flexible Benefit Plan (the "Plan") permits Eligible Employees to choose to pay for certain benefits on a pre-tax basis.

This *Summary* describes the Medical Flexible Spending Account ("Company-sponsored") Benefit Option under the Plan. Through the Medical FSA, you can pay Medical Expenses not covered by insurance for yourself and eligible family members on a pre-tax basis. This will generally result in a tax savings and increase your spendable income.

Refer to our *FSA Essential Guide* for a tax savings example. You may also want to use the *Tax Savings Calculator* link available at https://learn.hellofurther.com/ to estimate your tax savings.

The tax benefit you experience will depend on the benefits you elect, as well as other factors that affect the amount of taxes you pay. Although participating in the Plan can provide significant tax advantages, there may be tax disadvantages to participating in the Plan based on your particular situation. You may wish to consult with your tax advisor.

DETAILS REGARDING THE MEDICAL FSA BENEFIT

(a) **Medical expenses eligible for reimbursement:** To be eligible for reimbursement, an expense must be for medical care provided to diagnose, treat, or prevent disease or for sickness or injury and must be included on the list of eligible medical expenses for this Benefit Option.

(b) **Employee Elections: Your minimum annual contribution is $130 per plan year. The maximum annual contribution for this benefit is the maximum allowed by the IRS. Note that salary reduction amounts from the last paycheck of the Plan Year may be used to pay for the first month of benefits elected for the next Plan Year.**

(c) **Expenses cannot be reimbursed from any other source, including tax credits or tax deductions:** Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud and you personally will be responsible for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.

(d) **Limitations for HSA and Medical FSA combination:** If you elect to participate in both the HSA and the Medical FSA benefits under this Plan, your Medical FSA is automatically limited to reimbursement of the following HSA-Compatible expenses: Vision and Dental; Post Deductible Medical. You may also choose to participate in an HSA-Compatible Medical FSA to maintain your eligibility and/or the eligibility of your spouse to participate in an HSA outside of this Plan. If you have not elected HSA coverage under this Plan, however, you must notify Further that you wish to participate in an HSA-Compatible Medical FSA.

ELIGIBLE EMPLOYEES

Only eligible employees may participate. You are eligible if you are:

- Employed by the company or a participating employer
- Regularly scheduled to work 20 or more hours per week
- Are not an excluded individual
- Satisfy any other eligibility requirements

You are a participant if you are an eligible employee, have enrolled in the Medical FSA Plan, and have not terminated participation.

Eligible employees do not include:

- Leased employees
- Independent contractors
- Employees subject to a collective bargaining agreement (except as specifically provided in the collective bargaining agreement)
- Interns
- Employees classified as temporary
- Employees covered by written agreements stating they are not eligible to participate in this Plan.

DEPENDENTS

(a) To use the Medical FSA for reimbursement of medical expenses incurred by you for yourself or a family member who qualifies as your "Dependent".

(b) "Dependent" includes: (i) your spouse (to whom you are legally married); (ii) a person whom you can claim as a dependent on your federal income tax return; and (iii) a child whom you can claim as your health care tax dependent within the meaning of Code sections 105 or 106. This includes your son, daughter, stepson, stepdaughter or foster child who was under the age of 26 at the beginning of the calendar year.

ENROLLMENT AND PARTICIPATION

(a) **Initial enrollment:** You must enroll within 30 days after becoming an Eligible Employee. Employees are eligible for this benefit immediately after employment begins at which time participation will begin. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement.

(b) **Annual open enrollment:** If you do not enroll when you are first eligible, you must wait until the next Open Enrollment Period for another chance to participate (unless you experience an "Election Change Event" and make a "Qualifying Election Change," as discussed later in this *Summary*). Federal tax law prohibits any other mid-year enrollment. The Open Enrollment Period for each Plan Year will be determined by the Plan Administrator.

(c) **Enrollment procedure:** The Plan Administrator will provide enrollment instructions. You must complete your enrollment within the time specified by the Plan Administrator.

(d) **Medical FSA election:** You must indicate the amount you want to contribute, if any, to a Medical FSA when you enroll.

(e) **Mid-Year Enrollment:** You must enroll within 30 days after becoming an Eligible Employee. Employees are eligible for this benefit immediately after employment begins, at which time participation will begin. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement

ELECTION CHANGES DURING THE PLAN YEAR

(a) **Qualifying election changes:** Your election for any Plan Year cannot be changed during the Plan Year unless you experience an Election Change Event and make an election change that is on account of and consistent with the event (called a "Qualifying Election Change"). For complete details, request a copy of the Plan Document from the Plan Administrator or contact the Claims Administrator for assistance.

(b) **Examples:**

1. If you get married, add a child to your family through birth or adoption or have a child who gains dependent status, you can increase your Medical FSA election.

2. If you divorce, a child no longer qualifies as your dependent, or your dependent dies, you can decrease your Medical FSA election.

3. If your spouse or a dependent starts or ends a job or increases or decreases his or her work hours and gain or lose eligibility for employer-sponsored health insurance or health flexible spending account coverage as a result, you can make a corresponding increase or decrease your Medical FSA coverage through this Plan.

4. If a court order requires you or another person to provide health coverage for an eligible child, a corresponding change can be made in your Medical FSA contributions.

5. If you, your spouse or your dependent gains or loses Medicare or Medicaid coverage, a corresponding change can be made in the contributions to your Medical FSA.

6. You may change your Medical FSA election when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan Rules.

(c) **You cannot elect an amount less than the amount already reimbursed:** An election change will not be consistent with an Election Change Event if the new amount elected is less than the amount already reimbursed from the Medical FSA for the Plan Year.

(d) **Time limit for making election change:** To change your election, you must request an election change no later than 30 days after the Election Change Event (even if you are on leave at the time). You cannot change your election more than 30 days after an Election Change Event.

(e) **Election change process:** The Plan Administrator will provide instructions for requesting an election change. The Plan Administrator will determine whether an election change is permitted.

PARTICIPATION DURING A LEAVE OF ABSENCE

General Rules: Coverage will continue under this Plan during a leave of absence in accordance with the Company's leave policies and the terms and conditions of the Plan. If there is a conflict between the information provided in this section and the Company's leave policies, the Company's leave policies will control. The Company must approve your leave.

You will be required to make your premium/contribution payments ("payments") for coverage to continue. If you do not make the required payment when due, the Company may retroactively terminate your coverage to the last day for which you have paid. Expenses incurred during the period for which your coverage is retroactively terminated will not be covered. The Company can recover any payments owed. Upon return to work, the payments owed will be taken from your pay.

Contact the Plan Administrator for coverage payment options.

(a) **Paid leave of absence:** Your Medical FSA coverage and your contributions for the coverage will automatically continue during a leave of absence as long as you continue to receive pay.

(b) **Unpaid leave of absence:** Your right to continue Medical FSA coverage during unpaid leave depends on the type of leave. If you do not elect to continue your Medical FSA coverage at the beginning of leave, you will not be able to submit medical expenses you incur during the leave for reimbursement. Rules regarding specific types of unpaid leave are as follows.

1. **FMLA Leave:** If you take FMLA leave, you may choose to continue or discontinue your Medical FSA coverage. You must notify the Company's Human Resources Department of your decision.

   i. If your Medical FSA coverage terminated, it will be reinstated on return from leave. You may choose to either reinstate the per pay-period contributions you had in place prior to leave (your contribution election for the Plan Year is reduced by the contributions you missed during your leave); or increase your per pay-period contributions for the rest of the Plan Year to make up the contributions you missed during your leave (your contribution election for the Plan Year remains the same).

   ii. Even if you choose to increase your per pay-period contributions to make up the contributions you missed during the leave, you will still not be able to submit expenses you incurred during the leave for reimbursement. (Medical expenses you incur during the leave will be eligible for reimbursement only if you elected to continue your Medical FSA in advance of your leave.)

