AMENDMENTS ATTACHED

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

AJINOMOTO FOODS NORTH AMERICA, INC.
HEALTH AND WELFARE BENEFIT PLAN

EFFECTIVE: JANUARY 1, 2023

Claims Administrator
HealthComp Administrators, Inc.
P.O. Box 45018
Fresno, California 93718-5018
(877) 706-6268

TABLE OF CONTENTS

ARTICLE I
INTRODUCTION

This document is a description of Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

Where a court order, administrative order, judgement, new or changed law or regulation applies to the provisions of this Plan, the Plan will be deemed to have been automatically amended (without further action on the part of the Plan Administrator), to ensure that the Plan conforms to such change to the extent applicable. For the avoidance of doubt, it is the intent of the Plan Administrator that the Plan conform at all times to the requirements of any and all controlling law, including by way of example and not exclusion, the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

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

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

No action at law or in equity shall be brought to recover under any section of this Plan until the Claims Review Procedures have been exhausted. Specifically, before filing a lawsuit the Plan Participant must exhaust all available administrative remedies as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Expenses Incurred before termination, amendment or elimination.

This Plan is an employee welfare benefit plan within the meaning of ERISA. This Plan is a self-funded medical plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Code so that the portion of the cost of coverage paid by the Employer, and any benefits received by a Plan Participant through this Plan, are not taxable income to the Plan Participant. The specific tax treatment of any Plan Participant will depend on the individual's personal circumstances; the Plan does not guarantee any particular tax treatment. Plan Participants are solely responsible for any and all federal, state, and local taxes attributable to their participation in this Plan, and the Plan expressly disclaims any liability for such taxes. This Plan is “self-funded,” which means benefits are paid from the Employer's general assets and are not guaranteed by an insurance company.

The Plan is administered by the Plan Administrator, within the purview of ERISA and in accordance with these provisions. The Plan Administrator may delegate certain responsibilities for the operation and administration of the Plan. The Plan Administrator shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service Providers, adjust their compensation (if any), and exercise general administrative authority over them. The Plan Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder, unless otherwise delegated herein.

This document serves as both the written Plan Document and the Summary Plan Description (“SPD”) required under ERISA.

Certain Federal laws apply to most group health programs. The following is an overview of the laws and their impact. Should there be any conflict between the law and Plan provisions, the law will prevail.

Health Insurance Portability and Accountability Act of 1996. The Health Insurance Portability and Accountability Act (HIPAA) amended ERISA and was enacted, among other things, to improve portability and continuity of health care coverage. HIPAA also requires that Plan Participant and beneficiaries receive a summary of any change that is a "Material Reduction in Covered Services or benefits under a group health plan" within sixty (60) days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of ninety (90) days or less.

Pregnancy Discrimination Act of 1978. Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent spouse of an Employee.

Family and Medical Leave Act of 1993 ("FMLA"). So long as the Employer and the applicable Employer division is subject to FMLA, if a covered Employee ceases active employment due to an Employer-approved Family Medical Leave in accordance with the requirements of Public Law 103, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in active employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

Omnibus Budget Reconciliation Act of 1993 ("OBRA"). OBRA 1993 requires that an eligible Dependent Child of an Employee will include a Child who is adopted by the Employee or placed with him for adoption prior to age eighteen (18) and a Child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law under State law and which satisfies the QMCSO requirements of ERISA (section 609(a)). Plan Participants may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

Newborns' and Mothers' Health Protection Act of 1996. The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn Children following delivery, as follows: All applicable benefit provisions still apply, including Copayments and/or Coinsurance.

The Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. In the case of an Employee or Dependent who receives benefits under the Plan in connection with a Mastectomy or Lumpectomy and who elects breast reconstruction (in a manner determined in consultation with the attending Physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which the Mastectomy or Lumpectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or
- Prostheses and treatment of physical complications at all stages of the Mastectomy and Lumpectomy, including lymphedemas.

This coverage will be subject to the same annual Deductible, Copayment or Coinsurance provisions that currently apply to Mastectomy and Lumpectomy coverage, and will be provided in consultation with the attending Physician.

Genetic Information Nondiscrimination Act of 2008 ("GINA"). GINA prohibits the Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of Genetic Information.
2. Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study as long as the results are not used for underwriting purposes.

3. Requesting, requiring or purchasing Genetic Information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes. GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA? Under GINA, the term "Genetic Information" includes:

1. Information about an individual or his/her family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);
2. The manifestation of a Disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and
3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic Information does not include the sex or age of an individual.

Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The Mental Health Parity and Addiction Equity Act requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, benefits for such conditions must be provided in the same manner as benefits for any Illness. Also, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

Medicaid and The Children's Health Insurance Program ("CHIP") Offer Free Or Low-cost Health Coverage To Children And Families. If a Plan Participant is eligible for health coverage from their Employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for Employer-sponsored health coverage, but need assistance in paying their health premiums. If the Employee or eligible Dependents aren't eligible for Medicaid or CHIP, they won't be eligible for these premium assistance programs, but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If the Employee or eligible Dependents are already enrolled in Medicaid or CHIP, they can contact the State Medicaid or CHIP office to find out if premium assistance is available. If the Employee or eligible Dependents are NOT currently enrolled in Medicaid or CHIP, and they might be eligible for either of these programs, the State Medicaid or CHIP office can be contacted, or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility:

- The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Dependent special enrollment period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid

or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. *The effective date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time to the extent that the State law is applicable to the Plan, the Employer, and its Employees. **For more information regarding special enrollment rights, contact the Plan Administrator.**

No Surprises Act. The No Surprises Act, part of Title I of the Consolidated Appropriations Act of 2021, prohibits Physicians, Providers, health care facilities and air ambulance companies from balance billing Plan Participants or otherwise holding Plan Participants liable for any more than the applicable cost sharing amounts they would have owed for network care. Specifically, these balance billing protections apply when a Plan Participant receives Emergency Services from a Non-Network Provider or facility, when a Plan Participant receives non-Emergency Services from a Non-Network Provider at a Network Facility, and when a Plan Participant receives non-network air ambulance services.

However, these protections against balance billing do not apply if the Plan Participant consents to treatment by a Non-Network Provider (this consent exception generally does not apply in emergency situations).

In addition, this Plan generally will cover Emergency Services without Pre-Certification; cover Emergency Services by Non-Network Providers; base cost sharing amounts on network benefits; and count any cost sharing amounts for Emergency Services or non-network services toward a Plan Participant's out-of-pocket limit.

If a Plan Participant believes he or she has received a balance bill that is protected under the No Surprises Act, please contact HealthComp Administrators, Inc. for additional information.

Please visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for additional information regarding the No Surprises Act.

In the event of an inconsistency between this Summary Plan Description/Plan Document and the law relative to the No Surprises Act, the law prevails only to the extent required to satisfy compliance.

The Civilian Reservist Emergency Workforce Act of 2021 (CREW). Beginning September 29, 2022, the CREW Act provides Eligible Employees, who are called to service by the Federal Emergency Management Agency (FEMA) to respond to and perform services responding to natural disasters and emergencies, rights under the Uniformed Employment and Reemployment Rights Act (USERRA). *See USERRA section for additional information regarding benefits and coverage during such leave.*

ARTICLE II
OVERVIEW OF BENEFITS

MEDICAL BENEFITS

All benefits described in the Medical Benefits Schedule are subject to the Exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are limited to the Recognized Charge as defined; and services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are outlined under Defined Terms of this Plan.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all Covered Expenses and/or Exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments, or procedures.

This Plan pays Covered Expenses pursuant to the Recognized Charge, which is defined in this Plan. **Plan Participants are responsible for any amounts determined to be in excess of the Recognized Charge.**

It is highly recommended that prior to seeking health care treatment and/or services, Plan Participants contact HealthComp Administrators, Inc. HealthComp Administrators, Inc. can help Plan Participants determine which Providers and/or facilities have appropriate billing practices.

Pre-Certification of certain services is required by the Plan. Pre-Certification provides information regarding Medical Necessity and medical appropriateness *before* the Plan Participant receives treatment, services or supplies. *A Pre-Certification of services by Anthem Blue Cross is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations and Exclusions of the Plan at the time services are provided.*

If Pre-Certification is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care may be reduced by 50% up to $500. Such reduction will not go toward the maximum out-of-pocket amount.

Pre-Certification. The following services require Pre-Certification:

- All Inpatient Hospital and Skilled Nursing Facility stays;
- Facility based treatment for Mental or Nervous Disorders or Substance Abuse;
- Home health care;
- Infusion therapy that includes specialty drugs in the specialty pharmacy program, and related services (for each course of treatment) in any setting, including, but not limited to the Physician's office, infusion center, Outpatient Hospital or clinic, the Plan Participant's home or other residential setting;
- Organ and tissue transplants, peripheral stem cell replacement and similar procedures; and
- Other surgical, diagnostic procedures, Durable Medical Equipment and/or prosthetics wherever rendered as specified by Anthem Blue Cross.

All services requiring Pre-Certification, are to be authorized in advance, except for emergencies, by contacting Anthem Blue Cross at (800) 274-7767. The Plan Participant or their Authorized Representative is required to call for Pre-Certification at least 48 hours prior to the services being rendered. The Plan Participant or their Authorized Representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Pre-Certification determinations and service pre-pricing. For a list of current procedures, contact Anthem Blue Cross.

Contact Anthem Blue Cross at **(800) 274-7767** to obtain Pre-Certification of a non-emergency admission and services.

PROVIDER INFORMATION

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Plan Participant uses a Network Provider, that Plan Participant will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Plan Participant's choice as to which provider to use.

To access a list of Network Providers, please refer to the preferred provider organization (PPO) website and/or toll-free number listed on the **Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan** identification card. Prior to receiving medical care services, the Plan Participant should confirm with the provider and the PPO that the provider is a participant in this organization.

Covered Services will be reimbursed at the Network Provider benefit level based on the Allowable Charge. The Plan Participant may be balanced billed by the Non-Network Provider for any amount over the Allowable Charge.

Contact Anthem Blue Cross at (800) 274-7767 to preauthorize a non-emergency admission and services. Anthem Blue Cross will be able to suggest facility options that may lower out-of-pocket expenses.

Under the following circumstances, the network payment benefit level will be made for certain non-network services:

- If a Plan Participant has a medical emergency requiring immediate care.
- If a Plan Participant has no choice of a Network Provider and receives services by a Non-Network Provider at a Network Facility.
- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the PPO service area (within 100 miles of residence).

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

CHOICE OF PROVIDERS

The Plan is not intended to disturb the Physician-patient relationship. Each Plan Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Plan Administrator, Employer or Claims Administrator. The delivery of medical and other health care services on behalf of any Plan Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Plan Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

ARTICLE III
MEDICAL BENEFITS SCHEDULES

COPAY PLAN

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Claims must be received by the Claims Administrator within ***365 days*** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second opinion.		
LIFETIME MAXIMUM BENEFIT	**UNLIMITED**	
CALENDAR YEAR BENEFIT AMOUNT	**UNLIMITED**	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Plan Participant Per Family Unit	$1,000 $3,000	$2,000 $6,000
The family Deductible maximum includes Covered Expenses which are used to satisfy the Deductible for all family members combined. No one person must satisfy more than the individual Deductible amount. The network Deductible does not accumulate towards the non-network Deductible, but the non-network Deductible does accumulate to the network Deductible.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Plan Participant Per Family Unit	$3,000 $9,000	$6,000 $18,000
The family maximum out of pocket amount includes Covered Expenses which are used to satisfy the maximum out of pocket amount for all family members combined. No one person must satisfy more than the individual maximum out of pocket amount. The network maximum out-of-pocket amount does not accumulate towards the non-network maximum out-of-pocket amount, but the non-network maximum out-of-pocket amount accumulates towards the network maximum out-of-pocket amount. The maximum out-of-pocket amount includes Coinsurance and Copayments applied toward covered medical and prescription benefits as shown above. The following expenses may not count toward the maximum out-of-pocket amount and will not be paid at 100%, even when the maximum out-of-pocket amount has been met: • Non-compliance penalties; • Charges for non-covered services; • Balance-billing charges; and • Amounts in excess of the Recognized Charge.		
Covered Expenses are limited to the Recognized Charge as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.		
DESCRIPTION	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
Member Responsibility (unless otherwise stated)	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Acupuncture *Limited to 12 visits per Calendar Year.*	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Ambulance	20% Coinsurance after Deductible is met.	

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Ambulatory Surgical or Outpatient Surgical Center	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Bariatric Surgery *Surgeon fees limited to $10,000 per Plan Participant's Lifetime.* *Travel expenses are not covered.*	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Blood/Plasma	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Cardiac Rehabilitation		
Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Limited to 36 visits per Calendar Year.		
Chemotherapy		
Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician's Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Circumcision	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Chiropractic Care		
Physician Visit	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
X-Rays	No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met.
Limited to 20 visit per Calendar Year. X-rays are not included in the visit limitations.		
Diabetic Equipment, Education and Supplies		
Education *Limited to 3 visits per Calendar Year*	**Primary Care:** $25 Copay/visit, Deductible waived. **Specialist:** $50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Durable Medical Equipment	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Supplies	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Diagnostic Testing		
Outpatient Hospital & Independent Facility	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician's Office	No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met.
Dialysis	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Dietary Formulas	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Durable Medical Equipment (DME)	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Emergency Room Services		
Facility Fees *Copay is waived if admitted.*	$200 Copay then 20% Coinsurance after Deductible is met.	
Physician Fees	20% Coinsurance after Deductible is met.	

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Genetic Counseling *Limited to three (3) visits per Calendar Year.*	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Hearing Aids		
Exams and Fittings	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Hearing Aid	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Hearing Therapy	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Home Health Care Limited to 120 visits per Calendar Year.	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Hospice Care		
Inpatient Facility Services *Includes Inpatient respite.*	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Outpatient & Home Services	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Bereavement	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Hospice care services and supplies are available for Plan Participant's with a life expectancy of less than 6 months.		
Hospital Services *Limited to the semi-private room rate for Non-Network Hospitals, other than intensive care units.*	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Infertility Services *Benefit based on type and place of service.*	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Infusion Therapy		
Outpatient Hospital Services	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Home Based Services	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Live Health Online *Medical and behavioral health visits.*	$25 Copay/visit, Deductible waived.	N/A
Medical Supplies	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Maternity Care	Covered the same as any other Illness. Based on location and services provided.	
Nutritional Education *Limited to 5 visits per Calendar Year*	**Primary Care:** $25 Copay/visit, Deductible waived. **Specialist:** $50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Occupational Therapy		
Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with physical, speech, cognitive and pulmonary therapy.		
Oral Surgery	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Orthotics *Foot orthotics are not covered.*	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Oxygen and Supplies	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Phototherapy	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physical Therapy		
Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with occupational, speech, cognitive and pulmonary therapy.		
Physician Services		
Office Visit	$25 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Specialist Office Visit	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Surgeon, Assistant Surgeon and Anesthesiologists (Inpatient & Outpatient)	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Office Lab, X-Ray and Surgery	No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met.
Allergy Injections, Testing and Serum	No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met.
Preventive Care	No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met.
Breast Feeding Support *Limited to $500 per pregnancy Non-Network.*	No cost to Plan Participant. Deductible waived.	No cost to Plan Participant. Deductible waived.
Routine Well Care services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) or as otherwise required by law, *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website: www.HealthCare.gov/center/regulations/prevention.html **Routine Well Care services will include, but will not be limited to, the following routine services:** Office visits, routine physical exams, prostate screening, sterilization procedures patient education and counseling for men, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well childcare examinations. **Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. Additional information can be located using the following website: https://www.healthcare.gov/preventive-care-women		
Prosthetic Devices	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Pulmonary/Respiratory Therapy - *Limited to 60 visits per Calendar Year combined with occupational, physical, speech, and cognitive therapy.*		
Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Radiation Therapy		
Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Skilled Nursing Care *Limited to 120 days per Calendar Year.*	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Sleep Studies	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Speech Therapy		
Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with occupational, physical, cognitive and pulmonary therapy.		
Sterilization Services		
For Female Plan Participants (Any location)	No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met.
For Male Plan Participants – Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
For Male Plan Participants – Physician Office	No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met.
Transplant Services		
Recipient Facility & Surgeon Fees	20% Coinsurance after Deductible is met.	Not covered.
Donor Facility Fees	20% Coinsurance after Deductible is met.	Not covered.
Donor Surgeon Fees	20% Coinsurance after Deductible is met.	Not covered.
Donor Search Fees *Limited to $30,000 per transplant.*	No cost to Plan Participant after Deductible is met.	Not covered.
Travel Expenses *Limited to $10,000 per transplant.*	No cost to Plan Participant. Deductible waived.	No cost to Plan Participant. Deductible waived.
Services obtained at a Blue Distinction Center will be covered at 100% after the Deductible is met.		
Treatment of Mental or Nervous Disorders or Substance Abuse		
Inpatient Services	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Outpatient Services	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Counseling	$25 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Applied Behavioral Therapy	$25 Copay/visit, Deductible waived.	$25 Copay/visit, Deductible waived.
Psychological Testing	$25 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Urgent Care *Includes all services except advanced imaging.*	$50 Copay/visit, Deductible waived.	$50 Copay/visit, Deductible waived.
Walk-In Retail Clinic	$50 Copay/visit, Deductible waived.	$50 Copay/visit, Deductible waived.
Wigs and Scalp Prothesis *Limited to one (1) per Calendar Year when hair loss is due to chemotherapy or radiation treatment.*	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.