2. **Military Leave:** If you go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may continue your group health plan and Medical FSA coverage for up to 24 months during the military leave to the extent required by USERRA. You must pay for the coverage. You may reinstate your coverage on return from leave to the extent required by USERRA. Contact the Company's Human Resources Department for more information.

3. **Other Types of Leave:** Contact the Plan Administrator for details. If your Medical FSA coverage terminates as a result of your leave, you may elect to continue your coverage through COBRA. Medical FSA COBRA rights are explained in the *Notice* section of this *Summary*. If you do not elect to continue your coverage through COBRA, you will not be eligible to recommence participation until the next Open Enrollment Period or you experience an Election Change Event.

(c) **Open enrollment during your leave:** If the Open Enrollment Period for the next Plan Year occurs during your leave and your participation in the Plan continues, you will be able to make elections for Plan benefits for the new Plan Year in the same manner as active employees. If you do not elect Medical FSA benefits, you will not be eligible to participate in the Medical FSA in the new Plan Year, unless you experience an Election Change Event.

(d) **Making election changes on return from leave:** Election changes other than as noted in this section will not be permitted on return from leave unless you experience another Election Change Event.

OBTAINING REIMBURSEMENTS

(a) **Amount available for reimbursement:** Regardless of the amount you have contributed to the Medical FSA, the entire amount of your contribution election for the Plan Year (your Annual Contribution Election) less any prior reimbursements will be available to you at all times during the Plan Year. You will be reimbursed the entire amount of your claim, if it is less than your Annual Contribution Election.

(b) **Expense must be eligible for reimbursement under this plan:** The expense must qualify as medical care within the meaning of the Plan for reimbursement from the Medical FSA. Please refer to https://learn.hellofurther.com/ for a list of eligible expenses.

(c) **Expense must have been incurred during your period of coverage for plan year:** You may only use your Medical FSA to pay for Medical Expenses that you incurred during the Plan Year. Expenses incurred during one Plan Year cannot be reimbursed from contributions in another Plan Year. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter. The only exception is that expenses may be treated as incurred for orthodontia services before the services are provided if the orthodontist (following his or her normal practice) requires you to make advance payments to receive the services (*e.g.*, requires you to pay a lump sum for services to be provided that year and the next).

(d) **Expense cannot be reimbursed out of other accounts:** Amounts contributed to the Medical FSA cannot be used to reimburse expenses from the Dependent Care FSA and vice versa.

(e) **Claim submission requirements must be satisfied.** You may submit a completed claim form and independent third-party documentation of the claim to the Administrator. You may also submit your claim Online by signing into the Member Online Service Center via www.HelloFurther.com. If your Company implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Medical FSA Plan, some expenses may be validated at the time the expense is incurred (like copays for medical care). For other expenses, the card payment is only conditional. You will still have to submit supporting documents. You will receive more information from the Company about what you must do to obtain reimbursement if such a system is implemented.

1. *Claims must be submitted during the Plan's Claims Submission Period.* **Further must receive all claims for reimbursement in our office no later than 3 months after the plan year end date to be reimbursed.**

For employees that have terminated during the plan year and they have not elected COBRA (if available) claims must be received in our office 3 months from the termination date.

For employees that have terminated during the plan year and have elected COBRA (if available) claims must be received in our office 3 months from the plan year end. Upon termination of COBRA, claims must be received in office 3 months from the termination date.

2. *Documentation must be provided.* To receive reimbursement for an Eligible Expense, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill or receipt) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is incomplete, the claim may be denied and payment delayed.

3. *Claims cannot be reimbursed by Health Insurance.* You cannot submit claims for reimbursement if you have already been reimbursed by health insurance or if you intend to request reimbursement.

(f) **Method of reimbursement:** To the extent the Claims Administrator determines that a claim is properly payable under the Plan; you will be reimbursed for the expense either through a check or via direct deposit, if you have selected that option. Reimbursements will be issued as scheduled by the Claims Administrator.

(g) **Recovery of improper reimbursements:** You will be required to repay the Plan for reimbursements determined by the Claims Administrator to be ineligible for reimbursement under the Plan or otherwise improper. The Claims Administrator may use one or more of the following recovery methods: (i) you repay the amount to your Medical FSA or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount from future reimbursement payments to you for Eligible Medical Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement will be treated as a business debt and the amount reimbursed will be included in your W-2 income.

CLAIMS AND APPEAL PROCEDURE

(a) **Initial determination on claim for reimbursement**

1. *Time Period.* Within 30 days after receipt of a claim, the Claims Administrator will make its decision on the claim. The 30-day period for the initial review determination by the Plan Administrator may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Plan; and (ii) the Administrator provides notice of the extension to

you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Plan expects to render its decision. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.

2. *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notification of the denial to you which will include the specific reason for the denial, a reference to the Plan provision on which the denial is based, a description of additional information or documents necessary in order for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure. If a denial is based on an internal rule or guideline or medical judgment, information regarding the internal rule or guideline or medical judgment will either be included in the written response or you will be able to obtain a copy of the internal rule or guideline or an explanation of the medical judgment on request and free of charge.

(b) **Appeal rights and procedures.**

1. *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Plan Administrator. You must send a written request for an appeal review to the Plan Administrator within 180 days of your receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.

2. *Right to Review Documents/Submit Comments.* You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Plan administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.

3. *Person Conducting Review.* The review will be conducted by a named fiduciary for the Plan who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination. In deciding an appeal of any adverse benefit determination that is based, in whole or in part, on a medical judgment, the administrator will consult with a medical care professional who has appropriate training and experience in the applicable medical field and who is neither the individual who

was consulted in connection with the initial adverse determination nor a subordinate of such individual.

4. *Notice of Continued Denial.* If the denial is upheld in whole or part, the Claims Administrator will send notification of the denial to you. You will be notified of the Claims Administrator's decision on appeal in writing within 60 days after receipt of your appeal; this includes both levels of appeals. The notice will include the Claims Administrator's reason for its decision.

   i. *Level Two Appeal Process.* Following the Level One Appeal Process, you have additional voluntary appeal rights through Further. If you are not satisfied with our decision, you may elect to further appeal to Further by sending a letter within 30 days or the later of your run out end date requesting our Appeals Committee to reconsider the decision. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or our customer service department. You have the option to present your concerns to the Appeals Committee either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.

   ii. You may elect this voluntary appeal (Level Two Appeal) only after you have submitted a Level One Appeal and that appeal has been denied. You are not required to submit a Level Two Appeal prior to bringing a claim in court (the plan will not assert that you failed to exhaust administrative remedies in not submitting to a Level Two Appeal). The six-month limitation period provided in the Plan Document within which you may bring a claim to court is tolled during the time that the Level Two Appeal is pending.

FORFEITURE OF ACCOUNT BALANCE

Forfeiture: According to federal tax law, amounts remaining in your Medical FSA over $0 after the end of the Claims Submission Period following payment of Eligible Expenses incurred during the Plan Year must be forfeited. Such forfeited amounts will be used by the Plan Administrator, in its discretion, to pay the cost of benefits under the Plan, for administrative costs of the Plan, or to provide additional benefits to participants. Planning carefully on the amount to contribute to the spending accounts should help you to avoid forfeitures. Refer to our website at https://learn.hellofurther.com/ for a Medical FSA Election Worksheet to help you determine your contribution.

TERMINATION OF PARTICIPATION DUE TO TERMINATION OF EMPLOYMENT

(a) **When participation ends:** If your employment with the Company terminates, your participation in the Plan will end as of the date of your termination of employment.

(b) **Medical expenses incurred after termination:** Medical expenses incurred after the date of your termination from employment will not be eligible for reimbursement unless you elect to continue your participation in the Medical FSA. Please refer to the COBRA continuation information in the "Notice" section below.

(c) **Amounts remaining after termination:** Any amounts remaining in an account after the end of the Claims Submission Period for the Plan Year in which the termination occurred will be forfeited.

(d) **Re-employment by a Participating Employer:** If you terminate employment and are re-employed by a participating employer, you may participate in the Plan. Whether you are required to resume your elections in place prior to your termination or may make new elections depends on the length of time between your termination and reemployment and whether you are reemployed in the same Plan Year or a new Plan Year.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class within 30 days and within the same Plan Year will be required to resume participation in the Plan and the participant's prior benefit elections will be reinstated.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class after 30 days or more and within the same Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class in a new Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

OTHER REASONS FOR TERMINATION OF PARTICIPATION

(a) Your participation in this Plan can also end if:

1. you no longer qualify as an Eligible Employee;
2. your Employer stops participating in this Plan;
3. you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan;
4. the Company terminates the Plan; or
5. if the certifications you made to participate are no longer accurate

(b) The rules discussed above for termination of participation as a result of termination of employment also apply if termination of participation occurs for other reasons.

NOTICES

(a) **COBRA Continuation of Medical FSA Coverage:** You, your spouse or any of your dependents who lose coverage under the Medical FSA as a result of a "qualifying event" are “qualified beneficiaries” and will be eligible to continue Medical FSA coverage for the remainder of the current Plan Year as indicated in this section.

1. *Medical FSA Positive Balance Requirement.* To be eligible for COBRA: (i) there must be a positive balance in your Medical FSA as of the date your coverage would otherwise terminate because of a qualifying event; and (ii) the COBRA Premiums you are required to pay for the remainder of the Plan Year must exceed available reimbursements.

2. *Qualifying Events.* For employees, the qualifying events are: (i) termination of employment for any reason other than gross misconduct; and (ii) a reduction in hours. For a spouse or dependent, the qualifying events may include: (i) the employee's termination of employment for any reason other than gross misconduct; (ii) the employee's loss of eligibility for coverage due to a reduction in scheduled work hours; (iii) the employee's death; (iv) the employee's divorce or legal separation; (v) a dependent child's ceasing to qualify as an eligible dependent under the Medical FSA; and (vi) the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

3. *Maximum COBRA Coverage Period.* COBRA continuation coverage is a temporary continuation of Medical FSA coverage. For each qualified beneficiary who elects COBRA continuation coverage, the COBRA coverage will begin on the date of the qualifying event. The maximum COBRA coverage period is through the end of the Plan Year in which the qualifying event occurred. The continuation coverage period is a maximum period that will be reduced as described below.

4. *You must provide notice to the Plan Administrator of certain events.* The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or the employee’s death, the employer will notify the Plan Administrator of the Qualifying Event. Qualified beneficiaries must notify the Plan Administrator of the employee’s divorce, legal separation or child's ceasing to qualify as a dependent under the Medical FSA within 60 days of the date of the qualifying event. If the Plan Administrator is not given the notice within 60 days, the right to continue coverage will be lost.

5. The notice must be in writing, must contain the information described below, and must be mailed by first class mail, postage prepaid and addressed to the Plan Administrator at the address indicated in the **Plan Specifications** section of this summary.

6. The notice must contain the following information: (i) the name, address and Social Security Number of the employee; (ii) the name, address and Social Security Number of each qualified beneficiary (*e.g.*, employee, spouse, dependent child); (iii) a description of the qualifying event; (iv) the date of the qualifying event; and (v) a list of the Benefit Options under which the affected qualified beneficiaries are covered.

7. *Type of Coverage available for Continuation***.** A qualified beneficiary may elect to continue the Medical FSA coverage in effect immediately before the qualifying event.

8. *Who may elect COBRA Coverage?* An employee can make the election for himself or herself, his or her spouse, or any of his or her dependent children. If the employee does not make the election, his or her spouse can make the election for himself or herself and any dependent children. Finally, if neither the employee nor spouse makes the election for a dependent child, the dependent may make the election for him or herself. (A child who is born to, or placed for adoption with, the employee while the employee is continuing coverage under COBRA and who becomes covered by the Medical FSA will have independent COBRA election rights as if he or she were covered at the time of the qualifying event.)

9. *COBRA Election Period.* After a qualifying event or receiving notice of a qualifying event (if notice is required), the Plan Administrator will send qualified beneficiaries a notice regarding COBRA election rights. Qualified beneficiaries will have 60 days from the date of such notice (or from the date coverage would otherwise terminate because of the qualifying event, if the coverage would stop after the notice is sent) in which to file a written election to continue coverage. If a qualified beneficiary does not file the election within the 60-day period, he or she will lose the right to continue Medical FSA coverage. The election must be filed with the Plan Administrator at the address specified in the election form.

10. *COBRA Contributions.* Contributions for the continuation coverage will be on an after-tax basis unless your Compensation continues and the Plan Administrator permits pre-tax contributions for continuation coverage. A qualified beneficiary must pay the full contribution, plus a 2% administration fee, for any coverage he or she continues. He or she must make the first contribution payment, covering the period between the date coverage would otherwise stop and the end of the month preceding the date of the payment, within 45 days after the date the election to continue coverage was filed. Subsequent contributions are due on the first day of each month for which a qualified beneficiary continues coverage, and coverage will end if he or she fails to pay the contribution for any month within 30 days after the due date.

11. *No COBRA Coverage Pending Election or Payment.* A qualified beneficiary will not have COBRA coverage until he or she has elected the coverage and made the

required contribution payment. No claims for health care incurred while coverage is not in effect will be eligible for reimbursement. Once a qualified beneficiary makes the election and pays the contribution, coverage will be reinstated retroactively to the date he or she lost the coverage.

12. *Termination of COBRA Coverage.* The continuation coverage will terminate when the first of the following events occurs: (i) the end of the current Plan Year; (ii) the qualified beneficiary fails to pay the initial contribution within 45 days after your election, in which case he or she will be treated as not having elected to continue Medical FSA coverage; (iii) the qualified beneficiary fails to pay any other contribution within 30 days after it is due, in which case coverage will end as of the end of the last day of the month for which he or she made a timely contribution payment; (iv) after electing continuation coverage, the qualified beneficiary becomes entitled to any other group health plan that does not limit or exclude coverage because of a preexisting condition (coverage already in place at the time of the continuation coverage election will not cause termination of continuation coverage); and (v) the employer ceases to provide Medical FSA account benefits to any of its employees.

13. *Keep the Plan informed of Address Changes.* To protect Medical FSA COBRA continuation rights, qualified beneficiaries should keep the Plan Administrator informed of any address changes.

14. *Keep Copies of Notices.* Qualified beneficiaries should also keep copies for their records of any notices sent to the Plan Administrator.

15. *Plan Administrator Contact Information.* The address and telephone number for the Plan Administrator is listed in the **Plan Specifications** section of this summary.

(b) **HIPAA Privacy Rule Notice of Privacy Practices:** The Medical FSA component of the Plan is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the Plan's *Notice of Privacy Practices* (which summarizes the Plan's Privacy Rule obligations, your Privacy Rule rights, and how the Plan may use or disclose health information protected by the Privacy Rule) from the Plan Administrator.

(c) **Statement of ERISA Rights of Plan Participants:** As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. *Receive Information about your Plan and Benefits.*

   i. Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the Plan and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S.

Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

ii. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 series) and the latest updated summary plan description. This *Summary*, along with the Plan Document for the HRA, comprise the Plan Document for this benefit. The Plan Administrator may make a reasonable charge for the copies.

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

2. *Continue Group Health Plan Coverage.* Continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary for your HRA COBRA continuation rights.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide

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

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

(d) **Company's right to terminate or amend the Plan:** The Company reserves the right to amend or terminate the Plan at any time and without notice.

(e) **No guarantee of employment:** Participation in this Plan is not a guarantee of employment.