It is the intent of this Plan to comply with all Federal mandates, for so long as they remain in effect, regarding the services and testing of patients for COVID-19 as set forth below:

Cost sharing (Deductibles, Copayments and Coinsurance) will be waived for Medically Necessary screening and testing for FDA-approved COVID-19 including Hospital, emergency department, urgent care, and provider office visits, including telehealth where the purpose of the visit is to be screened and/or tested for COVID-19 for Network and Non-Network Providers. The screening services are included without cost share even if the visit does not result in an order or administration of the COVID-19 test.

HIGH DEDUCTIBLE HEALTH PLAN

A qualified High Deductible Health plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and is a tax advantaged way to help build savings for future medical expenses. The Plan gives Plan Participants greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum Deductibles and out-of-pocket expenses for both individual and family coverage. These minimum Deductibles and limits for out-of-pocket expense limits are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Claims must be received by the Claims Administrator within ***365 days*** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second opinion.		
LIFETIME MAXIMUM BENEFIT	**UNLIMITED**	
CALENDAR YEAR BENEFIT AMOUNT	**UNLIMITED**	
DEDUCTIBLE, PER CALENDAR YEAR		
Self-Only	$3,000	$3,000
Family Coverage Individual Family Unit	 $3,000 $6,000	 $3,000 $6,000
The family Deductible maximum includes Covered Expenses which are used to satisfy the Deductible for all family members combined. No one person must satisfy more than the individual Deductible amount. The network Deductible does not accumulate towards the non-network Deductible, but the non-network Deductible does accumulate to the network Deductible.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Self-Only	$4,500	$9,000
Family Coverage Individual Family Unit	 $4,500 $8,000	 $9,000 $16,000
The family maximum out of pocket amount includes Covered Expenses which are used to satisfy the maximum out of pocket amount for all family members combined. No one person must satisfy more than the individual maximum out of pocket amount. The network maximum out-of-pocket amount does not accumulate towards the non-network maximum out-of-pocket amount, but the non-network maximum out-of-pocket amount accumulates towards the network maximum out-of-pocket amount. The maximum out-of-pocket amount includes Coinsurance and Copayments applied toward covered medical and prescription benefits as shown above. The following expenses may not count toward the maximum out-of-pocket amount and will not be paid at 100%, even when the maximum out-of-pocket amount has been met: • Non-compliance penalties; • Charges for non-covered services; • Balance-billing charges; and • Amounts in excess of the Recognized Charge.		
Covered Expenses are limited to the Recognized Charge as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.		

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Member Responsibility (unless otherwise stated)	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Acupuncture *Limited to 12 visits per Calendar Year.*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Ambulance	No cost to Plan Participant, after Deductible is met.	
Ambulatory Surgical or Outpatient Surgical Center	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Bariatric Surgery *Surgeon fees limited to $10,000 per Plan Participant's Lifetime.* *Travel expenses are not covered.*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Blood/Plasma	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Cardiac Rehabilitation		
Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Limited to 36 visits per Calendar Year.		
Chemotherapy		
Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician's Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Circumcision	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Chiropractic Care		
Physician Visit	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
X-Rays	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Limited to 20 visit per Calendar Year. X-rays are not included in the visit limitations.		
Diabetic Equipment, Education and Supplies		
Education *Limited to 3 visits per Calendar Year*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Durable Medical Equipment	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Supplies	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Diagnostic Testing		
Outpatient Hospital & Independent Facility	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician's Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Dialysis	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Dietary Formulas	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Durable Medical Equipment (DME)	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Emergency Room Services		
Facility Fees	No cost to Plan Participant, after Deductible is met.	
Physician Fees	No cost to Plan Participant, after Deductible is met.	
Genetic Counseling *Limited to three (3) visits per Calendar Year.*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Hearing Aids		
Exams and Fittings	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Hearing Aid	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Hearing Therapy	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Home Health Care *Limited to 120 visits per Calendar Year.*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Hospice Care		
Inpatient Facility Services *Includes Inpatient respite.*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Outpatient & Home Services	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Bereavement	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Hospice care services and supplies are available for Plan Participant's with a life expectancy of less than 6 months.		
Hospital Services *Limited to the semi-private room rate for Non-Network Hospitals, other than intensive care units.*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Infertility Services	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Infusion Therapy		
Outpatient Hospital Services	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Home Based Services	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Live Health Online *Medical and behavioral health visits.*	No cost to Plan Participant, after Deductible is met.	N/A
Medical Supplies	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Maternity Care	Covered the same as any other Illness. Based on location and services provided.	
Nutritional Education *Limited to 5 visits per Calendar Year*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Occupational Therapy		
Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with physical, speech, cognitive and pulmonary therapy.		

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Oral Surgery	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Orthotics *Foot orthotics are not covered.*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Oxygen and Supplies	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Phototherapy	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physical Therapy		
Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with occupational, speech, cognitive and pulmonary therapy.		
Physician Services		
Office Visit	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Specialist Office Visit	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Professional Services	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Office Lab, X-Ray and Surgery	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Allergy Injections, Testing and Serum	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Preventive Care	No cost to Plan Participant. Deductible waived.	30% Coinsurance after Deductible is met.
Breast Feeding Support *Limited to $500 per pregnancy Non-Network.*	No cost to Plan Participant. Deductible waived.	30% Coinsurance, Deductible waived.
Routine Well Care services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) or as otherwise required by law, *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website: www.HealthCare.gov/center/regulations/prevention.html **Routine Well Care services will include, but will not be limited to, the following routine services:** Office visits, routine physical exams, prostate screening, sterilization procedures patient education and counseling for men, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well childcare examinations. **Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. Additional information can be located using the following website: https://www.healthcare.gov/preventive-care-women		
Prosthetic Devices	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Pulmonary and Respiratory Therapy		
Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with occupational, physical, speech, and cognitive therapy.		
Radiation Therapy		
Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Skilled Nursing Care *Limited to 120 days per Calendar Year.*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Sleep Studies	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Speech Therapy		
Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with occupational, physical, cognitive and pulmonary therapy.		
Sterilization Services		
For Female Plan Participants (Any location)	No cost to the Plan Participant. Deductible waived.	30% Coinsurance after Deductible is met.
For Male Plan Participants – Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
For Male Plan Participants – Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Transplant Services		
Recipient Facility & Surgeon Fees	No cost to Plan Participant, after Deductible is met.	Not covered.
Donor Facility Fees	No cost to Plan Participant, after Deductible is met.	Not covered.
Donor Search Fees *Limited to $30,000 per transplant.*	No cost to Plan Participant, after Deductible is met.	Not covered.
Travel Expenses *Limited to $10,000 per transplant.*	No cost to Plan Participant. Deductible waived.	No cost to Plan Participant. Deductible waived.
Treatment of Mental or Nervous Disorders or Substance Abuse		
Inpatient Services	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Outpatient Services	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Counseling	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Applied Behavioral Therapy	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Psychological Testing	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Urgent Care *Includes all services except advanced imaging.*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Walk-In Retail Clinic	No cost to Plan Participant, after Deductible is met.	No cost to Plan Participant, after Deductible is met.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Wigs and Scalp Prothesis *Limited to one (1) per Calendar Year when hair loss is due to chemotherapy or radiation treatment.*	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
It is the intent of this Plan to comply with all Federal mandates, for so long as they remain in effect, regarding the services and testing of patients for COVID-19 as set forth below: Cost sharing (Deductibles, Copayments and Coinsurance) will be waived for Medically Necessary screening and testing for FDA-approved COVID-19 including Hospital, emergency department, urgent care, and provider office visits, including telehealth where the purpose of the visit is to be screened and/or tested for COVID-19 for Network and Non-Network Providers. The screening services are included without cost share even if the visit does not result in an order or administration of the COVID-19 test.		

ARTICLE IV
PRESCRIPTION DRUG BENEFITS SCHEDULES

COPAY PLAN

Not all Prescription Drugs are covered.

PRESCRIPTION DRUG BENEFIT	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
Pharmacy Option - 31-90 day Supply		
Generic Drugs	$10 Copay/prescription.	Not covered.
Formulary Brand Drugs (Preferred)	$35 Copay/prescription.	Not covered.
Non-Formulary Brand Drugs (Non-Preferred)	$65 Copay/prescription.	Not covered.
Specialty Drugs	20% Coinsurance up to a maximum of $100.	Not covered.
Mail Order Option - 90 Day Supply		
Generic Drugs	$20 Copay/prescription.	Not covered.
Formulary Brand Drugs (Preferred)	$70 Copay/prescription.	Not covered.
Non-Formulary Brand Drugs (Non-Preferred)	$130 Copay/prescription.	Not covered.
Refer to the Prescription Drug Benefits for details on the Prescription Drug Program.		
Infertility drugs are limited to a lifetime maximum of $20,000.		
For additional information visit www.costcohealthsolutions.com or call (877) 908-6024.		
In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no Deductible or Coinsurance required.		

HIGH DEDUCTIBLE HEALTH PLAN

Not all Prescription Drugs are covered.

PRESCRIPTION DRUG BENEFIT	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
Pharmacy Option – 30 Day Supply		
Generic Drugs	$20 Copay/prescription, after Deductible is met.	Not covered.
Formulary Brand Drugs (Preferred)	$40 Copay/prescription, after Deductible is met.	Not covered.
Non-Formulary Brand Drugs (Non-Preferred)	$60 Copay/prescription, after Deductible is met.	Not covered.
Specialty Drugs	30% Coinsurance/prescription, after Deductible is met.	Not covered.
Mail Order Option - 90 Day Supply		
Generic Drugs	$40 Copay/prescription, after Deductible is met.	Not covered.
Formulary Brand Drugs (Preferred)	$80 Copay/prescription, after Deductible is met.	Not covered.
Non-Formulary Brand Drugs (Non-Preferred)	$120 Copay/prescription, after Deductible is met.	Not covered.
Refer to the Prescription Drug Benefits for details on the Prescription Drug Program.		
Infertility drugs are limited to a lifetime maximum of $20,000.		
For additional information visit www.costcohealthsolutions.com or call (877) 908-6024.		
In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no Deductible or Coinsurance required.		

ARTICLE V
ELIGIBILITY, FUNDING AND ENROLLMENT PROVISIONS

ELIGIBILITY

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

Eligible Classes of Employees

- All Active Employees of the Employer.

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

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

1. Is a full-time, Active Employee of the Employer. An Employee is considered to be full-time if he or she normally works at least 30 hours per week or 130 hours per month and is on the regular payroll of the Employer for that work (i.e., non-variable hour Employee); or is a variable hour Employee who has averaged at least 30 hours per week for a complete measurement period and is currently in a stability period as determined by the Plan Administrator.

   For Employees of a Large Employer:

   An Applicable Large Employer is an Employer with 50 full-time equivalents or more (combination of full-time and part-time Employees) in the prior Calendar Year.

   An Applicable Large Employer may use a look-back measurement method or a monthly measurement method to determine the full-time status. For more information on the measurement method elected by the Employer, contact the Employer's Human Resources staff;

2. Is in a class eligible for coverage; and

3. Completes the employment Waiting Period of 60 consecutive days of as an hourly Active Employee. There is no waiting period for salaried Active Employees.

Coverage will begin the first day of the calendar month following with the completion of all eligibility requirements and enrollment requirements as stated under this Plan.

A **Waiting Period** is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

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

1. A covered **Employee's legal spouse and Children** from birth until the limiting age of 26 years. When the Child reaches the limiting age, coverage will end on the last day of the Child's birthday month.

   The term **"spouse"** means a person recognized as the covered Employee's husband or wife by the laws of the state or country in which the marriage was formalized. "Married" means a legal union between two individuals and will not include a common law spouse. The Plan Administrator may require documentation proving a legal marital relationship.

The term **"domestic partner"** means a same sex or opposite sex domestic partner who meets the following eligibility criteria for coverage. In order for a domestic partner to be eligible as a Dependent, the Employee and the domestic partner must meet each of the following requirements: (1) they are eighteen (18) years of age or older and are mentally competent to enter into a legally binding contract, (2) they are not legally married to any other person or in a domestic partnership with any other person, (3) they are not so closely related that marriage would otherwise be prohibited, (4) they have lived together for at least twelve (12) months, sharing the common necessities of life and responsibility for each other's common welfare, including financial interdependence, and have the intention that the relationship will be indefinite, (5) they have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence, or similar type of ownership, and (6) the have registered as domestic partners if they reside in a state that provides for such registration. All references to the spouse of a Plan Participant shall include domestic partner, except for the purposes of coordinating benefits with Medicare.

The term **"Children"** means natural children, adopted children, Children placed with a covered Employee in anticipation of adoption and stepchildren.

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

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

Any Child of a Plan Participant who is an Alternate Recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A Plan Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax free benefits. (i.e., non-IRC Section 152 Dependent). There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s). The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

2. A covered Dependent Child who reaches the **limiting age** and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the Employee; foster children; any person who is on active duty in any military services of any country (this provision does not apply to Dependent Children; or any person who is covered under the Plan as an Employee.

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

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

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

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

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following with the date that the Employee satisfies all of the following:

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

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

FUNDING

Cost of the Plan. **The Employer may share the cost of Employee coverage under this Plan with the covered Employees.**

The covered Employees may be required to pay the entire cost for coverage for their Dependents.

The level of any required Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. If Dependent coverage is desired, the covered Employee will be required to enroll for Dependent coverage as well.

Enrollment Requirements for Newborn Children. A newborn Child of a covered Employee who is currently enrolled with Dependent coverage will not be automatically enrolled from the date of birth.

The Employee will be required to enroll the newborn Child on a timely basis, as defined in the section "Timely Enrollment" following this section, or there will be no further payment from the Plan and the parents will be responsible for all costs.

TIMELY, LATE OR OPEN ENROLLMENT

1. **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty-one (31) days after the person becomes eligible for the coverage either initially or under a special enrollment period.

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

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

   If an individual loses eligibility for coverage as a result of terminating employment, a reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a late enrollee.

   The time between the date a late enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins as specified in this Plan.

SPECIAL ENROLLMENT RIGHTS

Federal law provides special enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the Employer stops contributing towards the other coverage).

In addition, if an Employee or his or her Dependents (including his or her spouse) is losing coverage due to a loss of a government sponsored subsidy (due to ineligibility for coverage or cost of coverage) there may be a right to enroll in this Plan.

However, a request for enrollment must be made within thirty-one (31) days after the coverage ends (or after the Employer stops contributing towards the other coverage).

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

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a special enrollment period is the first date of coverage. The events described below may create a right to enroll in the Plan under a special enrollment period.

1. **Losing other coverage may create a special enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

   a. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
   b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
   c. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because Employer contributions

towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date of loss.

d. The Employee or Dependent requests enrollment in this Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date of loss.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

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

b. The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

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

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

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

2. Acquiring a newly eligible Dependent may create a special enrollment right. If:

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

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

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a Child, the spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this special enrollment period in order for his eligible Dependents to enroll.

The Dependent special enrollment period is a period of thirty-one (31) days and begins on the date of birth, adoption or placement for adoption, or on the date of the marriage. To be eligible for this special enrollment, the Dependent and/or Employee must request enrollment during this time period as stated above.

The coverage of the Dependent and/or Employee enrolled in the special enrollment period will be effective:

a. In the case of marriage, as of the date of marriage;

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

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

TERMINATION OF COVERAGE

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

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

1. The date the Plan is terminated.

2. The last day of the month in which the covered Employee ceases to be in one of the eligible classes. This includes death or termination of active employment of the covered Employee. This also includes failure to satisfy the eligibility requirements of the Plan due to periods of leave unless the plan specifically provides for continuation during these periods.