(f) **Plan Administrator's discretion:** The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

PLAN SPECIFICATIONS

Employer, Plan Sponsor and Plan Administrator:

INTACT SERVICES USA LLC
605 North Highway 169 Ste 800
Plymouth, MN 55441

Telephone: 952-852-6748

Claims Administrator:

Further
3535 Blue Cross Road
Eagan, MN 55122-1154
651-662-5065 or 800-859-2144
www.HelloFurther.com

Plan Year:

January 1 through December 31

INTACT SERVICES USA LLC

Flexible Spending Plan

Dependent Care FSA Summary

INTRODUCTION

INTACT SERVICES USA LLC's Flexible Benefit Plan (the "Plan") permits Eligible Employees to choose to pay for certain benefits on a pre-tax basis.

This *Summary* describes the Dependent Care Flexible Spending Account ("Dependent Care FSA") Benefit Option under the Plan. Terms may be defined in this *Summary* and in the *Plan Document*.

Through the Dependent Care FSA, you can pay Dependent Care Expenses on a pre-tax basis. This will generally result in a tax savings and increase your spendable income.

Refer to our *DCAP Essential Guide* for a tax savings example. You may also want to use the *Tax Savings Calculator* link available at https://learn.hellofurther.com/ to estimate your tax savings.

The tax benefit you experience will depend on the benefits you elect, as well as other factors that affect the amount of taxes you pay. Although participating in the Plan can provide significant tax advantages, there may be tax disadvantages to participating in the Plan based on your particular situation. You may wish to consult with your tax advisor.

DETAILS OF THE DEPENDENT CARE FSA BENEFIT

(a) **Dependent care Expenses Eligible for reimbursement:** You can use your Dependent Care FSA to pay for Dependent Care Expenses. Dependent Care Expenses must be work-related to be eligible for reimbursement. Details are provided below. Examples of Eligible Dependent Care Expenses are at https://learn.hellofurther.com/. **Your minimum annual contribution is $130 per plan year. The maximum annual contribution for this benefit is $5,000. Note that salary reduction amounts from the last paycheck of the Plan Year may be used to pay for the first month of benefits elected for the next Plan Year.**

1. "Dependent Care Expense" means:

   i. an amount that you incur for the Care of a Qualifying Individual and Household Services incidental to that care

   ii. to enable you, and if you are married, your spouse to be "gainfully employed" or to actively search for "gainful employment" (*i.e.*, the dependent care must be necessary for you to work or to find work)

2. A Dependent Care Expense is "incurred" on the date on which the services are provided, regardless of the date on which payment for such services is due or made.

3. "Qualifying Individual" is defined below.

4. "Care of a Qualifying Individual" means services, the primary purpose of which is to provide for the Qualifying Individual's well-being and protection. It does not include the provision of food, clothing or education unless such benefits are incidental to such primary purpose and does not include the provision of education to an individual in kindergarten or any higher grade.

5. "Household Services" are services performed in and around your home that are ordinary and usual services necessary to maintain your household and are attributable, at least in part, to the Care of the Qualifying Individual.

6. "Gainfully employed" or "gainful employment" means a job. Your spouse will be deemed to be gainfully employed during any month in which he or she is either a full-time student at an educational institution or is a Qualifying Individual (*i.e.*, physically or mentally incapable of caring for himself or herself).

(b) **You must request reimbursement:** To receive reimbursement for Dependent Care Expenses, you must submit a completed claim form (which includes your promise that the expenses have not been reimbursed from any other source and that you will not seek reimbursement for the expenses from any other source) and independent third-party documentation of the expense.

Online: To receive reimbursement for FSA expenses, you may submit your form by signing into the Member Online Service Center via www.HelloFurther.com and submitting your claim online.

(c) **Maximum benefits:** Federal law limits the amount that can be reimbursed from your Dependent Care FSA if you are married but file a separate federal income tax return and if you are single or married filing a joint federal income tax return. Moreover, benefits can never be more than your "earned income" for the year. Your earned income is your adjusted gross income or, if less, the adjusted gross income of your spouse if you are married. If your spouse is unemployed because he or she is incapable of self-care or is a full-time student, your spouse will be deemed to have an earned income of a certain amount per month depending upon whether there is one Qualifying Individual or two or more Qualifying Individuals. IRS Publication 503, which you may obtain from the IRS's web site at http://www.irs.gov describes the deemed earned income limitation.

Note: If the Plan provides a Grace Period, Carryover Amounts used to pay Eligible Expenses incurred during the Grace Period will count toward the $5,000 maximum for the calendar year in which such expenses are paid. Refer to the *Plan Specifications* section to determine whether the Plan provides a Grace Period.

(d) **Dependent Care tax credit:** The federal tax law allows you to take a tax credit on your federal income tax return for qualified dependent care expenses in an amount up to $3,000 for one dependent and up to $6,000 for two or more dependents. (Your potential tax credit is a percentage of these amounts that depends on your adjusted gross income).

The difference between the Dependent Care FSA and the tax credit is that the Dependent Care FSA provides a reduction in your taxable income, while the tax credit offers a direct reduction on the amount of tax you pay. You cannot use the Dependent Care FSA and the tax credit for the same expenses. In addition, use of the Dependent Care FSA will reduce dollar for dollar or eliminate your tax credit. You will need to determine which of these methods is best for you, because each person's tax situation is unique, your own tax advisor should be consulted to help you determine which approach is best for you. The Dependent Care Tax Savings Worksheet in our *DCAP Essential Guide* may be helpful in determining whether the tax credit is more advantageous for you.

(e) **Reimbursements are reported on form W-2:** The reimbursements you receive for Dependent Care Expenses will be reported to the IRS on your W-2 Form for the year. These amounts should not generally be taxable unless: (i) your reimbursements exceed your earnings for the year or, if you are married on the last day of the year, your spouse's earnings for the year; or (ii) you do not report the taxpayer identification number of your dependent care service provider when you file your federal income tax return.

(f) **Dependent Care provider information on tax return:** You will be required to list on your annual tax return the names and taxpayer identification numbers of any persons who provided you with dependent/day care services during the calendar year for which you have claimed a tax-free reimbursement.

(g) **Expenses cannot be reimbursed from any other source, including tax credits or tax deductions:** Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud and you personally will be responsible for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.

ELIGIBLE EMPLOYEES

Only eligible employees may participate. You are eligible if you are:

- Employed by the company or a participating employer
- Regularly scheduled to work 20 or more hours per week
- Are not an excluded individual
- Satisfy any other eligibility requirements

You are a participant if you are an eligible employee, have enrolled in the Dependent Care FSA Plan, and have not terminated participation.

Eligible employees do not include:

- Leased employees

- Independent contractors
- Employees subject to a collective bargaining agreement (except as specifically provided in the collective bargaining agreement)
- Interns
- Employees classified as temporary
- Employees covered by written agreements stating they are not eligible to participate in this Plan.

DEPENDENTS

(a) You may only use the Dependent Care FSA to be reimbursed for expenses of someone who qualifies as your Dependent.

(b) For the Dependent Care FSA, "Dependent" means someone who meets the requirements of a "Qualifying Individual." If a Dependent ceases to meet these requirements during a Plan Year (e.g., a dependent child turns 13), Eligible Dependent Care Expenses incurred before the Dependent ceased to meet the requirements may still be reimbursed.

(c) A Qualifying Individual means an individual who is your Qualifying Child, Qualifying Spouse or Qualifying Relative, as defined below

If you and your child's other parent do not live together, only the parent with primary physical custody (parent with whom the child resides for more than six months out of the year) can be reimbursed for Dependent Care Expenses for the child and then only for the days in which the child resides with him or her. The other parent cannot seek reimbursement of Dependent Care Expenses even for the days during which the child resides with him or her.