3. If an Employee fails to make the required premium payment, commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan will void coverage for the Employee and covered Dependents for the period of time coverage was in effect.

4. As otherwise specified in this Plan.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the COBRA Continuation Coverage section in this Plan.

Continuation During Periods of Employer-Approved Leave(s) of Absence. A person may remain eligible under the terms of this Plan during an Employer-approved leave of absence. While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the covered Employee. The Employer has sole discretion to determine the length of the Employer-approved leave of absence.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations.

This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave

law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA Leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired within 13 consecutive weeks from the date of termination will be credited for time towards the satisfaction of any applicable employment Waiting Period prior to the initial date of termination.

Coverage will begin the first day of the calendar month following the date of rehire or the first day of the calendar month following the satisfaction of any applicable employment Waiting Period, whichever comes first.

A terminated Employee who is rehired after 13 weeks from the date of termination will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

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

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

    a. The 24-month period beginning on the date on which the person's absence begins; or
    b. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

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

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

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

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

2. The last day of the month in which an Employee's coverage under the Plan terminates for any reason including death.

3. The last day of the month in which a covered spouse loses coverage due to loss of eligibility status.

4. The last day of the month in which the Dependent Child ceases to meet the applicable eligibility requirements.

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

6. As otherwise specified in this Plan.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the COBRA Continuation Coverage section in this Plan.

ARTICLE VI
OPEN ENROLLMENT

Each year there is an annual open enrollment period designated by the Plan Administrator during which Plan Participants may change their benefit elections under the Plan, and Employees and their Dependents, who are late enrollees, will be able to enroll in the Plan.

Benefit choices for late enrollees made during the open enrollment period will become effective January 1. Plan Participants will receive detailed information regarding open enrollment from the Plan Administrator.

Benefit choices made during the open enrollment period will remain in effect until the next open enrollment period unless there is a special enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

If an Employee drops spousal coverage during open enrollment in anticipation of divorce, the covered Employee should notify the Plan Administrator.

ARTICLE VII
MEDICAL BENEFITS

Medical benefits apply when Covered Expenses are Incurred by a Plan Participant for care of an Injury or Illness and while the person is covered for these benefits under the Plan.

PAYMENT OF BENEFITS

All benefits under this Plan are payable, in U.S. Dollars, to the Plan Participant whose Illness or Injury is the basis of a claim, unless the Plan Participant, in accordance with the terms of this Plan, compensates Hospital or Physician of medical care with an assignment of benefits. Payment of benefits from the Plan to a health care Hospital or Physician pursuant to written direction of the Plan Participant is subject to the approval of the Plan Administrator, and shall be made as consideration in full for services rendered. In the event of the death or incapacity of a Plan Participant and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Plan Participant.

COVERED EXPENSES

Charges for Covered Expenses are not to exceed the Recognized Charge that are Incurred for the following items of services and supplies when Medically Necessary to diagnose or treat a Plan Participant. These charges are subject to all benefit limits, Exclusions, and other provisions of this Plan. Covered Expenses and Medically Necessary are defined terms; see the Defined Terms section in this Plan for definitions of capitalized terms.

1. **3D Mammograms.** Charges associated with 3D mammograms.

2. **Acupuncture Treatment.** Expenses Incurred for acupuncture, including acupuncture administered by a Physician, licensed for this treatment, provided in lieu of anesthetic.

3. **Adoptive Cell Therapy.** Charges associated with adoptive cell therapy.

4. **Allergy Testing and Injections.** Charges for initial allergy testing and the cost of the resultant serum preparation (antigen) and its administration, when rendered by a Physician, or in the Physician's office.

5. **Ambulance.** Benefits will be provided for licensed ground, air, and water ambulance services used to transport a Plan Participant from the place where they are injured or stricken by Illness, or for inter-facility transport, as deemed Medically Necessary, to the nearest accredited Hospital with adequate facilities for treatment. Charges for services requested for a licensed ground, air, or water ambulance service when the patient is not transported will be covered by the Plan. Pre-Certification is required for non-emergency ambulance.

6. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care.

7. **Anesthetics.** Includes anesthetic, oxygen, blood, and blood derivatives that are not donated or replaced, intravenous injections/solutions, and the administration of these items.

8. **Applied Behavior Analysis (ABA) Therapy.** Applied Behavioral Analysis therapy services prescribed in relation to a Diagnosis of Autism Spectrum Disorder (ASD) by a Physician or behavioral health practitioner.

9. **Behavioral.** Diagnosis and treatment of behavioral problems and learning disabilities, behavior modification, sensitivity training, special education, counseling, therapy, and care for learning deficiencies or behavioral problems. Habilitative services are not included.

10. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing.

11. **Biofeedback.** Charges for services or supplies in connection with biofeedback when Medically Necessary.

12. **Cardiac Rehabilitation.** Phase II cardiac rehabilitation provided on an Outpatient basis following Diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based Outpatient program following an Inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring. Services are subject to the limitation outlined in the Medical Benefits Schedule.

    Phase III and phase IV cardiac rehabilitation is not covered. Phase III follows phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through phases I and II. Phase IV is an advancement of phase III which includes more active participation and weight training.

13. **Cataract Surgery.** Services and supplies associated with cataract surgery.

14. **Chemotherapy**. Charges for chemotherapy, including materials and services of technicians are included.

15. **Chiropractic Care**. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. Services are limited as outlined in the Medical Benefits Schedule.

16. **Circumcision.** Circumcision for newborns from birth to twenty-eight (28) days old. After twenty-eight (28) days, only Medically Necessary circumcisions will be covered.

17. **Clinical Trials.** Covered Expenses will include charges made for routine patient costs associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

    a. The clinical trial is registered on the National Institute of Health (NIH) maintained web site www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial for cancer treatment.
    b. The Plan Participant meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
    c. The Plan Participant has signed an informed consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed informed consent;
    d. The trial is approved by the Institutional Review Board of the Institution administering the treatment.
    e. Routine patient costs will not be considered Experimental and/or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Plan Participant would receive whether or not he or she were participating in a clinical trial.

    Routine patient costs do not include, and reimbursement will not be provided for:

    - The Investigational service, supply, or drug itself; or
    - Services or supplies listed herein as Plan Exclusions; or
    - Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Plan Participant; or
    - Services that are clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis; or
    - Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial Plan Participant.

18. **Cognitive Therapy.** Charges associated with cognitive therapy.

19. **Contraceptives.** Injections, implants, devices, and associated Physician charges are covered under the preventive care provision of this Plan. Self-administered contraceptives (not over the counter) are covered under the Prescription Drug Program of this Plan.

20. **Dental Hospital Services.** Services for general anesthesia and related Hospital or Ambulatory Surgical Center services are covered for dental procedures if Medically Necessary and if any of the following conditions apply:

    a. The Plan Participant is under age twelve (12).
    b. The Plan Participant is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office.
    c. The Plan Participant has a medical condition besides the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a Hospital or Ambulatory Surgical Center.

21. **Dental Injuries.** Injury to or care of the mouth, teeth, gums, and alveolar processes will be covered under this Plan only if that care is initiated within six (6) months following the Injury and is for the following oral surgical procedures:

    a. Emergency repair due to Injury to sound natural teeth; or
    b. Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.

    For the listed services only, non-network dentists will be considered at the network rate.

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

22. **Developmental Delay.** Includes services for testing, office visits and consultations. Habilitative services are not covered.

23. **Diabetic Education.** Services and supplies used in Outpatient diabetes self-management programs are covered under this Plan when they are provided by a Physician. Limited to three (3) visits per Calendar Year.

24. **Diabetic Equipment.** The following diabetic equipment will be covered when Medically Necessary, under the Durable Medical Equipment (DME) provision of this Plan:

    a. Continuous blood glucose monitor;
    b. Insulin pump and supplies; and
    c. Glucometer.

25. **Diagnostic Services and Supplies.** Covered Expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging, radiology and oncology, sleep studies, and x-ray.

26. **Dialysis.** If a Plan Participant is diagnosed with a condition requiring dialysis, they may be able to enroll in Medicare. Upon beginning dialysis treatments, Medicare, if applicable, will coordinate benefits with the Plan as the secondary payer for months four (4) through thirty-three (33) of the coordination period while dialysis treatments are received. The Plan will not enroll the Plan Participant in Medicare; it is their decision and their responsibility to enroll in Medicare, if applicable.

27. **Durable Medical Equipment (DME).** Rental of Durable Medical Equipment (DME) if deemed Medically Necessary. The total rental fee for Durable Medical Equipment will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the lifetime of the equipment. Delivery and set-up charges are a benefit of the Plan.

    Replacement of purchased equipment if the replacement is needed because of a change in the Plan Participant's physical condition. Maintenance and repairs needed due to misuse or abuse are not covered.

    The following items will be considered under the DME benefit:

28. **Oxygen.** Oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.

29. **Jobst/Compression Stockings.** Limited to four (4) units, or two (2) pair, per Plan Participant per Calendar Year.

30. **Mastectomy Bras and Camisoles.** Limited to two (2) per Plan Participant per Calendar Year.

31. **Emergency Services.** Coverage is provided for a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in: (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn Child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the Diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

32. **Family History.** Charges related to services provided with a Diagnosis of family history, including as covered under the preventive care benefits or under applicable law.

33. **Foot Disorders.** Treatment for metabolic or peripheral-vascular disease or plantar fasciitis. Foot orthotics are not covered.

34. **Gender.** Services will be considered under the applicable benefit level and limited as any other service outlined in the Plan. Services will not be limited based on an individual's documented gender.

35. **Gender Dysphoria/Gender Identity Disorder.** Medically Necessary treatment, supplies, and services for the Diagnosis of gender dysphoria or gender identity disorder. Gender reassignment surgery is also a Covered Expense. Travel benefits are not covered.

36. Genetic Testing & Counseling. Charges for genetic testing to identify the potential for, or existence of, a medical condition (such as a test for the breast cancer gene), as mandated by PPACA. Other genetic testing is only covered if any the following conditions are met:

    a. A person has symptoms or signs of a genetically linked inheritable disease;
    b. It has been determined that a person is at risk for carrier status as supported by existing peer reviewed, evidence-based, scientific literature for the development of a genetically linked inheritable disease when the results will impact clinical outcome; or
    c. The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to three (3) visits per Calendar Year for both pre- and post-genetic testing. Pre-certification is required.

37. **Genomic Testing.** Charges for genomic testing, which examines abnormalities in groups of genes to aid in designing specific treatment options for an individual's cancer.

38. **Growth Hormones.** Charges associated with growth hormones. Pre-certification is required.

39. **Hearing Aids and Implantable Hearing Devices.** Charges for services or supplies in connection with hearing aids, semi-implantable hearing devices, audient bone conductors, Bone Anchored Hearing Aids (BAHAs), and exams for their fitting. Pre-certification is required for bone anchored implants.

40. **Home Births.** Charges associated with home births.

41. **Home Health Care.** Charges for home health care services and supplies received from a Home Health Care Agency are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The Diagnosis, care, and treatment must be certified by the attending physician and be contained in a home health care plan.

    a. Benefit payment for physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described in the Medical Benefits Schedule.
    b. A home health care visit will be considered a periodic visit by a nurse, therapist, home health aide services, or outpatient private duty nursing as Medically Necessary.

    Pre-Certification is required. Covered Expenses will be payable as shown in the Medical Benefits Schedule.

42. **Home Infusion Therapy Services.** Charges treatment or service required for the administration of intravenous drugs or solutions by a Home Infusion Therapy Provider. Home infusion therapy does not apply to the home health care maximum. Pre-certification is required.

43. **Hospice Care.** Hospice care services and supplies for Plan Participants with a life expectancy of less than six (6) months. Services must be rendered by a state-licensed Hospice Agency and included in a written hospice care plan established and periodically reviewed by the attending physician. The Physician must certify the Plan Participant is terminally ill and that Hospital confinement would be required in the absence of the hospice care. The hospice care plan shall also describe the services and supplies for palliative care and Medically Necessary treatment to be provided to the Plan Participant by the Hospice Agency. Benefits are provided for:

    a. Medical supplies;
    b. Respite care;
    c. Visits by a registered or licensed practical nurse, master of social work (M.S.W.), or a home health aide; and
    d. Bereavement counseling services by a psychologist, licensed social worker, family counselor, or ordained minister for the hospice patient's immediate family (covered spouse and/or other covered Dependents).

    NOTE: Bereavement counseling not related to hospice care will be provided under the mental health benefits. Covered Expenses will be payable as shown in the Medical Benefits Schedule.

44. **Hospital Care.** The medical services and supplies furnished by a Hospital, Ambulatory Surgical Center, or a birthing center. An office visit when the Provider's office is located inside a Hospital will apply to the office visit benefit, however, any other services will apply toward their applicable benefit level. Pre-certification is required for Inpatient admissions.

    a. Room and board charges made by a network hospital having only private rooms will be paid at the allowed amount. If the hospital is non-network, rooms will be paid at the semi-private room rate.
    b. Charges for an intensive care unit stay are payable as described in the Medical Benefits Schedule and do not apply to the semi-private room rate.
    c. Services for general anesthesia and related Hospital or Ambulatory Surgical Center services are covered for dental procedures if Medically Necessary and if any of the following conditions apply:
        i. The Plan Participant is under age twelve (12);
        ii. The Plan Participant is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office; or
        iii. The Plan Participant has a medical condition besides the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a Hospital or Ambulatory Surgical Center. This benefit does not cover the Dentist's services.

45. **Infertility Services.** Services for male and female infertility include office visits, diagnostic testing to determine the cause of infertility; testing and treatment performed in connection with an underlying medical condition; treatment and/or procedures performed specifically to restore fertility; infertility drugs which are administered or provided by a Physician; services of an embryologist; artificial insemination, in-vitro, GIFT, ZIFT, etc. Includes all related services billed with an infertility diagnosis (i.e., x-ray or lab services billed by an independent facility).

46. **Laboratory Studies.** Covered Expenses for diagnostic lab testing and services.

47. **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy or Lumpectomy. The Federal law requires group health plans that provide Mastectomy or Lumpectomy coverage to also cover breast reconstruction surgery and prostheses following a Mastectomy or Lumpectomy.

    As required by law, the Plan Participant is being provided this notice to inform him or her about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy or Lumpectomy will also receive coverage for:

    a. Reconstruction of the breast on which the Mastectomy or Lumpectomy has been performed.
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
    c. Prostheses and physical complications from all stages of Mastectomy or Lumpectomy, including lymphedemas.

    The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the Plan Participant.

    This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy or Lumpectomy coverage, and will be provided in consultation with the Plan Participant and his or her attending Physician.

48. **Medical Food.** Medical foods are considered a Covered Expense if intravenous therapy (IV) or tube feedings are Medically Necessary. Medical foods taken orally are not covered under the Plan, except for PKU formula when Medically Necessary.

49. **Medical Supplies.** Charges for surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations. Also included are supplies and dressings when Medically Necessary for surgical wounds, cancer, burns, diabetic ulcers, colostomy bags and catheters, ostomy supplies, and surgical and orthopedic braces, unless covered under the Prescription Drug Program.

50. **Mental or Nervous Disorders and Substance Abuse Treatment.** Inpatient and Outpatient treatment for Mental or Nervous Disorders will be eligible when rendered by a licensed psychiatrist or licensed psychologist or when rendered by a Physician as defined, provided the counselor is employed by and working under the direct supervision of a psychiatrist or clinical psychologist. Diagnosis and treatment of behavioral problems and learning disabilities associated with attention deficit disorders (ADD and ADHD). Includes residential treatment.

    Partial hospitalization services are rendered no less than four (4) hours and not more than twelve (12) hours in any twenty-four (24) hour period by a certified/licensed mental health program in accordance with the laws of the appropriate legally authorized agency.

    An intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program in accordance with the laws of the appropriate, legally authorized agency. Intensive outpatient therapy programs provide a combination of individual, family, and/or group therapy in a day, totaling nine (9) or more hours in a week.

    Pre-certification is required for Inpatient admissions, residential treatment, partial hospitalization, and intensive outpatient therapy.

51. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of his/her license. This Plan will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.

52. **Morbid Obesity.** Charges made for medical and surgical services for the treatment or control of clinically severe morbid obesity if the services are demonstrated, through existing peer-reviewed, evidence based, scientific literature, and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Counseling prior to surgery is covered.

53. **National Emergency.** In the event of a declared National Health Emergency, the Plan will offer coverage as mandated for the condition(s) as outlined in the National Health emergency, as required by federal regulation. This provision shall override any potentially conflicting, specific Exclusions, defined terms, or other Plan provisions as necessary to provide, and limited to, any mandated services as outlined in the public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the public health emergency, as declared by the governing federal agency, has ended.

54. **Nutritional Evaluation.** Charges made for nutritional evaluation and counseling when diet is a part of medical management. Limited to five (5) visits per Plan Participant per Calendar Year. Visit limit does not apply to treatment of Mental or Nervous Disorders and substance use disorder conditions.

55. **Occupational Therapy.** Services provided by a licensed occupational therapist, payable up to the limits as stated in the Medical Benefits Schedule. Therapy must be ordered by a Physician, result from an Injury or Illness and improve a body function. Covered Expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

56. **Oral Surgery.** Care of the mouth, teeth, gums, and alveolar processes will be a Covered Expense under this Plan only if that care is for the following oral surgical procedures:

    a. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth;
    b. Excision of benign bony growths of the jaw and hard palate;
    c. External incision and drainage of cellulitis;

d. Removal of all teeth at an Inpatient or Outpatient Hospital or Dentist's office if removal of the teeth is part of standard medical treatment that is required before the Plan Participant can undergo radiation therapy for a covered medical condition;
e. Organ transplant preparation; and
f. Removal of bony impacted teeth.

For the listed services only, non-network dentists will be considered at the network rate.

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

57. **Orthognathic Surgery.** Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:

    a. The deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement;
    b. The orthognathic surgery is Medically Necessary as a result of tumor, trauma, Disease; and
    c. The orthognathic surgery is performed prior to age nineteen (19) and is required as a result of severe congenital facial deformity or congenital condition.

    Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review physician.

58. **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness. Benefits for repair or replacement of an orthotic appliance due to normal use, adolescent growth, or pathological changes will be provided.

59. **Osteopathic Manipulative Therapy.** Charges associated with osteopathic manipulative therapy.

60. **Pervasive Developmental Disorder (Autism).** Includes services for testing, office visits, consultations and ABA therapy.

61. **Physical Therapy.** Services provided by a licensed physical therapist, payable up to the limits as stated in the Medical Benefits Schedule. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Services include aquatic therapy. Wound debridement does not apply to the rehabilitation maximum.

62. **Physician Care.** The professional services of a Physician for surgical or medical services. If an assistant surgeon is required, the assistant surgeon's Covered Expense will not exceed the surgeon's Recognized Charge.

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

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

b. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Recognized Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Recognized Charge allowed for that procedure.

63. Pre-admission Testing. Charges for preadmission testing (x-rays and lab tests) performed within a reasonable timeframe prior to a Hospital admission which are related to the condition which is necessitating the confinement. Such tests shall not be payable if the same tests are performed again after the Plan Participant has been admitted.

64. Pregnancy Care. Pregnancy and complications of Pregnancy shall be covered as any other Illness for the Employee or spouse and Dependent Child. Benefits include pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and complications resulting from the Pregnancy. Charges for a planned home birth will be considered a covered benefit if performed be a covered physician.

NOTE: Breastfeeding support, supplies, and counseling are also available without cost sharing when services are received from a Network or Non-Network Provider.

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

65. Prenatal Testing. Services for prenatal diagnosis or congenital disorders of the fetus by means of screening and diagnostic procedures will be provided the same as for any other condition during a covered Pregnancy. Such services must be Medically Necessary.

66. Prescription Medications. Covered Expenses include drugs that are administered or dispenses as take-home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription Drug benefit.

67. Preventive Care. Covered Expenses under medical benefits are payable for routine preventive care as described in the Medical Benefits Schedule. Standard preventive care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force or as otherwise identified in applicable law. Examples of standard preventive care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    - Breastfeeding support, supplies, and counseling.
    - Gestational diabetes screening.

Standard preventive care includes women's contraceptives sterilization procedures, and counseling. The list of services included as standard preventive care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html and
- www.cdc.gov/vaccines/schedules/hcp/index.html.

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

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Illness. Standard preventive care for Children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of standard preventive care include:

- Immunizations for Children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  - Diphtheria,
  - Pertussis,
  - Tetanus,
  - Polio,
  - Measles,
  - Mumps,
  - Rubella,
  - Hemophilus influenza b (Hib),
  - Hepatitis B,
  - Varicella.
- Preventive care and screenings for infants, Children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as standard preventive care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html; and
- www.cdc.gov/vaccines/schedules/hcp/index.html.

68. **Prosthetics Devices.** Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Charges made for the initial purchase and fitting of external prosthetic devices which are used as replacements or substitutes for missing body parts and are necessary to alleviate or correct Illness, Injury, or congenital defect, including only artificial arms and legs and terminal devices such as hands or hooks. Medically Necessary repair, maintenance, or replacement of a covered appliance is also covered if needed due to normal anatomical growth. Pre-certification is required when the purchase price is expected to exceed $1,000.

69. **Pulmonary Rehabilitation.** Charges associated with pulmonary rehabilitation.

70. **Radiation Therapy.** Charges for radiation therapy and treatment.

71. **Rehabilitation Services.** Rehabilitation services rendered on an Inpatient or Outpatient basis. Therapy in the home applies to the limits outlined in the Medical Benefits Schedule.

72. **Reconstructive Surgery.** Reconstructive surgery expenses to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit are covered in only the following circumstances:

    a. The surgery or therapy restores or improves function;
    b. Reconstruction is required as a result of Medically Necessary, non-cosmetic surgery;
    c. When needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part up to age nineteen (19); and

d. To correct damage caused by an Accidental Injury.

73. Second Surgical Opinion. If a Physician recommends surgery or other medical treatment, it is often in the Plan Participant's best interest to obtain a second opinion with a specialist regarding the necessity of the procedure. In many cases an alternative method of treatment is available that would save the Plan Participant the discomfort of surgery or other medical treatment as well as the time and extra expenses.

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

a. The patient is confined as a bed patient in the facility;
b. The attending physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
c. The attending physician completes a treatment plan which includes a Diagnosis, the proposed course of treatment, and the projected date of discharge from the Skilled Nursing Facility.

Pre-certification is required for Inpatient admissions. Covered Expenses will be payable as shown in the Medical Benefits Schedule.

75. Sleep Apnea Oral Devices. Charges associates with sleep apnea oral devices.

76. Sleep Disorders and Sleep Studies. Care and treatment for sleep disorders, including sleep studies performed in the home.

77. Speech Therapy. Services provided by a licensed speech therapist, payable up to the limits as stated in the Medical Benefits Schedule. Therapy must be ordered by a Physician and follow either:

a. Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a Plan Participant;
b. An Injury; or
c. An Illness that is other than a learning or Mental or Nervous Disorder.

78. Sterilization Procedures. Charges for male and female sterilization procedures. Sterilization procedures for female Plan Participants will be payable as shown under the preventive care benefit. The Plan does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

79. Surgery. Benefits for the treatment of Illnesses and Injuries, including fractures and dislocations, are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies. Pre-certification is required for certain Outpatient surgical procedures.

80. Transplants. The transplant program provides access to a network of transplant centers that perform many transplants each year and have historically high success rates. They are often affiliated with renowned teaching and research facilities with access to experienced surgeons and advanced medical techniques. Using a hospital with transplant experience can result in shorter Hospital stays, fewer complications, and fewer repeat transplants.

Under the transplant program, the Plan reimburses the Plan Participant for Covered Expenses and supplies arising out of, and specifically limited to, the following human organ and tissue transplants for a Plan Participant recipient:

a. Bone marrow;
b. Cornea;
c. Double lung;
d. Heart;
e. Heart/lung;

f. Intestine;
g. Kidney;
h. Kidney/liver;
i. Kidney/pancreas;
j. Liver;
k. Pancreas;
l. Small bowel/liver; or
m. Multi-visceral.

When the donor of an organ or tissue is not a Plan Participant, Hospital, surgical, and medical expenses will be eligible on the basis of a claim made by the Plan Participant.

Medical and surgical treatment or devices related to transplantation that are Experimental and/or Investigational, or unproven are those not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, subject to review and approval by any institutional Review Board for the proposed use; or non-demonstrative through prevailing peer-reviewed medical literature to be efficacious for the treatment of the Disease state at the time of the request. The Plan reserves the right to make final judgment regarding coverage of Experimental and/or Investigational, and unproven procedures and treatments. Medically Necessary means those transplant related services which are determined by the Plan to be medically appropriate for the Diagnosis and clinical status of the Plan Participants and their Dependents, rendered in an appropriate setting, and of demonstrated medical value. The fact that a Physician has performed or prescribed a transplant-related service, or the fact that it may be the only treatment for a Disease does not mean that is Medically Necessary.

Transplant-related services are services and supplies related to transplantation when recommended by a Physician, provided at or arranged by a transplant hospital, and determined to be Medically Necessary. Such services and supplies include but are not limited to Hospital charges, Physician charges, organ acquisition charges, tissue typing donor search charges, and ancillary services.

Program Benefits

a. Access to a Blue Distinction Center or Network Provider.

b. Reimbursement for travel and lodging expenses Incurred during the transplant (immediately prior to and after the transplant) for the Plan Participant and one (1) companion up to a total maximum of $10,000.

   The term companion includes the Plan Participant's spouse, a member of their family, their legal guardian, or any person not related to the Plan Participant, but actively involved as a caregiver who is at least eighteen (18) years of age.

   These benefits will be reimbursed upon the submission to the Plan of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. The Plan Administrator reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision. Travel benefits are not available for cornea transplants.

c. Bone marrow transplant donor search fee up to $30,000.

d. Services of a transplant case manager, who will coordinate services and savings.

e. Charges related to procuring and transporting a donated organ or tissue.

Requirements. Transplant benefits under the Plan are only available when a Plan Participant fully utilizes a Blue Distinction Center or Network Provider and meets all of the following requirements:

a. Pre-notification of the upcoming transplant must be given by the Plan Participant or the Plan Participant's Physician as soon as the Plan Participant is identified as a potential transplant candidate.

b. Pre-certification must be obtained.

All transplant services must be rendered at a transplant center facility. Certain transplant procedures are not available at a Blue Distinction Center. In these instances, Plan Participants may have access to an Anthem Center of Medical Excellence for the procedure, depending on the state of residence. When neither a Blue Distinction Center or Anthem Center of Medical Excellence facility is available, the Plan provides coverage for the procedure and reimbursement of travel expenses to the closest available network location that performs the procedure. **If these requirements are not met, transplant benefits are not available under the Plan.**

Transplant Exclusions. The following transplant-related expenses are not covered by the Plan:

a. When the recipient is not an eligible Plan Participant.
b. When the organ or tissue is sold rather than donated to the recipient.
c. Charges that are covered or funded by governmental, foundation, or charitable rants or programs.
d. Charges for any artificial or mechanical organ.
e. Travel costs incurred due to travel within sixty (60) miles of the Plan Participant's home.
f. Food and meals, laundry bills, telephone bills, and charges for transportation that exceed coach class rates.

81. Urgent Care Facility. Services and supplies provided by an Urgent Care facility. Eligible expenses will be payable as shown in the Medical Benefits Schedule.

82. Video Conferencing. Physician-to-Physician video consultation with another specialist.

83. Virtual Visits. Services rendered telephonically or electronically, performed by Providers other than the Plan's telemedicine vendor.

84. Well Newborn Nursery/Physician Care. Charges for the following:

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

This coverage is only provided if the newborn child, who is neither injured nor ill, is an eligible Dependent and a parent (1) is a Plan Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the special enrollment provisions with coverage effective as of the date of birth.

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

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

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours

as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Recognized Charges made by a Physician for the newborn child while Hospital confined, including circumcision, as a result of the Child's birth.

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

If the baby is ill, suffers an Injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided the Child is added to the Plan and coverage is in effect.

85. Wigs. These are considered a Covered Expense when generalized hair loss is due to chemotherapy or radiation therapy. Limited to one (1) wig per Calendar Year.

ARTICLE VIII
MEDICAL MANAGEMENT SERVICES

Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan has contracted with Anthem Blue Cross in order to assist the Plan Participant in determining whether or not proposed services are appropriate for reimbursement under the Plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

ANTHEM BLUE CROSS
(800) 274-7767

UTILIZATION REVIEW

Utilization Review is a program designed to help ensure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

PRE-CERTIFICATION

Pre-Certification is the process of performing a Medical Necessity review. This process is performed by Anthem Blue Cross. The following non-Emergency Services require Pre-Certification:

- All Inpatient Hospital and Skilled Nursing Facility stays;
- Facility based treatment for Mental or Nervous Disorders or Substance Abuse;
- Home health care;
- Infusion therapy that includes specialty drugs in the specialty pharmacy program, and related services (for each course of treatment) in any setting, including, but not limited to the Physician's office, infusion center, Outpatient Hospital or clinic, the Plan Participant's home or other residential setting;
- Organ and tissue transplants, peripheral stem cell replacement and similar procedures; and
- Other surgical, diagnostic procedures, Durable Medical Equipment and/or prosthetics wherever rendered as specified by Anthem Blue Cross.

The purpose of the program is to determine Medical Necessity, medical appropriateness, health care setting, and level of care.

All services requiring Pre-Certification, are to be authorized in advance, except for emergencies, by contacting Anthem Blue Cross at (800) 274-7767. The Plan Participant or their Authorized Representative is required to call for Pre-Certification for the services specified above at least 48 hours prior to the services being rendered. The Plan Participant or their Authorized Representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Pre-Certification determinations and service prepricing. For a complete list of current procedures, contact Anthem Blue Cross toll free at (800) 274-7767.

If Pre-Certification is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care may be reduced by 50% up to $500. Such reduction will not go toward the maximum out-of-pocket amount.

If a particular course of treatment or medical service is not Preauthorized as Medically Necessary before the Plan Participant receives the care or treatment, it means that the charges for the care or treatment may be denied.

Any reduced reimbursement or denied claims, due to failure to follow Pre-Certification procedures will not accrue toward the maximum out-of-pocket amount.

The attending Physician does not have to obtain Pre-Certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

HOW THE UTILIZATION REVIEW PROGRAM WORKS

Before a Plan Participant enters a Hospital on a non-emergency basis or receives other listed medical services, Anthem Blue Cross will, in conjunction with the attending Physician, certify the care as Medically Necessary. A non-emergency stay in a Hospital is one that can be scheduled in advance.

The Utilization Review program is set in motion by a telephone call from, or on behalf of, the Plan Participant or the treating Provider. Contact Anthem Blue Cross at the number listed above before services are scheduled to be provided with the following information.

- The name of the Plan Participant and relationship to the covered Employee
- The name, Employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an emergency admission to the Hospital, the Plan Participant, Plan Participant's family member, Hospital or attending Physician must contact Anthem Blue Cross **within 48 hours** after admission.

Anthem Blue Cross will review and make a determination on the Medical Necessity of the care, treatment or service.

Note: *Pre-Certification does not guarantee payment of the claim(s) Incurred during the period of authorization. Whether an individual is a Plan Participant, whether a charge is eligible for payment, and how much of a charge is paid are determined after the claim for the care, treatment or service is received by the Claims Administrator. All claims are subject to all Plan terms and conditions, limitations, and Exclusions at the time the charges are Incurred. Providers and Plan Participants are informed at the time the Hospital stay is authorized, that authorization by Anthem Blue Cross, does not guarantee payment of claims for the same.*

Concurrent Review and Discharge Planning. Concurrent review of a course of treatment and discharge planning from a Hospital are parts of the Utilization Review. Anthem Blue Cross will monitor the Plan Participant's Hospital stay or use of other medical services and coordinate with the attending Physician, Hospital and Plan Participant either the scheduled discharge or extension of the Hospital stay or extension or cessation of other medical services.

If the attending Physician believes it Medically Necessary for a Plan Participant to receive additional services or to stay in the Hospital for a greater length of time than has been Preauthorized, the attending Physician must request the additional services or days.

RETROSPECTIVE REVIEW

The Utilization Review Service will review and evaluate the medical records and other pertinent data of an individual whose Hospital stay, or a portion of his stay, was not authorized under the provisions of the Plan.

Requests for such review must be made, in writing, by the attending Physician or Hospital and must define the medical basis for the review.

Benefits will be limited to only those expenses Incurred during the period of hospitalization which **would have been** authorized. Benefits are not payable for expenses related to any period of Hospital confinement which is deemed not Medically Necessary.

CONTINUITY OF CARE

In the event a Plan Participant is a continuing care patient receiving a course of treatment from a Network Provider or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is

terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Plan Participant shall have the following rights to continuation of care.