1. *A Qualifying Child*. This means an individual who:

   i. has one of the following relationships to you: son, daughter, stepdaughter, stepson, brother, sister, stepbrother, stepsister, foster child, or child for whom the you have legal guardianship (or a descendent of any of these individuals);

   ii. is under the age of 13;

   iii. lives with you for more than one half the year; and

   iv. does not provide more than one half of his or her own support.

2. *A Qualifying Spouse*. This means your spouse who:

i. lives with you for more than half of the year; and

ii. is physically or mentally incapable of self-care.

3. *A Qualifying Relative*. This means an individual:

i. who has a "Qualifying Child" relationship to you (as specified in subsection (c)(1)(i) above) or who is your father, mother, stepfather, stepmother, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law, or who lives with you and is a member of your household;

ii. who is not your Qualifying Child or the Qualifying Child of any other person;

iii. for whom over one half of whose support for the year is provided by you;

iv. who lives with you more than half of the year; and

v. who is physically or mentally incapable of self-care.

ENROLLMENT AND PARTICIPATION

(a) **Initial Enrollment:** You must enroll within 30 days of becoming an Eligible Employee. An eligible employee may participate in the Plan immediately after employment begins. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement.

(b) **Annual Open Enrollment:** If you do not enroll when you are first eligible, you must wait until the next Open Enrollment Period for another chance to participate (unless you experience an "Election Change Event" and make a "Qualifying Election Change," as discussed later in this *Summary*). Federal tax law prohibits any other mid-year enrollment. The Open Enrollment Period for each Plan Year will be determined by the Plan Administrator.

(c) **Enrollment procedure:** The Plan Administrator will provide enrollment instructions. You must complete your enrollment within the time specified by the Plan Administrator.

(d) **Dependent Care FSA election:** You must indicate the amount you want to contribute, if any, to a Dependent Care FSA when you enroll.

(e) **Mid-Year Enrollment:** You must enroll within 30 days after becoming an Eligible Employee. Employees are eligible for this benefit immediately after employment begins, at which time participation will begin. Days of employment prior to termination or unpaid leave of an employee is not counted for the service requirement.

ELECTION CHANGES DURING THE PLAN YEAR

(a) **Qualifying Election Changes:** Your election for any Plan Year cannot be changed during the Plan Year unless you experience an Election Change Event and make an election change that is on account of and consistent with the event (called a "Qualifying Election Change"). For complete details, request a copy of the Plan Document from the Plan Administrator or contact the Claims Administrator for assistance.

(b) **Examples.**

1. If you add a child to your family (through birth or adoption), you can increase your Dependent Care FSA election.

2. If a child or other Dependent is no longer a Qualifying Individual (for example, your child turns 13), you may decrease or terminate your Dependent Care FSA election.

3. If you divorce and your child no longer lives with you, you may decrease or terminate your Dependent Care FSA election.

4. If your cost for dependent care changes, you may make a corresponding change to your Dependent Care FSA election (unless your Dependent Care provider is a relative).

5. If your need for dependent care changes due to a job change or a change in work hours, you may make a corresponding change to your Dependent Care FSA election.

(c) **You cannot elect an amount less than the amount already reimbursed:** An election change will not be consistent with an Election Change Event if the new amount elected is less than the amount already reimbursed from the Dependent Care FSA for the Plan Year.

(d) **Time limit for making election change:** To change your election, you must request an election change not later than 30 days after the Election Change Event (even if you are on leave at the time). You cannot change your election more than 30 days after an Election Change Event.

(e) **Election change process:** The Plan Administrator will provide instructions for requesting an election change. The Plan Administrator will determine whether an election change is permitted.

PARTICIPATION DURING A LEAVE OF ABSENCE

General rules. Coverage will continue under this Plan during a leave of absence in accordance with the Company's leave policies and the terms and conditions of the Plan. If there is a conflict between the information provided in this section and the Company's leave policies, the Company's leave policies will control. Your leave must be approved by the Company.

You will be required to make your premium/contribution payments ("payment" or "payments") for coverage to continue. If you do not make the required payment when due (including any grace period), the Company may retroactively terminate your coverage to the last day for which you have paid. Expenses incurred during the period for which your coverage is retroactively terminated will not be covered. The Company can recover any payments owed. Upon return to work, any payments owed will be taken from your pay. Contact the Plan Administrator for coverage payment options.

Additional Rules for Dependent Care FSAs

(a) **Paid Leave of Absence:** Your Dependent Care FSA contributions will automatically continue as long as you continue to receive pay. Although you will continue to contribute to your Dependent Care FSA during a paid leave, dependent care expenses you incur during the leave will not be eligible for reimbursement due to tax rules. Do not submit claims for reimbursement for dependent care expenses incurred during your leave.

(b) **Unpaid Leave of Absence:** Your Dependent Care FSA contributions will terminate during an unpaid leave. Dependent care expenses you incur during an unpaid leave will not be eligible for reimbursement. You may reinstate your Dependent Care FSA contributions on return from leave.

(c) **Open Enrollment during your Leave:** If the open enrollment period for the next Plan Year occurs during your leave and your participation in the Plan continues, you will be able to make elections for Plan benefits for the new Plan Year in the same manner as active employees. If you do not elect Dependent Care FSA benefits, you will not be eligible to participate in these benefits in the new Plan Year, unless you experience an Election Change Event and make an election change within 30 days of that event.

(d) **Making Election Changes on return from Leave:** Election changes other than as noted in this section will not be permitted on return from leave unless you experience another Election Change Event and make the election change within 30 days of the event.

PART-TIME EMPLOYMENT AND ABSENCES FROM WORK FOR MINOR ILLNESS OR VACATION

(a) **Part-Time Employment:** Only Dependent Care Expenses incurred on the days during the week that both you and your spouse are working are eligible for reimbursement. If you and/or your spouse work part-time but are required to pay for dependent care on a weekly or monthly basis for both days worked and not worked (part-time daycare is not available), the entire cost will be eligible for reimbursement.

(b) **Temporary-Absences due to minor illness or vacation:** Only Dependent Care Expenses incurred on the days during the week that both you and your spouse are working are eligible for reimbursement. Dependent Care Expenses incurred while you and/or your spouse are absent from work for a few days due to a minor illness or vacation, however,

are still eligible for reimbursement if you are required to pay for dependent care on a weekly or monthly basis for both days worked and not worked. An absence of no more than two consecutive weeks is considered a temporary absence.

OBTAINING REIMBURSEMENTS

(a) **Amount available for reimbursement:** The amount available for reimbursement during the Plan Year will be limited to the balance in your Dependent Care FSA (your payroll contributions, less any reimbursements already made from the Account for that Plan Year).

(b) **Expense must be eligible for reimbursement under this Plan:** The expense must qualify as a Dependent Care Expense within the meaning of the Plan for reimbursement from the Dependent Care FSA. Please refer to https://learn.hellofurther.com/ for a list of eligible expenses.

(c) **Expense must have been incurred during your period of coverage for Plan Year:** You may only use your Dependent Care FSA to pay for Dependent Care Expenses that you incurred during the Plan Year and Grace Period following the Plan Year. Expenses incurred during one Plan Year cannot be reimbursed from contributions made during another Plan Year, except that expenses incurred during a Grace Period can be reimbursed from Grace Period Amounts from the prior Plan Year. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter.

(d) **Expense cannot be reimbursed out of other accounts:** Amounts contributed to the Dependent Care FSA cannot be used to reimburse expenses from the Medical FSA and vice versa.

(e) **Claim submission requirements must be satisfied.** You may submit a completed claim form and independent third-party documentation of the claim to the Administrator. You may also submit your claim Online by signing into the Member Online Service Center via www.HelloFurther.com

1. *Claims must be submitted during the Plan's Claims Submission Period.* **Further must receive all claims for reimbursement in our office no later than 3 months after the plan year end date to be reimbursed.**

   For employees that have terminated during the plan year, claims must be received 3 months from the plan year end.