The Plan shall notify the Plan Participant that the Provider's contractual relationship with the Plan has terminated, and that the Plan Participant has rights to elect continued transitional care from the Provider. If the Plan Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Plan Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. Is undergoing a course of treatment for a serious and complex condition from a specific Provider,

2. Is undergoing a course of institutional or Inpatient care from a specific Provider,
3. Is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. Is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. Is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the Provider termination had not occurred, and the Plan Participant is responsible for their network share of cost.

CASE MANAGEMENT AND ALTERNATIVE BENEFIT

If a Plan Participant has an ongoing Illness or Injury, a Case Manager may be assigned to monitor the Plan Participant, and to coordinate with the attending Physician and Plan Participant to design a treatment plan and coordinate appropriate Medically Necessary care. The case manager will consult with the Plan Participant, the family, and the attending Physician to assist in coordinating a plan of care approved by the Plan Participant's attending Physician and the Plan Participant.

Case management is a voluntary program of the Plan. If the Plan Participant chooses not to participate in the case management program, there will be no reductions of benefits or penalties.

Each treatment plan is individualized to a specific Plan Participant and is not appropriate or recommended for any other Plan Participant, even one with the same Diagnosis. All treatment and care decisions will be the sole determination of the Plan Participant and the attending Physician.

Alternative Benefit. The Plan may elect, in its sole discretion, to allow for alternative benefits that are otherwise excluded under the Plan. The Plan's decision to allow alternative benefits shall be determined on a case-by-case basis in conjunction with the treating Provider and the Plan Participant. The Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Plan Participant, nor shall it be deemed to waive the right of the Plan Administrator to strictly enforce the provisions of the Plan.

The Alternative Benefit must be beneficial to both the Plan Participant and the Plan. Alternative benefits, if approved by the Plan Administrator, are subject to all applicable Plan terms and conditions, limitations and Exclusions at the time the charges are Incurred. Once agreement has been reached, the Plan Administrator or its delegate will direct the Claims Administrator to reimburse for Medically Necessary expenses as stated in the alternative treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses Incurred in connections with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

ARTICLE IX
DEFINED TERMS

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

Accident means a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury means an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

Active Employee is an Employee who on any day performs in the customary manner all of the regular duties of employment. An Employee will be deemed active on each day of a regular paid vacation or on a regular non-working day on which the covered Employee is not Totally Disabled, provided the covered Employee was working on the last preceding regular workday. An Employee shall be deemed active if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan's leave of absence provisions. An Employee will not be considered under any circumstances active if he or she has effectively terminated employment.

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a claim that is based on any: (a) determination of an individual's eligibility to participate in a Plan or health insurance coverage; (b) determination that a claimed benefit is not a Covered Service; (c) imposition of a source-of-injury Exclusion, or other limitation on otherwise Covered Services; (d) determination that a claimed benefit is Experimental and/or Investigational, or not Medically Necessary or appropriate; (e) invalid charges; or (f) improper balance, of (g) as otherwise defined in the Plan.

Affordable Care Act (ACA) means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

Allowable Charge means a charge which is either the Network Provider's reduced fee or the Recognized Charge for a service or supply.

Allowable Expense(s) means any Medically Necessary item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Coordination of Benefits, this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore, whether or not it is actually made.

Alternate Recipient means any Child of a Plan Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Plan Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Plan Participant.

Ambulatory Surgical Center means a freestanding outpatient surgical facility. It must be licensed as an Outpatient clinic according to state and local laws and must meet all requirements of an Outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

1. Federally Funded Trials. The study or investigation is approved or funded (which include funding through in-kind contributions) by one or more of the following:

    a. The National Institutes of Health;
    b. The Centers for Disease Control and Prevention;
    c. The Agency for Health Care Research and Quality;
    d. The Centers for Medicare & Medicaid Services;
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or Department of Veterans Affairs; or
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

2. The study or investigation is conducted under an Investigational new drug application reviewed by the Food and Drug Administration.

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

Authorized Representative is a person designated by the Plan Participant to act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be made in writing, signed and dated by the Plan Participant, and include all information required in the Authorized Representative form.

Calendar Year means is the 12-month period beginning on January 1st and ending the following December 31st.

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Child and/or Children means the Employee's natural child, any stepchild, legally adopted child, or any other Child for whom the Employee has been named Legal Guardian, or an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. For purposes of this definition, a legally adopted child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

CHIP means the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Claimant means a Plan Participant or an Authorized Representative of a Plan Participant making a claim or for whom a claim is made.

Claims Administrator is HealthComp Administrators, Inc.

Clean Claim means one that can be processed in accordance with the terms of this Plan without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this Plan, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this Plan, and only as permitted by this Plan, from being made. A Clean Claim does not include claims under investigation for

fraud and abuse or claims under review for Medical Necessity, or fees under review for Recognized Charge or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this Plan.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this Plan and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this Plan. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

CMS means Centers for Medicare and Medicaid Services.

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

Coinsurance means a cost sharing feature of many plans. It requires a Plan Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Plan Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Recognized Charge for Covered Services.

Copayment or Copay means the specified dollar amount that a Plan Participant must pay each time certain medical care is provided, as specified in the Medical Benefits Schedule.

Covered Expense(s)/Covered Service(s) are Provider charges for Covered Services. Covered Expenses are billed charges minus non-Covered Expenses and invalid charges. Covered Expenses also means a reasonable fee for an appropriate, Medically Necessary service, treatment or supply, meant to improve a condition or Plan Participant's health, which is specified in this Plan as a Covered Expense. Covered Expenses will be determined based upon all other Plan provisions.

All treatment is subject to benefit payment maximums shown in the Medical Benefits Schedule and as determined elsewhere in this Plan.

Custodial Care means care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: Preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel. If Medically Necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Deductible means an amount of money that is paid once a Calendar Year per Plan Participant and Family Unit. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any medical care.

Dentist means a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

Dependent(s) means the covered Employee's eligible family members as outlined in this Plan.

Diagnosis means the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of Plan Participant history, examination, and review of laboratory data.

Diagnostic Service means an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a Disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

Disease means any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any worker's compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness or Disease.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

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

Employer is Ajinomoto Foods North America, Inc. and any entity under common control as elected by the Plan Administrator to participate in the Plan.

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

Errors mean any billing mistakes or improprieties including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or medical care not actually rendered or performed, or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard.

Emergency Services means a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the Diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

Excess Charge means a charge or portion thereof billed for care and/or treatment of an Illness or Injury that is not payable under the terms of the Plan because it exceeds the Recognized Charge, or is determined by the Plan Administrator to be based on Invalid Charges or Errors as defined by this Plan Document. Also, charges for a service or supply furnished by a direct contract Provider in excess of the applicable negotiated rate.

Exclusion means conditions or services that this Plan does not cover.

Experimental procedures are those that are mainly limited to laboratory and/or animal research, but which are not generally accepted as proven and effective procedures within the organized medical community. The utilization manager has discretion to make this determination. However, if a Plan Participant has a seriously debilitating condition and the utilization manager determines the requested treatment is not a Covered Service because it is Experimental, the Plan Participant may request an Independent Medical Review.

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

FDA means the Food and Drug Administration.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

FMLA means the Family and Medical leave Act of 1993, as amended.

FMLA Leave means an unpaid, job protected leave of absence for certain specified family and medical reasons, which an Employer may be required to extend to an eligible Employee under the provisions of the FMLA.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of Disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes as defined by the *Genetic Information Nondiscrimination Act of 2008 (GINA)*.

Home Health Care Agency is a home health care provider which is licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the Plan Participant's home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home Infusion Therapy Provider is a Provider licensed according to state and local laws as a Pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice Agency is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed home health agency with federal Medicare certification pursuant to Health and Safety Code section 1726 and 1747.1.

Hospital means a facility which provides Diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of Physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations. For limited purpose of Inpatient care, the definition of Hospital also includes: (1) psychiatric health facilities (only for the acute phase of a Mental or Nervous Disorder or substance abuse), and (2) residential treatment centers.

Illness means a bodily disorder, Disease, physical Illness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Incurred means that a Covered Expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Freestanding Emergency Department means a health care Facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Centers or Clinics.

Injury means an Accidental Injury to the body caused by unexpected external means.

Inpatient means a Plan Participant who receives medical care at a Hospital and is admitted as a registered overnight bed patient.

Institution means a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital,

Ambulatory Surgical Center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse treatment center, alternative birthing center, or any other such facility that the Plan approves.

Investigational Procedures (Investigational) are those:

1. That have progressed to limited use on humans, but which are not generally accepted as proven and effective procedures within the organized medical community; or
2. That do not have final approval from the appropriate governmental regulatory body; or
3. That are not supported by scientific evidence which permits conclusions concerning the effect of the service, drug or device on health outcomes; or
4. That do not improve the health outcome of the patient treated; or
5. That are not beneficial as any established alternative; or
6. Whose results outside the Investigational setting cannot be demonstrated or duplicated; or
7. That are not generally approved or used by Physicians in the medical community.

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

Lumpectomy means the surgical removal of a small tumor, which may be benign or cancerous.

Mastectomy means the surgical removal of all or part of a breast.

Medical Child Support Order means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that meets one of the following requirements:

1. Provides for child support with respect to a Plan Participant's Child or directs the Plan Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Medically Necessary procedures, supplies, equipment or services are those determined to be:

1. Appropriate and necessary for the Diagnosis or treatment of the medical condition;

2. Provided for the Diagnosis or direct care and treatment of the medical condition;

3. Within standards of good medical practice within the organized medical community;

4. Not primarily for the Plan Participant's convenience, or for the convenience of the Physician or another Provider; and

5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

    a. There must be valid scientific evidence demonstrating that the expected health benefit from the procedure, supply, equipment or services are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the Plan Participant with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c. For hospital stays, acute care as an Inpatient is necessary due to the kind of services the Plan Participant is receiving or the severity of the condition, and safe and adequate care cannot be received by as an Outpatient or in a less intensified medical setting.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary, and whether an exception to the Medical Necessity requirement is available.

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

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

National Medical Support Notice (NMSN) means a notice that contains all of the following information:

1. The name of an issuing State child support enforcement agency.
2. The name and mailing address (if any) of the Employee who is a Plan Participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Plan Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
4. Identity of an underlying child support order.

Network Provider or Network Facility means a healthcare institution or healthcare provider who has by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a health care Facility and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Non-Network Provider or Non-Network Facility means a healthcare institution or healthcare provider who does not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

Outpatient means a Plan Participant who receives medical care at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than 24 hours.

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

Physician means a person permitted to perform services provided by this Plan who is legally entitled to perform certain medical services according to applicable and current licensure, certification or registration ("License" or "Licensed" or "Licensure") in the state or jurisdiction where the services are rendered. The person must be acting within the scope of his or her Licensure and must hold one of the following Licenses, degrees and/or titles: Medical Doctor or Surgeon (M.D.); Doctor of Osteopathy (D.O.); Doctor of Optometry (O.D.); Doctor of Podiatric Medicine (D.P.M.); Doctor of Dental Surgery (D.D.S.); Doctor of Dental Medicine (D.M.D.); or Doctor of Chiropractic (D.C.).

Plan means Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan which is a benefits plan for covered Employees, and Dependents of Ajinomoto Foods North America, Inc.

Plan Administrator or Plan Sponsor means Ajinomoto Foods North America, Inc.

Plan Participant means an Employee, a Dependent, a COBRA Qualified Beneficiary, a COBRA Qualified Beneficiary's Dependent or other person meeting the eligibility requirements for coverage as specified in the Plan, and who is properly enrolled in the Plan.

Pre-Certification means a decision by the Plan that a health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary. Sometimes called prior authorization, prior approval or Pre-

Certification. The Plan may require Pre-Certification for certain services before the Plan Participant receive them, except in an emergency.

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

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

Provider means a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

Recognized Charge is the lower of:

1. The Provider's usual charge to provide a service or supply; or

2. The charge the Claims Administrator determines to be the recognized charge percentage for the service or supply; or

3. The charge the Claims Administrator determines to be appropriate, based on factors such as:

    a. The cost of supplying the same or similar service or supply;
    b. The manner in which the charges for the service or supply are made;
    c. The complexity of the service or supply;
    d. The degree of skill needed to provide it;
    e. The Provider's specialty; and
    f. The Recognized Charge in other areas.

4. For non-network charges subject to the No Surprises Act, the Recognized Charge may be the amount deemed payable by a Certified IDR Entity.

Skilled Nursing Facility is an Institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

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

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    c. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).
2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Total Disability (Totally Disabled) means, in the case of a Dependent, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. To prove Total Disability, the covered Employee must prove that he or she has claimed the Dependent on his or her tax returns.

Waiting Period means the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE X
MEDICAL PLAN EXCLUSIONS

Note: All Exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits section.

The following are not covered under this Plan:

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

2. **Administrative Costs.** Charges for failure to keep scheduled appointments, completion of a claim form, obtaining medical records, late payments, telephone charges or information required to process a claim.

3. **Alcohol.** Services, supplies, care, or treatment to a Plan Participant for an Injury or Illness arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for injured plan participants other than the person partaking in any activity made illegal due to the use of alcohol, and expenses may be covered for substance abuse treatment as specified in this Plan, if applicable, except as required under the No Surprises Act.

4. **Alternative Medicine.** Holistic or homeopathic treatment, naturopathic services, acupressure, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy, extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, hypnosis, electro-hypnosis, and thermography, including drugs.

5. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any Plan participant in the armed forces of a government.

6. **Blood.** Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery. Blood administration for the purpose of general improvement in physical condition.

7. **Chelation Therapy.** Charges associated with chelation therapy except when treating lead poisoning.

8. **Clinical Trials.** The following items are excluded from Approved Clinical Trial coverage under this Plan:

    a. The Investigational item, device, or service, itself;
    b. Items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient; and
    c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.

    If one (1) or more participating providers do participate in the Approved Clinical Trial, the qualified Plan Participant must participate in the Approved Clinical Trial through a Network Provider, if the Provider will accept the Plan Participant into the trial. The Plan does not cover routine patient care services that are provided outside of this health care provider network unless non-network benefits are otherwise provided under this Plan.

9. **Complications of Non-Covered Expenses.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan. Complications of a non-covered abortion are covered, except as required under the No Surprises Act.

10. **Cosmetic Surgery.** Charges that are Incurred in connection with the care and/or treatment of surgical procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or

supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons; (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term Cosmetic Services includes those services which are described in IRS Code Section 213(d)(9).

11. **Counseling.** Benefits for counseling in the absence of Illness or Injury, including, but not limited to, premarital or marital counseling; counseling for family problems; education, social, behavioral, or recreational therapy; sex or interpersonal relationship counseling; or counseling with Plan Participant's friends, employer, school counselor, or schoolteacher. Family and group counseling will be considered when billed with an otherwise covered Diagnosis.

12. **Court-Ordered Treatment.** Any treatment of a Plan Participant in a public or private Institution as the result of a court order, unless such treatment is prescribed by a Physician and listed as covered in this Plan.

13. **Custodial Care.** Charges for Custodial Care, domiciliary care or rest cures.

14. **Dental Care.** Charges for normal dental care benefits, including any dental, gum treatments, or oral surgery, except as outlined under Covered Expenses.

15. **Developmental Disorders.** Charges associated with treatment for developmental disorders.

16. **Dietary Supplements.** Charges associated with dietary supplements unless required to be covered by applicable law.

17. **Doula Services.** Charges associated with doula services.

18. **Educational or Vocational Testing.** Services for educational or vocational testing or training.

19. **Examinations.** Any health examination required by any law of a government to secure insurance or school admissions or professional or other licenses, except as required under applicable Federal law.

20. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Recognized Charge, or are for services not deemed to be reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this Plan.

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

22. **Experimental and/or Investigational or not Medically Necessary.** Care and treatment that is either Experimental and/or Investigational, is not Medically Necessary. This Exclusion will not apply if the charge is for routine patient care for costs Incurred by a qualified individual who is a participant in an Approved Clinical Trial. Charges will be covered only to the extent specifically set forth in this Plan.

23. **Foot Care.** Services for palliative or cosmetic foot care including flat foot conditions, treatment of subluxation of the foot, care of corns, bunions (except capsular or bone surgery), callouses, toenails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, except for the treatment for metabolic or peripheral-vascular disease or unless specifically provided herein.

24. **Foot Orthotics.** Charges for foot orthotics including over the counter foot orthotics.

25. **Foreign Travel.** Expenses for non-emergent services received or supplies purchased outside the United States, including those rendered on a cruise ship are excluded under this Plan. Services in the case of a medical emergency are a Covered Expense.