2. *Documentation must be provided.* To receive reimbursement for an Eligible Expense, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill or receipt) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is

incomplete, the claim may be denied and payment delayed.

(f) **Method of reimbursement:** To the extent the Claims Administrator determines that a claim is properly payable under the Plan; you will be reimbursed for the expense, either through a check or via direct deposit, if you have selected that option. Reimbursements will be issued as scheduled by the Claims Administrator. Your claim for a Dependent Care Expense will be paid up to the amount you have contributed to your Dependent Care FSA as of the day the claim is processed. If the claim amounts exceed the amount in your account, you will be reimbursed up to the amount available in your account. A claim balance will be carried forward and will be paid when additional funds become available. You do not need to send in more than one claim for an Eligible Expense.

(g) **Recovery of improper reimbursements:** You will be required to repay the Plan for reimbursements determined by the Claims Administrator to be ineligible for reimbursement under the Plan or otherwise improper. The Claims Administrator may use one or more of the following recovery methods: (i) you repay the amount to your Dependent Care FSA or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount from future reimbursement payments to you for Eligible Dependent Care Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement may be treated as a business debt and the amount reimbursed will be included in your W-2 income.

CLAIMS AND APPEAL PROCEDURE

(a) **Initial determination on claim for reimbursement**

1. *Time Period.* Within 30 days after receipt of a claim, the Claims Administrator will make its decision on the claim. The 30-day period for the initial review determination by the Claims Administrator may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Plan; and (ii) the Administrator provides notice of the extension to you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Plan expects to render its decision. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.

2. *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notification of the denial to you which will include the specific reason for the denial, a reference to the Plan provision on which the

denial is based, a description of additional information or documents necessary in order for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure.

(b) **Appeal Rights and Procedures.**

1. *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Claims Administrator. You must send a written request for an appeal review to the Claims Administrator within 180 days of your receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.

2. *Right to Review Documents/Submit Comments.* You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Claims Administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.

3. *Person Conducting Review.* The review will be conducted by a person who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination.

4. *Notice of Continued Denial.* If the denial is upheld in whole or part, the Claims Administrator will send notification of the denial to you. You will be notified of the Claims Administrator's decision on appeal in writing within 60 days after receipt of your appeal, this includes both levels of appeals. The notice will include the Claims Administrator's reason for its decision.

    i. *Level Two Appeal Process.* Following the Level One Appeal Process, you have additional voluntary appeal rights through Further. If you are not satisfied with our decision, you may elect to further appeal to Further by sending a letter within 30 days or the later of your run out end date requesting our Appeals Committee to reconsider the decision. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or our customer service department. You have the option to present your concerns to the Appeals Committee either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.

ii. You may elect this voluntary appeal (Level Two Appeal) only after you have submitted a Level One Appeal and that appeal has been denied. You are not required to submit a Level Two Appeal prior to bringing a claim in court (the plan will not assert that you failed to exhaust administrative remedies in not submitting to a Level Two Appeal). The six-month limitation period provided in the Plan Document within which you may bring a claim to court is tolled during the time that the Level Two Appeal is pending.

GRACE PERIOD AND FORFEITURE OF ACCOUNT BALANCE

(a) **Grace Period:** You will now have an additional 2.5 months in the following Plan Year in which you can incur Eligible Expenses that may be reimbursed from your Account balance from the previous Plan Year. The Grace Period claims need to be submitted by the end of the Claims Submission Period. Any amounts remaining in your Accounts following the Grace Period (and after the end of the Claims Submission Period) will be forfeited.

(b) **Forfeiture:** According to federal tax law, amounts remaining in your Dependent Care FSA after the end of the Claims Submission Period following payment of Eligible Expenses incurred during the Plan Year and any Grace Period must be forfeited. Such forfeited amounts will be used by the Plan Administrator, in its discretion, to pay the cost of benefits under the Plan, for administrative costs of the Plan, or to provide additional benefits to participants. Planning carefully on the amount to contribute to the spending accounts should help you to avoid forfeitures. Refer to our https://learn.hellofurther.com/ for a Dependent Care FSA Election Worksheet to help you determine your contribution.

TERMINATION OF PARTICIPATION DUE TO TERMINATION OF EMPLOYMENT

(a) **When Participation ends:** If your employment with the Company terminates, your participation in the Plan will end as of the date of your termination of employment.

(b) **Dependent Care Expenses incurred after termination:** If you have a balance remaining in your Dependent Care FSA after your termination from employment, your participation in this benefit will be deemed to continue until you have "spent down" your Account or through the end of the Plan Year in which your termination occurred, whichever occurs first. You can submit Dependent Care Expenses incurred after the date of your termination but before the end of that Plan Year. All other Plan requirements for eligibility of Dependent Care Expenses, including that the expenses must be necessary for you to work or to find work, must be satisfied.

(c) **Amounts remaining after Termination:** Any amounts remaining in an account after the end of the Claims Submission Period for the Plan Year in which the termination occurred will be forfeited.

(d) **Re-employment by a Participating Employer:** If you terminate employment and are re-employed by a participating employer, you may participate in the Plan. Whether you are

required to resume your elections in place prior to your termination or may make new elections depends on the length of time between your termination and reemployment and whether you are reemployed in the same Plan Year or a new Plan Year.

A Participant who terminates employment and is re-employed by a participating employer in an Eligible Employee class within 30 days and within the same Plan Year will be required to resume participation in the Plan and the participant's prior benefit elections will be reinstated.

A Participant who terminates employment and is re-employed by a participating employer in an eligible employee class after 30 days or more and within the same Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

A Participant who terminates employment and is re-employed by a participating employer in an eligible employee class in a new Plan Year will be treated as a new employee. Such a person must satisfy any Service Requirement and re-enroll in the Plan.

OTHER REASONS FOR TERMINATION OF PARTICIPATION

(a) Your participation in this Plan can also end if:

1. you no longer qualify as an Eligible Employee;

2. your Employer stops participating in this Plan;

3. you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan; or

4. the Company terminates the Plan.

(b) The rules discussed above for termination of participation as a result of termination of employment also apply if termination of participation occurs for other reasons.

NOTICES

(a) **ERISA, HIPAA and COBRA do not apply:** The Dependent Care FSA is not an employee benefit plan within the meaning of ERISA and is not subject to ERISA, HIPAA or COBRA.

(b) **Company's right to terminate or amend the Plan:** The Company reserves the right to amend or terminate the Plan at any time and without notice.

(c) **No guarantee of employment:** Participation in this Plan is not a guarantee of employment.

(d) **Plan Administrator's discretion:** The Plan Administrator (and persons to whom it has

delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

PLAN SPECIFICATIONS

Employer, Plan Sponsor and Plan Administrator:

INTACT SERVICES USA LLC
605 North Highway 169 Ste 800
Plymouth, MN 55441

Telephone: 952-852-6748

Claims Administrator:

Further
3535 Blue Cross Road
Eagan, MN 55122-1154
651-662-5065 or 800-859-2144
www.HelloFurther.com

Plan Year:

January 1 through December 31

INTACT INSURANCE GROUP USA SEVERANCE PLAN

Summary Plan Description

Date of Issue: July 1, 2021

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INTACT INSURANCE GROUP USA SEVERANCE PLAN

Summary Plan Description

1. What is the Plan about?

The Intact Insurance Group USA Severance Plan (the "Plan") provides severance and other benefits to eligible employees of Intact Services USA LLC (the "Company"), Atlantic Specialty Insurance Company and A.W.G. Dewar who suffer a termination of employment, subject to the terms and conditions set forth in the Plan.

2. What is this Summary Plan Description?

This document is called a Summary Plan Description (the "SPD"). Its purpose is to summarize the main provisions of the Plan by providing highlights of the Plan and answers to questions employees frequently ask. This SPD reflects the provisions of the Plan that are in effect as of the date of issuance of this SPD.