26. **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This Exclusion does not apply to Medicaid, a Veteran's Administration facility, or when otherwise prohibited by applicable law.

27. **Habilitation Services.** Charges for habilitative services for all medical and mental health disorders.

28. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy or radiation therapy.

29. **Hearing Exams.** Charges for a hearing exam, except as may be covered under the hearing aid benefit, preventive care benefits, or under applicable federal law.

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

31. **Hospital Services.** Hospital services when hospitalization is primarily for Diagnostic Testing, studies or physical therapy when such procedures could have been done adequately and safely on an Outpatient basis.

32. **Illegal Acts.** Any charge for care, supplies, treatment, and/or services for any Injury or Illness which is Incurred while taking part or attempting to take part in an illegal activity, including, but not limited to, misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act, except as required under the No Surprises Act.

33. **Illegal Drugs or Medications.** Services, supplies, care, or treatment to a Plan Participant for Injury or Illness resulting from that Plan Participant voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Plan Participants other than the person using controlled substances, except as required under the No Surprises Act.

34. **Immediate Family Member.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

35. **Immunizations.** Charges for immunizations and vaccinations for the purpose of travel outside of the United States or to protect against occupational hazards and risks.

36. **Long Term Care.** Charges related to long term care or convalescent care.

37. **Massage Therapy.** Services for massage therapy or services performed by a massage therapist.

38. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the Plan Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any federal law or regulation, except as provided in the Coordination of Benefits section in this Plan.

39. **Mental Health and Substance Abuse.** The following are specifically excluded from mental health and substance use disorder services:

    a. Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;

b. Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders, or developmental articulation disorders;
c. Counseling for activities of an educational nature;
d. Counseling for borderline intellectual functioning;
e. Counseling for occupational problems;
f. Counseling related to consciousness raising;
g. Vocational or religious counseling;
h. I.Q. testing;
i. Custodial Care, including but not limited to geriatric day care;
j. Psychological testing on Children requested by or for a school system; and
k. occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

40. Methadone Clinic. Methadone clinics are not covered. Methadone treatment is only covered as part of detoxification under Substance Abuse treatment.

41. Milieu Therapy. A treatment program based on manipulation of the Plan Participant's environment for their benefit.

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

43. No Legal Obligation. Any charge for care, supplies, treatment, and/or services that are provided to a Plan Participant for which the provider of a service customarily makes no direct charge, for which the Plan Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the Plan Participant or this Plan, may be liable for necessitating the fees, care, supplies, or services.

44. Non-Compliance. All charges in connection with treatments or medications Incurred due to the Plan Participant's non-compliance with or discharge from a Hospital or Skilled Nursing Facility against medical advice, except as required under the No Surprises Act.

45. Non-Emergency Hospital Admissions. Care and treatment billed by a Hospital for non-medical emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

46. No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician. Treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

47. Obesity. Screening and counseling for obesity will be covered as required under standard preventive care. Other care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness is excluded. Medically Necessary non-surgical and surgical treatment for morbid obesity are covered.

48. Occupational or Workers' Compensation. Charges for care, supplies, treatment, and/or services for any condition, Illness, Injury, or complication thereof arising out of or in the course of employment (including self-employment), or an activity for wage or profit. If a Plan Participant is covered as a Dependent under this Plan and is self-employed or employed by an employer that does not provide health benefits, make sure that other medical benefits are available to provide for the medical care in the event that the Plan Participant is hurt on the job. In most cases workers' compensation insurance will cover the costs, but if the Plan Participant does not have such coverage, they may end up with no coverage at all.

49. **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-medical grade stockings, non-prescription drugs and medicines, first aid supplies, modifications to homes or vehicles, and non-hospital adjustable beds.

50. **Private Duty Nursing**. Charges in connection with care, treatment, or services of a private duty nurse, except as provided under home health care services.

51. **Rehabilitation Therapy.** Sensory integration therapy; group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder; treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia, or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and maintenance or preventive treatment consisting of routine, long-term or non-medically necessary care provided to prevent recurrence or to maintain the patient's current status.

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

53. **Services Before or After Coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

54. **Sexual Dysfunction.** Care, treatment, services, supplies or medication in connection with treatment for impotence.

55. **Smoking Cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under the preventive care provision. Tobacco cessation care and treatment is otherwise excluded. Refer to the Prescription Drug Program for details on coverage of certain tobacco cessation medications.

56. **Speech Devices.** Charges associated with speech devices.

57. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.

58. **Surrogate.** Charges for services related to a surrogate pregnancy.

59. **Temporomandibular Joint Disorder (TMJ).** Surgical and non-surgical services for treatment of temporomandibular joint disorders.

60. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges or travel required for an approved organ or tissue transplant.

61. **Vision Care.** Expenses for the following will not be covered:

    a. Surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK).
    b. Diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting, and repair of eyeglasses or lenses and associated supplies, except one (1) pair of eyeglasses or contact lenses is payable as following ocular surgery when the lens of the eye has been removed such as with a cataract extraction;
    c. Vision therapy (orthoptics) and supplies; and
    d. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

62. War. Any treatment of an Injury or Illness that is due to a declared or undeclared act of war, riot or insurrection.

ARTICLE XI
PRESCRIPTION DRUG BENEFITS

The purpose of the Ajinomoto Food North America, Inc. Prescription Drug Program is to provide eligible Employees and their Dependents with certain Prescription Drugs approved by the Food and Drug Administration (FDA) and dispensed at a retail or mail in Pharmacy.

The Plan has partnered with a Costco Health Solutions, a Pharmacy Benefits Manager, to offer Plan Participants covered Prescription Drugs. For a list of covered Prescription Drugs as well as participating pharmacies that have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs, please contact the Plan Administrator. More information about the Plan's Prescription Drug Program can be found in the Prescription Drug Benefit Schedule.

Costco Health Solutions is always available to assist Plan Participants and can be contacted at (877) 908-6024.

Participating Pharmacy. Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs.

Prescription Drug Copayments. A Prescription Drug Copayment is applied to each covered Pharmacy drug, specialty medication or mail order drug charge.

Specialty Drugs. Certain injectables and other covered under the prescription drug card program require a letter of Medical Necessity and prior authorization review from the Pharmacy Benefit Manager. Most injectables and specialty drugs are brand name drugs. Most injectables and specialty drugs are filled only for a single month's supply.

Mail Order Pharmacy. The mail order Pharmacy benefit is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). **Injectable drugs are not available through mail order.**

Any one mail order prescription is limited up to a 90-day supply.

Note: Some quantity limitations and/or prior authorization may apply.

PRIOR AUTHORIZATION (PA)

Prior authorization is required for all new drugs after-market availability for 12 months. There are additional medications that may require Pre-Certification, check with the Pharmacy Benefits Manager for the most updated information.

LIMITATIONS TO THIS BENEFIT

1. Certain Prescription Drugs are subject to supply limits. The limit may restrict the amount dispensed for each prescription or refill and/or the amount dispensed for any month's supply (for example, medications used to treat sexual dysfunction), and this is to ensure certain medications are not utilized inappropriately or recommended maximum dosages are not exceeded.
2. Limitations and Exclusions may apply to certain classes of Prescription Drugs where lower cost clinical alternatives exist.
3. Specific rules, including increased supply limits, may apply. Contact the Pharmacy Benefit Manager for more information.

EXCLUSIONS

1. **Administration.** Any charge for the administration of a covered drug.

2. **Athletic.** Drugs used to enhance athletic performance.

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

4. **Cosmetic Drugs.** Prescription Drugs used for cosmetic purposes, such as but not limited to drugs used to reduce wrinkles, hair stimulants and hair removal products, and pigmenting and depigmenting agents.

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

6. **Experimental & Non-FDA Approved Drugs.** Experimental drugs and medicines, even though a charge is made to the Plan Participant and drugs not approved by the Food and Drug Administration (FDA).

7. **Immunization.** Immunization agents, biological sera, biological products for allergy immunization, blood, and blood plasma.

8. **Impotence.** Charges for impotence medication.

9. **Infertility.** A charge for injectable infertility medication

10. **Injectable.** Injectable drugs that require Physician supervision and are not typically considered self-administered drugs.

11. **Inpatient Medication.** A drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any Institution that has a facility for the dispensing of drugs and medicines on its premises.

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

13. **Medical Exclusions.** A charge for medication to treat a condition excluded under the medical plan.

14. **No Charge.** A charge for Prescription Drugs that may be properly received without charge under a local, state, or federal program.

15. **Non-Legend Drugs.** A charge for FDA-approved that are prescribed for non-FDA approved uses.

16. **Over the Counter**. Drugs available over the counter that do not require a prescription by federal or state law unless state or federal law requires coverage of such drugs. Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin.

17. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

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

19. **Tobacco/Smoking Cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation, except as required by law.

ARTICLE XII
CLAIMS PROCEDURES

When services are received from a health care Provider, a Plan Participant should show his or her **identification card** to the Provider.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from his or her health care Provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill;
- Group name and number;
- Provider Billing Identification Number;
- Employee's name and Identification Number;
- Name of Plan Participant;
- Name, address, telephone number of the Provider of care;
- Date of service(s);
- Place of service; and
- Amount billed.

Note: A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at:

www.hconline.healthcomp.com

WHERE TO SUBMIT CLAIMS

Claims for expenses should be submitted to the address below:

HealthComp Administrators, Inc.
P.O. Box 45018
Fresno, CA 93718-5018
(877) 706-6268

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second opinion. The Plan also encourages Plan Participants to obtain second opinions as outlined in the Covered Expenses section set forth above. **The Plan Administrator will only process Clean Claims as defined by this Plan Document.**

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this Plan and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this Plan. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

TYPES OF CLAIMS

A **claim** means a request for a Plan benefit, made by a Claimant (Plan Participant or by an Authorized Representative of a Plan Participant that complies with the Plan's procedures for filing benefit claims).

A Claimant may appoint an Authorized Representative to act upon his or her behalf with respect to the claim. Only those individuals who satisfy the Plan's requirements to be an Authorized Representative will be considered an Authorized Representative. A healthcare Provider is not an Authorized Representative simply by virtue of an assignment of benefits; however, a healthcare Provider can represent the Claimant in claims involving Urgent Care. Contact the Claims Administrator for information on the Plan's procedures for Authorized Representatives. There are four types of claims:

A **pre-service claim** is a reduction in benefits for certain Covered Services because the Plan Participant did not obtain the required Plan approval before receiving the care or treatment. This Plan does require Pre-Certification for certain Covered Services or treatments as a condition to receiving benefits under the Plan. The review program is known as Pre-Certification. See the Medical Benefits Schedule and Medical Management Services sections in this Plan for more information.

An **urgent care claim** is any pre-Service claim where the application of the time periods for review and determination of the pre-service claim could seriously jeopardize the life or health of the Plan Participant or the Plan Participant's ability to regain maximum function, or – in the opinion of the Plan Participant's treating Physician, would subject the Plan Participant to severe pain that cannot be managed without the proposed care or treatment.

A **concurrent care determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If case management is appropriate for a Plan Participant, case management is not considered a concurrent care determination. Please refer to the Medical Management Services section of this Plan.*

A **post-service claim** is a claim for medical care, treatment, or services that a Claimant has already received.

INITIAL BENEFIT DETERMINATION

All questions regarding claims should be directed to the Claims Administrator. All claims will be considered for payment according to the Plan's terms and conditions, limitations and Exclusions, and industry standard guidelines in effect at the time charges were Incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims involving specialized medical knowledge or judgment.

A claim will not be deemed submitted until it is received by the Claims Administrator.

The initial benefit determination will be made as follows:

Pre-Service Claims for Urgent Care. If the pre-service claim is determined by the Claims Administrator to be a claim involving urgent care, notice of the Plan's decision will be provided to the Plan Participant as soon as possible but no later than 72 hours after receipt of the pre-service claim by the Claims Administrator.

The exception is if the Plan Participant does not provide sufficient information to decide the pre-service claim. In that case, notice requesting specific additional information will be provided to the Plan Participant within 24 hours of receipt of the pre-service claim.

The Plan's decision regarding the pre-service claim will be made as soon as possible but no later than 48 hours after the earlier of:

- The Plan's receipt of the requested information or
- The expiration of the time period set by the Plan for the requested information (at least 48 hours).

Pre-Service Claims for non-Urgent Care. If the pre-service claim is not an urgent care claim, written notice of the Plan's decision will generally be provided to the Plan Participant within a reasonable period of time, but no later than 15 days after receipt of the pre-service claim by the Claims Administrator.

If matters beyond the control of the Claims Administrator so require, one 15-day extension of time for processing the pre-service claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to the Plan Participant before the end of the initial 15-day period. If an extension is required because the Plan Participant did not provide the information necessary to make a determination on the claim, the notice of extension will specifically describe the required information.

The time-period for processing the pre-service claim will be deferred beginning on the date this extension notice is sent to the Plan Participant and ending on the earlier of:

- The date the Plan receives a response to the request for additional information, or
- The date set by the Plan for a response (which will be at least 45 days).

Concurrent Care Determination. The initial benefit determination on a concurrent care determination will be made within 15 days of the Claim Administrator's notice of a concurrent care claim. If additional information is necessary to process the concurrent care claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant or the healthcare Provider must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a concurrent care claim is suspended until the earlier of:

- The date the Plan receives the Claimant's or healthcare Provider's response for additional information, or
- The date set by the Plan for the Claimant or healthcare Provider to respond (which will be at least 45 days).

A benefit determination on the concurrent care claim will be made within 15 days of the Plan's receipt of the additional information.

Post-Service Claim. The initial benefit determination on a post-service claim will be made within 30 days of the Claim Administrator's receipt of the claim. If additional information is necessary to process the claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a post-service claim is suspended until the earlier of:

- The date the Plan receives the Claimant's additional information; or
- The date set by the Plan for the Claimant to respond (which will be at least 45 days).

A benefit determination on the claim will be made within 15 days of the Plan's receipt of the additional information.

NOTICE OF DETERMINATION

1. The Plan shall provide written or electronic notice of the determination on a claim in a manner meant to be understood by the Claimant. If a claim is denied in whole or in part, notice will include the following:
2. Specific reason(s) for the denial.
3. Reference to the specific Plan provisions on which the denial was based.

4. Description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
5. Description of the Plan's claims review procedures and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following a notice of the determination on final review.
6. 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.

If applicable:

1. Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the notice of the determination and that a copy will be provided free of charge to the Claimant upon request).
2. If the notice of the determination is based on the Medical Necessity or Experimental and/or Investigational Exclusion or similar such Exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the claim, or a statement that such explanation will be provided free of charge, upon request.
3. Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the notice of determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Plan Participant’s failure to timely pay required premiums.

CLAIMS REVIEW PROCEDURE - GENERAL

A Claimant may appeal an Adverse Benefit Determination as follows:

- The Plan offers a one-level internal review process for pre-service claims for urgent care; or
- The Plan offers a two-level internal review procedure for a pre-service claim (non-urgent care), concurrent care claim, and post service claim.

The Plan Administrator will provide for a review that does not give deference to the previous benefit determination and that is conducted by either an appropriate plan fiduciary or the Claims Administrator on the Plan’s behalf who was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final notice of the determination so that the Claimant has a reasonable amount of time to respond.
- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant’s benefit determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is “independent” to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the initial benefit determination.

Note: Providers who have submitted claims to the Plan that are subject to the NSA, cannot avail themselves to the internal and external claims procedure set forth herein. All disputes regarding all payments for claims subject to NSA must be resolved through open negotiating or through a Certified Independent Dispute Resolution (IDR) Entity as outlined in the NSA.

INTERNAL APPEAL PROCEDURE

First Level of Internal Review. To appeal a denial of a claim, the Claimant must submit in writing, a request for a review of the claim. The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the denial. The Claimant may include any additional supporting information, even if not initially submitted with the claim.

The written request for review must be submitted within 180 days of the Claimant's receipt of an Adverse Benefit Determination.

The written request for review should be addressed to:

Claims Administrator
HealthComp Administrators, Inc.
Attn: Appeals
P.O. Box 45018
Fresno, CA 93718-5018

An appeal will not be deemed submitted until it is received by the Claims Administrator. Failure to appeal the initial denial within the prescribed time period will render that determination final. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the initial benefit determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic notice of determination to the Claimant within:

- 72 hours of the receipt of the appeal for an urgent care claim;
- 15 days of the receipt of the appeal for a pre-service claim or a concurrent care claim; or
- 30 days of the receipt of the appeal for a post service claim.

Second Level of Internal Review

If the Claimant does not agree with the Claims Administrator's determination from the first level of internal review, the Claimant may submit a second level appeal in writing. The Claimant may request a second level appeal on pre-service claims (non-urgent care) and post-service only along with any additional supporting information.

The written request for review of the first level of internal review must be submitted within 60 days of the Claimant's receipt of the first level of internal review.

The written request for review should be addressed to:

Claims Administrator
HealthComp Administrators, Inc.
Attn: Appeals
P.O. Box 45018
Fresno, CA 93718-5018

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. Failure to appeal the determination from the first level of review within the prescribed time period will render that determination final. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The second level of internal review will be done by the Plan Administrator, or its designee. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Final Internal Adverse Benefit Determination for the second level of review to the Claimant within:

- 15 days of the Plan's receipt of Claimant's second level appeal on a pre-service claim (non-urgent care);
- 15 days of the Plan's receipt of Claimant's second level appeal on a concurrent care determination; or
- 30 days of the Plan's receipt of Claimant's second level appeal on a post-service claim.

If the Claimant is not satisfied with the outcome of the final determination on the second level of internal review, the Claimant may be eligible for an external review. The Claimant must exhaust both levels of the internal review procedure before requesting an external review. In certain circumstances, the Claimant may also request an expedited external review.

EXTERNAL REVIEW PROCEDURE

This Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within 4 months from the date of receipt of the notice of the Final Internal Adverse Benefit Determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a Final Internal Adverse Benefit Determination of a claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or services is not Medically Necessary;
- Determination that a treatment is Experimental and/or Investigational;
- Rescission of coverage, whether or not the rescission involved a claim; or
- Determination on whether the Plan is complying with the No Surprises Act, as applicable.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an external review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within 6 business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four-month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for external review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law.

Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the notice of determination on the final level of internal or external review, whichever is applicable.

Generally, a Claimant must exhaust the Plan's Claims Procedures in order to be eligible for the external review process. However, in some cases the Plan provides for an expedited external review if:

1. The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal claims and appeal procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

2. The Claimant receives a final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the Claimant and the Plan.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Plan Participant may designate another individual to be an Authorized Representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Plan Participant, and include all the information required in the Authorized Representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator. The Plan does not recognize the appointment of an Authorized Representative by any other instrument.

Should a Plan Participant designate an Authorized Representative, all future communications from the Plan will be conducted with the Authorized Representative instead of the Plan Participant, unless the Plan Administrator is otherwise notified in writing by the Plan Participant. A Plan Participant can revoke the Authorized Representative designation at any time. A Plan Participant may authorize only one person as an Authorized Representative at a time.

Recognition as an Authorized Representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion of a similar form. An assignment of benefits by a Plan Participant shall not be recognized as a designation of the Provider as an Authorized Representative.

CONDITIONS AND LIMITATIONS OF AN ASSIGNMENT OF BENEFITS

The validity of an assignment of benefits by a Plan Participant to a Provider is limited by the terms of this Plan Document. An assignment of benefits is considered valid on the condition that the Provider accepts the payment received from the Plan as consideration, in full, for Covered Expenses. This amount does not include any cost sharing amounts (i.e., Copayments or Coinsurance), or charges for non-Covered Expenses; the Provider may bill the Plan Participant directly for these amounts.

A Provider with a valid assignment of benefits does **not** have the right to exhaust, on behalf of the Plan Participant, the administrative remedies available under this Plan. This right is reserved exclusively for the Plan Participant or his or her Authorized Representative. An assignment of benefits by a Plan Participant to a Provider will not constitute the appointment of an Authorized Representative. The Plan Participant does not, under any circumstances, have the right to assign to any Provider (or their representative) through an assignment of benefits any right to initiate any cause of action against the Plan that the Plan Participant them self may be afforded under applicable law and the terms of the Plan. This includes, but is not limited to, any right to bring suit as such is afforded to Plan Participants under ERISA section 502(a). The assignment of any right to initiate suit against the Plan to a Provider is strictly prohibited.

An assignment of benefits does not grant the Provider any rights other than those specifically set forth herein.

The Plan Administrator may disregard an assignment of benefits at its discretion and continue to treat the Plan Participant as the sole recipient of the benefits available under the terms of the Plan.

By submitting a claim to the Plan and accepting payment by the Plan, the Provider is expressly agreeing to the foregoing conditions and limitations of an assignment of benefits in addition to the terms of the Plan Document. The Provider further agrees that the payments received constitute an "accord and satisfaction" and consideration in full for the Covered Expenses rendered. The Provider agrees that the conditions and limitations of an assignment of benefits as set forth herein shall supersede any previous terms and/or agreements. The Provider agrees to the specific condition that the Plan Participant may not be balance billed for any amount beyond applicable cost sharing amounts (i.e., Copayments or Coinsurance), or charges for non-Covered Expenses; the Provider may bill the Plan Participant directly for these amounts.

If a Provider refuses to accept an assignment of benefits under the conditions and limitations as set forth herein, any benefits payable under the terms of the Plan Document will be payable directly to the Plan Participant and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Expenses.

ARTICLE XIII
COORDINATION OF BENEFITS

DEFINED TERMS

Allowable Expense(s) means the Recognized Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Application to Benefit Determinations provision in this section, this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses.

When some "other plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any other plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Other plan includes, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Plan Participant.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Coordination of the Benefit Plans. Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. When a Plan Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

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

Benefits Subject to This Provision. The following shall apply to the entirety of the Plan and all benefits described therein.

Excess Insurance. If at the time of Injury, Illness, Disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment of law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

1. Any primary payer besides the Plan.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation. When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

EFFECT ON BENEFITS

Application to Benefit Determinations. The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a claim determination period.

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

In certain instances, the benefits of the other plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

1. The other plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.

2. The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the other plan.

Order of Benefit Determination. For the purposes of the provision entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan.

2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such person as a Dependent.

3. If the person for whom claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

4. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody.

5. When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that

Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

6. Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the Child as a Dependent Child.

7. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

8. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information. The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any other plan. Any Plan Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment. A payment made under any other plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery. Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Plan Participant or his or her Dependents.

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

Applicable to Active Employees and Spouses Ages 65 and Over. An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Plan Participants Eligible for Medicare Benefits. To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan. If any Plan Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless

applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XIV
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Plan Participant(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first- and third-party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Participant shall be a trustee over those Plan assets.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Participant(s) fails to so pursue said rights and/or action.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Participant is obligated to notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant's/Plan Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Plan Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Plan Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Plan Participant's/Plan Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, Disease or disability.

Plan Participant is a Trustee Over Plan Assets. Any Plan Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement,

judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Plan Participant understands that he or she is required to:

1. Notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

2. Instruct his or her attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on all settlement drafts.

3. In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its Authorized Representative as a payee on the settlement draft.

4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Plan Participant disputes this obligation to the Plan under this section, the Plan Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Plan Participant, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability. The Plan's right to reimbursement extends to any incident related care that is received by the Plan Participant(s) (Incurred) prior to the liable party being released from liability. The Plan Participant's/Plan Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Plan Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Separation of Funds. Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Reimbursement Due to Surrogacy Arrangement. If a Plan Participant enters into a Surrogacy Arrangement, the Plan Participant must reimburse the Plan for Covered Expenses received related to conception, Pregnancy, delivery, or postpartum care in connection with that Surrogacy Arrangement. The reimbursed amount shall not exceed the payments or other compensation the Plan Participant or another person is entitled to receive under the Surrogacy Arrangement.

A "Surrogacy Arrangement" is one in which a Plan Participant agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the Child (or Children), whether or not the Plan Participant receives payment for being a surrogate.

A Surrogacy Arrangement does not affect a Plan Participant's obligation to pay any and all patient responsibility amounts for these services. These amounts will be taken into account at the time of reimbursement.

After a Plan Participant surrenders a baby to the legal parents, the Plan is not obligated to pay for any services that the baby receives (the legal parents are financially responsible for any services that the baby receives).

As set forth above, as a condition precedent to the Plan Participant receiving benefits under the Plan, the Plan Participant automatically assigns to the Plan any right to receive payments that are payable to the Plan Participant or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy the Plan's lien.

Within 30 days after entering into a Surrogacy Arrangement, the Plan Participant must send written notice of the arrangement to the Plan, including all of the following information:

1. Names, addresses and telephone numbers of all parties to the arrangement;

2. Names, addresses and telephone numbers of any escrow or trustee;

3. Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for the services of baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive;

4. A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and

5. Any other information the Plan requests in order to satisfy its rights.

Information must be sent to:

Plan Administrator
Ajinomoto Foods North America, Inc.
4200 East Concours Drive, Suite 100
Ontario, CA 91764
(909) 477-4700

The Plan Participant must complete and send the Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for the Plan to determine the existence of any rights the Plan may have under this Surrogacy Arrangement and to satisfy those rights. The Plan Participant may not agree to waive, release, or reduce the Plan's rights without the Plan's prior, written consent.

If a Plan Participant's estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the Plan Participant had asserted the claim against the third party. The Plan may assign its rights to enforce its liens and/or other rights.

Wrongful Death. In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

Obligations. It is the Plan Participant's/Plan Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

2. To provide the Plan with pertinent information regarding the Illness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.

3. To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights.

4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

6. To notify the Plan or its Authorized Representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

7. To notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement.

8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

9. To instruct his or her attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on any settlement draft.

10. In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement to include the Plan or its Authorized Representative as a payee on the settlement draft.

11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Participant over settlement funds is resolved.

If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant's/Plan Participants' cooperation or adherence to these terms.

Offset. If timely repayment is not made, or the Plan Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the Plan. This provision applies even if the Plan Participant has disbursed settlement funds.

Minor Status. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation. The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability. In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or the Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE XV
COBRA CONTINUATION COVERAGE

INTRODUCTION

The right to COBRA Continuation Coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your Dependent Children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA.

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child is no longer eligible for coverage under the Plan as a "Dependent Child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's spouse, surviving spouse, and Dependent Children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator
Ajinomoto Foods North America, Inc.
4200 East Concours Drive, Suite 100
Ontario, CA 91764
(909) 477-4700

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

HOW LONG DOES COBRA CONTINUATION COVERAGE LAST?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage can last for up to a total of 36 months.

MEDICARE EXTENSION OF COBRA CONTINUATION COVERAGE

If you (as the covered Employee) become entitled to Medicare benefits, your spouse and Dependents may be entitled to an extension of the 18-month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your spouse and Dependent Children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18-month period.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months.

The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Ajinomoto Foods North America, Inc.
4200 East Concours Drive, Suite 100
Ontario, CA 91764
(909) 477-4700

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child. This extension is only available if the second Qualifying Event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Ajinomoto Foods North America, Inc.
4200 East Concours Drive, Suite 100
Ontario, CA 91764
(909) 477-4700

DOES COBRA CONTINUATION COVERAGE EVER END EARLIER THAN THE MAXIMUM PERIODS ABOVE?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Plan Participant.

HOW DO I PAY FOR COBRA CONTINUATION COVERAGE?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

ADDITIONAL INFORMATION

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator: Please see General Plan Information for contact information.

Plan Administrator
Ajinomoto Foods North America, Inc.
4200 East Concours Drive, Suite 100
Ontario, CA 91764
(909) 477-4700

COBRA Administrator:
Discovery Benefits
P.O. Box 869
Fargo, ND 58107-0869
(866) 451-3399

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

CURRENT ADDRESSES

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

ARTICLE XVI
RESPONSIBILITIES FOR PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible. The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator, in its discretion, that the Plan Participant is entitled to them.

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

DUTIES OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;

2. To determine all questions of eligibility, status and coverage under the Plan;

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

4. To make factual findings;

5. To decide disputes which may arise relative to a Plan Participant's rights;

6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

7. To keep and maintain the Plan Documents and all other records pertaining to the Plan;

8. To appoint and supervise a Claims Administrator to pay claims;

9. To perform all necessary reporting as required by ERISA;

10. To establish and communicate procedures to determine whether a Medical Child Support Order or National Medical Support Notice is a QMCSO;

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

12. To perform each and every function necessary for or related to the Plan's administration.

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

Fiduciary. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

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

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

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

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

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

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

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

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

ARTICLE XVII
FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived from contributions made to the Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan by the covered Employees and Employer contributions.

For Dependent Coverage: Funding is derived from contributions made by the covered Employees.

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

AMENDING AND TERMINATING THE PLAN

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

The Plan Sponsor or Plan Administrator reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

DISTRIBUTION OF ASSETS

Subject to the requirements of ERISA §402, in the event of a termination or partial termination of the Plan or Trust (if applicable), Ajinomoto Foods North America, Inc. shall direct the disposition of Plan assets pursuant to applicable law and governing documents, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by an Employer.

ARTICLE XVIII
HIPAA PRIVACY AND SECURITY

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

DISCLOSURE OF SUMMARY HEALTH INFORMATION TO THE PLAN SPONSOR

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

Summary Health Information may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

Protected Health Information (PHI) means individually identifiable health information, created or received by a health care Provider, health plan, Employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or

employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

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

10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)) is established as follows:

    a. Only certain Employees, or classes of Employees, or other persons under control of the Privacy Officer, and other individuals trained and authorized by the Privacy Officer shall be given access to the PHI to be disclosed.

    b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

    c. In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non- compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

    "Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

CONTACT INFORMATION

Privacy Officer Contact Information:
Privacy Officer
Ajinomoto Foods North America, Inc.
4200 East Concours Drive, Suite 100
Ontario, CA 91764
(909) 477-4700

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "SECURITY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

4. Report to the Plan any security incident of which it becomes aware.

ARTICLE XIX
CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

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

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

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

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

- Review this summary plan description and the documents governing the Plan or the rules governing COBRA Continuation Coverage rights.

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

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

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, he or she may file suit in federal court.

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

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

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

ARTICLE XX
GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Claims Administrator. The funding for the benefits is derived from contributions by Ajinomoto Foods North America, Inc. and contributions made by the covered Employees. The Plan is not insured.

PLAN NAME: Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan

PLAN NUMBER: 503

TAX ID NUMBER: 46-1701609

PLAN EFFECTIVE DATE: January 1, 2023

PLAN YEAR: January 1st through December 31st

APPLICABLE LAW: Employee Retirement Income Security Act of 1974, as amended (ERISA).

PLAN SPONSOR

Ajinomoto Foods North America, Inc.
4200 East Concours Drive, Suite 100
Ontario, CA 91764
(909) 477-4700

PLAN ADMINISTRATOR

Ajinomoto Foods North America, Inc.
4200 East Concours Drive, Suite 100
Ontario, CA 91764
(909) 477-4700

NAMED FIDUCIARY

Ajinomoto Foods North America, Inc.
4200 East Concours Drive, Suite 100
Ontario, CA 91764
(909) 477-4700

CLAIMS ADMINISTRATOR

HealthComp Administrators, Inc.
P.O. Box 45018
Fresno, CA 93718-5018
(877) 706-6268

GROUP HEALTH PLAN AMENDMENT #1

TO THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

AJINOMOTO FOODS NORTH AMERICA, INC.

This amendment is attached to and made a part of the Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan. Amendment #1 reflects the following changes:

EFFECTIVE JANUARY 1, 2023

(1) The definition of Emergency Services is replaced as shown below with the underlined language and the strikethrough.

(2) The Plan Exclusions for Self-Inflicted is replaced as shown below with the underlined language and the strikethrough.

(3) The Plan Exclusions for Infertility is stricken. Injectable infertility medication is covered and applies to the $20,000 lifetime maximum for infertility drugs.

ARTICLE IX
DEFINED TERMS

~~**Emergency Services** means a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the Diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.~~

Emergency Services means, with respect to an Emergency Medical Condition, the following:

(1) An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(2) Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

ARTICLE X
MEDICAL PLAN EXCLUSIONS

~~**(52) Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.~~

(52) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence, or a physical and/or mental health condition, or services required to be covered under the No Surprises Act.

ARTICLE XI
PRESCRIPTION DRUG BENEFITS

EXCLUSIONS

~~**9. Infertility.** A charge for injectable infertility medication.~~

EFFECTIVE MAY 12, 2023

(1) Cost Sharing will apply to all services related to COVID-19 screenings and or testing. The language following the Article III Medical Benefits Schedules of the Copay Plan and the High Deductible Health Plan is stricken. These services are allowed the same as any other illness based on place of service.

MEDICAL BENEFITS SCHEDULE

- ~~Cost sharing (deductibles, copayments and coinsurance) will be waived for medically necessary screening and testing for FDA-approved COVID-19 including hospital, emergency department, urgent care, and provider office visits, including telehealth where the purpose of the visit is to be screened and/or tested for COVID-19 for Network and Non-Network providers. The screening services are included without cost share even if the visit does not result in an order or administration of the COVID-19 test.~~

It is agreed that these changes shall be an amendment to the Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan, and shall become a part of the Plan, but shall not otherwise vary, alter or extend the terms of the Plan.