You are urged to read this SPD carefully. Although every effort has been made to describe the essential provisions of the Plan as of the date of issuance of this SPD as accurately as possible, the requirements for participation and the benefits payable will be determined strictly in accordance with the Plan document. If any conflict should arise between the SPD and the Plan, or if any point is not covered in this SPD or is only partially covered, the terms of the Plan will govern in all cases.

This SPD is provided for informational purposes only and is not a contract between the Company and any employee, and it should not be construed as an inducement of employment with respect to any employee. Nothing contained in the SPD or the Plan will give any employee or other service provider the right to be retained in the service of the Company or any of its affiliates, or interfere with the right of the Company or any of its affiliates to discharge or change the status of any employee or other service provider at any time.

3. Who administers the Plan?

The Board of Managers of the Company will designate the persons responsible for administering the plan, whom we refer to as the "Plan Administrator". As of the effective date of the Plan, the Plan Administrator is the Human Resources Department of the Company.

4. Who is eligible to participate in the Plan?

Certain employees of the Company, Atlantic Specialty Insurance Company and A.W.G. Dewar who experience a Qualifying Termination (defined below) are eligible to participate in the Plan and, subject to certain terms and conditions described in this SPD, may be eligible for severance benefits. We refer to an eligible employee who experiences a Qualifying Termination as a "Severed Employee".

The following individuals are not eligible to participate in the Plan:

- any temporary, seasonal or leased employees;
- any members of a collective bargaining unit (unless the applicable collective bargaining agreement provides for participation in the Plan); or
- any independent contractors.

5. What does "Qualifying Termination" mean?

A "Qualifying Termination" is a termination of an eligible employee's employment either:

(i) by the Company (or Atlantic Specialty Insurance Company or A.W.G. Dewar, as applicable) other than due to "Cause" or "Disability" (as such terms are defined below); or

(ii) by the eligible employee due to "Constructive Termination" (defined below).

A Qualifying Termination does not include, and severance benefits will not be paid under the Plan in the event of, any termination of an employee's employment by reason of retirement, death, Disability, a termination by the Company for Cause, or a resignation by an employee other than due to Constructive Termination.

6. What qualifies as "Cause", "Disability" and "Constructive Termination"?

Generally, "Cause" means any of the following, as determined by the Plan Administrator in good faith:

(i) an employee's dereliction of duties or negligence or failure to perform his or her duties or willful refusal to follow any lawful directive of his or her immediate supervisor, the President of the Company (or the chief executive officer (or title of similar import) of any direct or indirect parent company of the Company) or the Board of Managers of the Company (or similar governing body of any direct or indirect parent company of the Company), as applicable;

(ii) an employee's conviction of, or plea of *nolo contendere* to, a felony or any crime involving moral turpitude or dishonesty;

(iii) an employee's commission of fraud, embezzlement, theft or any deliberate misappropriation of money or other assets of the Company;

(iv) an employee's breach of any term of any employment or similar agreement entered into between the Company and such employee, or breach of his or her fiduciary duties to the Company;

(v) any willful act, or failure to act, by an employee in bad faith to the detriment of the Company or business unit thereof (whether financially or reputationally); or

(vi) an employee's willful failure to cooperate in good faith with a governmental or internal investigation of the Company or any of its directors, managers, officers or employees, if the Company requests his or her cooperation.

Generally, "Disability" means a determination that an employee is disabled in accordance with a long-term disability insurance program maintained by the Company or a determination by the U.S. Social Security Administration that an employee is totally disabled.

Generally, "Constructive Termination" means a resignation by an employee following:

(i) a material decrease in such employee's total annual compensation opportunity (calculated as a the sum of such employee's annual base salary plus target annual bonus);

(ii) a material diminution in the authority, duties or responsibilities of his or her position such that such employee cannot continue to carry out his or her job in substantially the same manner as it was intended to be carried out immediately before such diminution; or

(iii) a relocation of such employee's principal place of employment by more than 35 miles.

In order for a resignation to qualify as a Constructive Termination, the employee must declare that the resignation is due to Constructive Termination by delivering prior written notice to the Secretary of the Company within 30 days following the initial existence of the circumstances giving rise to the Constructive Termination. Upon receipt of such notice, the Company will have 30 days in which it may fix or "cure" the circumstances giving rise to the Constructive Termination. If the Company fails to cure, then the employee's effective date of resignation must be no later than 10 days after the Company's failure to cure.

If the Company cures the circumstances giving rise to the Constructive Termination within 30 days of receipt of the employee's notice, or if the employee fails to tender notice or resignation within the prescribed time periods, then a Constructive Termination will not have occurred.

7. Will I be eligible for severance if my employment is terminated in connection with a sale?

If the business for which your services are principally performed are sold or transferred to a third party, and your employment is terminated without Cause as a result, then you may be eligible for severance benefits. It depends on whether you receive a comparable offer of employment from the third party or its affiliate (which we refer to as the "purchaser").

If the purchaser provides you with an offer of employment that includes (i) compensation and benefits that are at least equal to your total compensation and benefits with the Company and its affiliates as of immediately prior to such sale or transfer and (ii) a comparable position at the same or a nearby geographic work location (in each case, as determined by the Plan Administrator), and you *refuse* to accept the offer, you will not be eligible for severance benefits under the Plan.

If you receive a comparable offer of employment from the purchaser and accept the offer, you will not be eligible for severance benefits under the Plan.

If, however, you don't receive a comparable offer of employment from the purchaser, and your employment with the Company and its affiliates is terminated without Cause as a result of the sale or transfer, then you will be eligible for severance benefits under the Plan.

8. Do I need to sign anything in order to receive severance benefits under the Plan?

Yes. In order to receive severance benefits under the Plan, a Severed Employee must sign and deliver an effective release of claims, in the form provided by the Company. (In the case of death or disability occurring after termination, the Severed Employee's legal guardian or the legal representative of his or her estate may sign and deliver the release.)

The release of claims must be signed and delivered within 45 days following the date of the Qualifying Termination. In addition, the Severed Employee must not revoke the release within the applicable revocation period (which is generally seven days after the employee signs the release (or 14 days for those employees whose termination is subject to Minnesota law)).

If you fail to timely deliver an effective release of claims, you will not be entitled to any benefits under the Plan (including severance pay, subsidized COBRA coverage or outplacement benefits).

9. What severance benefits does the Plan provide?

Eligible employees who experience a Qualifying Termination, and who execute and do not revoke the release of claims described above, are eligible to receive severance benefits under the Plan, as described below.

A. Severance Pay. Severance pay will equal a multiple of the employee's weekly base salary (plus, in the case of executives only, a multiple of target bonus for the year of termination), as detailed in the table below:

Employee Level (Determined by Base Salary)	**Severance Pay**
(1) Employees with an annual base salary of less than $125,000.	Total (x) 4 weeks' base salary minimum OR (y) 2 weeks' base salary for each fully completed year of service plus prorated share for partial year of service, whichever is greater, subject to a maximum total of 26 weeks' base salary.
(2) Employees with an annual base salary equal to or greater than $125,000, but less than $175,000.	Total 26 weeks' base salary, regardless of years of service.
(3) Employees with an annual base salary equal to or greater than $175,000.	Total 52 weeks' base salary, regardless of years of service.
(4) Executives (i.e., (i) the executive-level employees who report directly to the chief executive officer of Intact Services USA LLC and (ii) the chief executive officer of Intact Services USA LLC).	Total (x) 104 weeks base salary, regardless of years of service, plus (y) 2 times annual target bonus under the STIP Plan for the year in which the Qualifying Termination occurs.

For purposes of the table above:

- The base salary rate used to calculate the severance pay above is the employee's base salary rate as of immediately prior to the Qualifying Termination, without regard to any decrease in such base salary giving rise to Constructive Termination.

- If the employee is entitled to any notice pay, the severance pay described in the table above will be reduced dollar-for-dollar by any such notice pay.

- In the unlikely event that the Plan Administrator determines that the amount of severance pay calculated pursuant to the table above would exceed the limits applicable to the Plan in order to qualify as a "severance pay arrangement" within the meaning of regulations published by the Secretary of Labor at Title 29, Code of Federal Regulations §2510.3-2(b), an employee's severance benefits under the Plan may be adjusted (reduced) accordingly.

B. COBRA Continuation. If a Severed Employee properly elects continuation coverage under the Company's group health plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), within the time period prescribed pursuant to COBRA, then commencing as of the Severed Employee's Qualifying Termination and continuing for the same number of weeks of base salary used to calculate the severance pay, as described above (without regard to any reduction for notice pay), up to a maximum of 18 months, the Severed Employee will be charged the same monthly premium as is charged to active employees of the Company. Such monthly premium will be subject to any increases or decreases that may be implemented during the continuation period for active employees generally. If necessary or desirable under applicable law, the Company may elect instead to deliver such benefit in the form of reimbursement, cash stipend or other economically equivalent method.

C. Outplacement Assistance. Outplacement assistance will be offered to a Severed Employee based on his or her band level or other relevant classification pursuant to the Company's guidelines for outplacement assistance.

10. When will I receive my severance pay?

If you are entitled to any notice pay, the notice pay will be paid via payroll in your final paycheck. Any severance pay in excess of any the notice pay will be paid to you in a cash lump sum in the next payroll period administratively available following the date on which the release of claims described in Question 8 becomes effective and irrevocable (but, in any event, no later than March 15th of the calendar year following the year in which your Qualifying Termination occurs).

11. Who is responsible for interpreting the Plan and making benefit determinations?

The Plan will be interpreted, administered and operated by the Plan Administrator, who will have complete authority, in its sole discretion subject to the express provisions of the Plan, to determine whether a Qualifying Termination has occurred, to interpret the Plan, to prescribe, amend and rescind rules and regulations relating to it, and to make all other determinations necessary or advisable for the administration of the Plan. Except as otherwise provided in the Plan, the decision of the Plan Administrator upon all matters within the scope of its authority will be conclusive and binding on all parties, provided that any determination by the Plan Administrator of whether Cause or Constructive Termination

exists will be subject to *de novo* review. The Plan Administrator may delegate any of its duties under the Plan.

The Plan is part of the Intact Insurance Group USA Welfare Plan, and the plan administration authority set forth in the Intact Insurance Group USA Welfare Plan also applies to the Plan. Please refer to the Summary Plan Description of the Intact Insurance Group USA Welfare Plan for further information.

12. How do I submit a claim for benefits under the Plan?

If you are an eligible employee and you have satisfied all applicable Plan requirements, you will automatically receive the benefits for which you are eligible under the Plan. If you feel you have not been provided with all benefits for which you are eligible under the Plan, or if you have any questions arising in connection with the interpretation of the Plan or its administration or operation, you may file a written claim with the Plan Administrator with respect to your rights to receive benefits from the Plan. The Plan Administrator will respond to the claim with a written notification within 30 days of receipt.

13. What if my claim is denied?

If your claim is wholly or partially denied, the written notification from the Plan Administrator will provide details stating reasons for the denial and making specific reference to the Plan provisions on which the denial is based. The written notification will also provide a description of any additional material or information necessary for you to fix the claim, if possible, and will set forth the procedure by which you may appeal the denial of the claim.

If you wish to appeal the denial of your claim, you may request a review of such denial by written application to the Plan Administrator within 60 days after receipt of such denial. You (or your legal representative) may, upon written request to the Plan Administrator, review any documents pertinent to your claim, and submit in writing issues and comments in support of your position. Within 30 days after receipt of a written appeal (unless special circumstances, such as the need to hold a hearing, require an extension of time, but in no event more than 30 days after such receipt), the Plan Administrator will notify you of its final decision. The final decision will be in writing, and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

14. Do I have a duty to mitigate damages by seeking new employment?

No. You have no duty to mitigate damages by seeking new employment or otherwise. This means that, even if you obtain subsequent employment after your Qualifying Termination, you will remain eligible for payments under the Plan and you do not need to reimburse the Company for payments already made to you under the Plan.

15. Are my severance benefits subject to tax withholding?

You should consult with your own tax advisor about your personal tax situation. Severance pay is generally subject to tax withholding, and the Company and its affiliates are authorized to deduct any U.S. Federal, state or local income or other taxes required by law to be withheld from any payment made under the Plan. You are solely responsible and liable for the satisfaction of all taxes and penalties that may be imposed on you in connection with the Plan.

16. Are my severance benefits considered as part of my earnings under the 401(k) plan or other benefit plans?

Generally no, severance benefits under the Plan are not considered to be part of earnings for purposes of calculating current or future benefits under any compensation or benefit programs maintained or sponsored by the Company or its affiliates, including retirement plans, 401(k) plans and the like, unless such plans expressly provide otherwise by its terms.

17. Can the Plan be modified or terminated?

Yes. The Board of Managers of the Company may amend or terminate the Plan at any time. However, no amendment or termination may reduce the severance benefits payable under the Plan to an eligible employee if such employee has incurred a Qualifying Termination before such termination or amendment takes effect, as applicable. Further, during the period beginning on the effective date of the Plan (which was on September 28, 2017 and ending on the latest of (x) the one year anniversary of the effective date, (y) December 31, 2018 and (z) the time required by applicable law, the Plan may not be terminated and may not be amended (except as required by law), if such amendment would be adverse to the rights or interests of any eligible employee.

18. Is the Plan an ERISA plan?

Yes. The Plan is intended to be a "severance pay arrangement" under Section 3(2)(B)(i) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and a "severance pay plan" within the meaning of regulations published by the Secretary of Labor at Title 29, Code of Federal Regulations, 2510.3-2(b).

19. What are my rights under ERISA?

As a participant in the Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants be entitled to:

Receive Information about Your Plan and Benefits, which includes -

- Examining, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan,

including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtaining, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series), if any, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receiving a summary of the Plan's annual financial report (if any). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

20. What other important information about the Plan should I know about?

OFFICIAL NAME OF THE PLAN:	Intact Insurance Group USA Welfare Plan *[Note: The* Intact Insurance Group USA *Severance Plan is part of the* Intact Insurance Group USA *Welfare Plan.]*
PLAN NUMBER:	506
PLAN SPONSOR:	Intact Services USA LLC 605 Waterford Park 605 Highway 169 North, Suite 800 Plymouth, MN 55441
EMPLOYER IDENTIFICATION NUMBER (EIN):	26-3300555
PLAN ADMINISTRATOR:	Intact Services USA LLC 605 Waterford Park 605 Highway 169 North, Suite 800 Plymouth, MN 55441 952-852-0480 https://benefits.intactspecialty.com/ benefits@intactinsurance.com
AGENT FOR SERVICE OF LEGAL PROCESS:	Plan Administrator
PLAN YEAR:	January 1 through December 31
PLAN TYPE:	Welfare benefit plan providing severance pay

The Plan Administrator keeps records of the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may

have about the Plan. A complete list of the employers sponsoring or participating in the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries, as required by U.S. Department of Labor Regulation Sections 2520.104b-l and 2520.104b-30.

Service of legal process may be made upon the Plan Administrator at the address listed above.

21. Does the Plan have any assets?

No, the Plan is not funded. The Company is not required to establish any special or separate fund or to make any other segregation of assets to assure benefits under the Plan. Neither the Company nor any other person is required to make contributions to the Plan.

22. What laws govern the Plan?

The Plan will be construed and enforced according to the laws of the State of Minnesota, without giving effect to its principles of conflicts of law, to the extent not preempted by Federal law (e.g., ERISA), which will otherwise control.