GROUP HEALTH PLAN AMENDMENT #2

TO THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

AJINOMOTO FOODS NORTH AMERICA, INC.

This amendment is attached to and made a part of the Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan. Amendment #2 reflects the following changes:

EFFECTIVE JANUARY 1, 2023

(4) Amend all Articles throughout the document to remove all reference of the Eligibility Waiting Period. The Plan shall no longer apply an Eligibility Waiting Period.

(5) Amend Article III, High Deductible Health Plan, Medical Benefits Schedule, to clarify LiveHealth Online is not subject to the deductible as shown below with strikethrough and underline.

(6) Amend Eligibility Requirements for Employee Coverage and Effective Date sections within Article V, to change the effective date of coverage from the first day of the calendar month following completion of all eligibility requirements to on the date the Employee is hired as show below with strikethrough and underline.

(7) Amend the Termination of Coverage section within Article V to replace the language in its entirety as shown below.

ARTICLE III
MEDICAL BENEFITS SCHEDULES

HIGH DEDUCTIBLE HEALTH PLAN

Live Health Online *Medical and behavioral health visits.*	No cost to Plan Participant, ~~after Deductible is met.~~ Deductible is waived.	N/A

ARTICLE V
ELIGIBILITY, FUNDING, AND ENROLLMENT PROVISIONS

ELIGIBILITY

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

4. Is a full-time, Active Employee of the Employer. An Employee is considered to be full-time if he or she normally works at least 30 hours per week or 130 hours per month and is on the regular payroll of the Employer for that work (i.e., non-variable hour Employee); or is a variable hour Employee who has averaged at least 30 hours per week for a complete measurement period and is currently in a stability period as determined by the Plan Administrator.

For Employees of a Large Employer:

An Applicable Large Employer is an Employer with 50 full-time equivalents or more (combination of full-time and part-time Employees) in the prior Calendar Year.

An Applicable Large Employer may use a look-back measurement method or a monthly measurement method to determine the full-time status. For more information on the measurement method elected by the Employer, contact the Employer's Human Resources staff;

~~5.~~ Is in a class eligible for coverage.

Coverage will begin on the date the Employee is hired ~~the first day of the calendar month~~ following with the completion of all eligibility requirements and enrollment requirements as stated under this Plan.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of ~~the first day of the calendar month following with~~ the date of hire when the Employee satisfies the following:

4. The Eligibility Requirement;
5. The Active Employee Requirement; and
6. The Enrollment Requirements of the Plan.

TERMINATION OF COVERAGE

Rehiring a Terminated Employee. A terminated Employee who is rehired will be reinstated as of the rehire date.

EFFECTIVE JANUARY 1, 2024

(1) Amend Article III, Medical Benefits Schedule, Copay Plan, changing chiropractic x-rays as shown below with strikethrough and underline.

(2) Amend Article III, Medical Benefits Schedule, Copay Plan, changing diagnostic testing – Physician's office as shown below with strikethrough and underline.

(3) Amend Article III, Medical Benefits Schedule, Copay Plan, adding Habilitative Therapy as shown below with underline.

(4) Amend Article III, Medical Benefits Schedule, Copay Plan, adding Rehabilitative Therapy to Occupational, Physical and Speech Therapy as shown below with underline.

(5) Amend Article III, Medical Benefits Schedules, Copay and High Deductible Plan, removing the age limit requirement under Preventive Care as shown below with strikethrough.

(6) Amend Article III, Medical Benefits Schedules, Copay and High Deductible Plan, adding a limit for Mammograms to Preventive Care as shown below with underline.

(7) Amend Article III, Medical Benefits Schedule, Copay Plan, Applied Behavioral Therapy as shown below with strikethrough and underline.

(8) Amend Article III, Medical Benefits Schedule, Copay Plan, Psychological Testing as shown below with strikethrough and underline.

(9) Amend Article III, Medical Benefits Schedule, High Deductible Health Plan, changing the Deductible amounts as shown below with strikethrough and underline.

(10) Amend Article III, Medical Benefits Schedule, High Deductible Health Plan, adding Rehabilitative/Habilitative to Occupational, Physical and Speech Therapies as shown below with underline.

(11) Amend Article IV, Prescription Drug Benefits Schedule, High Deductible Health Plan for Specialty Drugs as shown below with strikethrough and underline.

(12) Amend Article VII, Medical Benefits, Covered Expenses, Ambulance language as shown below with strikethrough.

(13) Amend Article VII, Medical Benefits, Covered Expenses adding Habilitation Services as shown below.

(14) Amend Article VII, Medical Benefits, Covered Expenses, Mental or Nervous Disorder adding language shown below with underline.

(15) Amend Article X, Medical Plan Exclusions, deleting Habilitation Services as shown below with strikethrough.

ARTICLE III
MEDICAL BENEFITS SCHEDULES

COPAY PLAN

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Chiropractic Care		
Physician Visit	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
X-Rays	~~No cost to Plan Participant. Deductible waived.~~ 20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Limited to 20 visit per Calendar Year. X-rays are not included in the visit limitations.		
Diagnostic Testing		
Physician's Office	~~No cost to Plan Participant. Deductible waived.~~ 20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Habilitative Therapy	No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met.
Occupational Therapy / Rehabilitative		
Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with physical, speech, cognitive and pulmonary therapy.		

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Physical Therapy / Rehabilitative		
Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with occupational, speech, cognitive and pulmonary therapy.		
Physician Services		
Office Lab, X-Ray ~~and Surgery~~	~~No cost to Plan Participant. Deductible waived.~~ 20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
In-Office Surgery	No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met
Routine Well Care services will be subject to ~~age and~~ developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) or as otherwise required by law, *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website: www.HealthCare.gov/center/regulations/prevention.html **Routine Well Care services will include, but will not be limited to, the following routine services:** Office visits, routine physical exams, prostate screening, sterilization procedures patient education and counseling for men, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well childcare examinations. **Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. Additional information can be located using the following website: https://www.healthcare.gov/preventive-care-women		
Mammogram (1 per Calendar Year)	No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met.
Speech Therapy / Rehabilitative		
Outpatient Hospital	20% Coinsurance after Deductible is met.	40% Coinsurance after Deductible is met.
Physician Office	$50 Copay/visit, Deductible waived.	40% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with occupational, physical, cognitive and pulmonary therapy.		
Treatment of Mental or Nervous Disorders or Substance Abuse		
Applied Behavioral Therapy	~~$25 Copay/visit, Deductible waived.~~ No cost to Plan Participant. Deductible waived.	~~$~~25 Copay/visit, Deductible waived.
Psychological Testing	~~$25 Copay/visit, Deductible waived.~~ No cost to Plan Participant. Deductible waived.	40% Coinsurance after Deductible is met

HIGH DEDUCTIBLE HEALTH PLAN

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Claims must be received by the Claims Administrator within ***365 days*** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second opinion.		
LIFETIME MAXIMUM BENEFIT	**UNLIMITED**	
CALENDAR YEAR BENEFIT AMOUNT	**UNLIMITED**	
DEDUCTIBLE, PER CALENDAR YEAR		
Self-Only	~~$3,000~~ $3,200	~~$3,000~~ $3,200
Family Coverage Individual Family Unit	 ~~$3,000~~ $3,200 ~~$6,000~~ $6,400	 ~~$3,000~~ $3,200 ~~$6,000~~ $6,400
The family Deductible maximum includes Covered Expenses which are used to satisfy the Deductible for all family members combined. No one person must satisfy more than the individual Deductible amount. The network Deductible does not accumulate towards the non-network Deductible, but the non-network Deductible does accumulate to the network Deductible.		

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Occupational Therapy / Rehabilitative / Habilitative		
Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with physical, speech, cognitive and pulmonary therapy.		
Physical Therapy / **Rehabilitative / Habilitative**		
Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with occupational, speech, cognitive and pulmonary therapy. Limits do not apply to Autism Spectrum Disorder.		

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Routine Well Care services will be subject to ~~age and~~ developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) or as otherwise required by law, *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website: www.HealthCare.gov/center/regulations/prevention.html **Routine Well Care services will include, but will not be limited to, the following routine services:** Office visits, routine physical exams, prostate screening, sterilization procedures patient education and counseling for men, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well childcare examinations. **Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. Additional information can be located using the following website: https://www.healthcare.gov/preventive-care-women		
Mammogram (1 per Calendar Year)	No cost to Plan Participant. Deductible waived.	30% Coinsurance after Deductible is met.
Speech Therapy / Rehabilitative / Habilitative		
Outpatient Hospital	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Physician Office	No cost to Plan Participant, after Deductible is met.	30% Coinsurance after Deductible is met.
Limited to 60 visits per Calendar Year combined with occupational, physical, cognitive and pulmonary therapy.		

ARTICLE IV
PRESCRIPTION DRUG BENEFITS SCHEDULES

HIGH DEDUCTIBLE HEALTH PLAN
Not all Prescription Drugs are covered.

PRESCRIPTION DRUG BENEFIT	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
Pharmacy Option – 30 Day Supply		
Generic Drugs	$20 Copay/prescription, after Deductible is met.	Not covered.
Formulary Brand Drugs (Preferred)	$40 Copay/prescription, after Deductible is met.	Not covered.
Non-Formulary Brand Drugs (Non-Preferred)	$60 Copay/prescription, after Deductible is met.	Not covered.
Specialty Drugs	30% Coinsurance/prescription, after Deductible is met. Up to a maximum of $100.	Not covered.

ARTICLE VII
MEDICAL BENEFITS

COVERED EXPENSES

~~**86.**~~ **Ambulance.** Benefits will be provided for licensed ground, air, and water ambulance services used to transport a Plan Participant from the place where they are injured or stricken by Illness, or for inter-facility transport, as deemed Medically Necessary, to the nearest accredited Hospital with adequate facilities for treatment. Charges for services requested for a licensed ground, air, or water ambulance service when the patient is not transported will be covered by the Plan. ~~Pre-Certification is required for non-emergency ambulance.~~

28. Habilitative Services. Charges for habilitative services for all medical and mental health disorders.

50. Mental or Nervous Disorders and Substance Abuse Treatment. Inpatient and Outpatient treatment for Mental or Nervous Disorders will be eligible when rendered by a licensed psychiatrist or licensed psychologist or when rendered by a Physician as defined, provided the counselor is employed by and working under the direct supervision of a psychiatrist or clinical psychologist. Diagnosis and treatment of behavioral problems and learning disabilities associated with attention deficit disorders (ADD and ADHD). Includes residential treatment and Habilitative Therapy.

Partial hospitalization services are rendered no less than four (4) hours and not more than twelve (12) hours in any twenty-four (24) hour period by a certified/licensed mental health program in accordance with the laws of the appropriate legally authorized agency.

An intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program in accordance with the laws of the appropriate, legally authorized agency. Intensive outpatient therapy programs provide a combination of individual, family, and/or group therapy in a day, totaling nine (9) or more hours in a week.
Methadone clinics are not covered. Methadone treatment is only covered as part of detoxification.

Pre-certification is required for Inpatient admissions, residential treatment, partial hospitalization, and intensive outpatient therapy.

Ambulatory or Outpatient detoxification which includes outpatient services that monitor withdrawals from alcohol or other substances, including administration of medications.

ARTICLE X
MEDICAL PLAN EXCLUSIONS

~~**63. Habilitation Services.** Charges for habilitative services for all medical and mental health disorders.~~

It is agreed that these changes shall be an amendment to the Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan, and shall become a part of the Plan, but shall not otherwise vary, alter or extend the terms of the Plan.

GROUP HEALTH PLAN AMENDMENT #3

TO THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

AJINOMOTO FOODS NORTH AMERICA, INC.

This amendment is attached to and made a part of the Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan. Amendment #3 reflects the following changes:

EFFECTIVE January 1, 2023

- Amend Article X, Medical Plan Exclusions, item 54, Sexual Dysfunction to allow charges for sexual dysfunction when due to organic disease.

ARTICLE X
MEDICAL PLAN EXCLUSIONS

54. Sexual Dysfunction. Care, treatment, services, supplies or medication in connection with treatment for impotence, except when due to an organic disease.

EFFECTIVE January 1, 2025

- Amend Article III, Medical Benefits Schedules, High Deductible Health Plan to change the Network and Non-Network deductible for Self-Only and Family Coverage, Individual from $3,200 to 3,300 and Family from $6,400 to $6,600 as shown below.

- Amend Medical Benefits Schedules, High Deductible Health Plans to remove deductible waived from LHO as shown below.

ARTICLE III
MEDICAL BENEFITS SCHEDULES

HIGH DEDUCTIBLE HEALTH PLAN

	NETWORK PROVIDER	NON-NETWORK PROVIDER
DEDUCTIBLE, PER CALENDAR YEAR		
Self-Only	$3,300	$3,300
Family Coverage		
Individual	$3,300	$3,300
Family Unit	$6,600	$6,600
The family Deductible maximum includes Covered Expenses which are used to satisfy the Deductible for all family members combined. No one person must satisfy more than the individual Deductible amount. The network Deductible does not accumulate towards the non-network Deductible, but the non-network Deductible does accumulate to the network Deductible.		

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Live Health Online *Medical and behavioral health visits.*	No cost to Plan Participant, after Deductible is met.	N/A

It is agreed that these changes shall be an amendment to the Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan, and shall become a part of the Plan, but shall not otherwise vary, alter or extend the terms of the Plan.

GROUP HEALTH PLAN AMENDMENT #4

TO THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

AJINOMOTO FOODS NORTH AMERICA, INC.

This amendment is attached to and made a part of the Ajinomoto Foods North America, Inc. Health and Welfare Benefit Plan. Amendment #4 is effective **JANUARY 1, 2026**, and reflects the following changes:

(1) Amend Article III, Medical Benefits Schedules, Copay Plan, Network and Non-Network Urgent Care copay to $40 as shown below.

(2) Amend Article III and IV Medical Benefits Schedules, Prescription Drug Benefits Schedules, High Deductible Health Plan, Network and Non-Network deductibles to change the accumulation method from embedded to non-embedded and the amounts as shown below.

(3) Amend Article III, Medical Benefits Schedules, High Deductible Health Plan Prescription Drug Benefits Schedules Maximum Out-of-Pocket, to change the accumulation method from embedded to non-embedded and the amounts as shown below.

(4) Amend Article III, Medical Benefits Schedules High Deductible Health Plan LiveHealth Online Deductible is waived as shown below.

ARTICLE III
MEDICAL BENEFITS SCHEDULES

COPAY PLAN

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Urgent Care *Includes all services except advanced imaging.*	$40 Copay/visit, Deductible waived.	$40 Copay/visit, Deductible waived.

HIGH DEDUCTIBLE HEALTH PLAN

	NETWORK PROVIDER	NON-NETWORK PROVIDER
DEDUCTIBLE, PER CALENDAR YEAR		
Self-Only	$2,750	$5,500
Family Coverage	$5,550	$11,100
No benefits will be paid for any member of a Family Unit until the Family Unit Deductible has been met regardless of the number of participants it takes to meet the family Deductible. The network Deductible does not accumulate towards the non-network Deductible, but the non-network Deductible does accumulate to the network Deductible.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Self-Only	$4,500	$9,000
Family Coverage	$8,000	$16,000

The family maximum out-of-pocket amount includes Covered Expenses which are used to satisfy the maximum out of pocket amount for all family members combined. The Plan will pay the designated percentage of Covered Charges until Out-of-Pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The network maximum out-of-pocket amount does not accumulate towards the non-network maximum out-of-pocket amount, but the non-network maximum out-of-pocket amount accumulates towards the network maximum out-of-pocket amount. The maximum out-of-pocket amount includes Coinsurance and Copayments applied toward covered medical and prescription benefits as shown above. The following expenses may not count toward the maximum out-of-pocket amount and will not be paid at 100%, even when the maximum out-of-pocket amount has been met: • Non-compliance penalties; • Charges for non-covered services; • Balance-billing charges; and • Amounts in excess of the Recognized Charge.		
LiveHealth Online *Medical and behavioral health visits.*	$25/visit Deductible waived.	N/A

ARTICLE IV
PRESCRIPTION DRUG BENEFITS SCHEDULES

HIGH DEDUCTIBLE HEALTH PLAN

Not all Prescription Drugs are covered.

PRESCRIPTION DRUG BENEFIT	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
DEDUCTIBLE, PER CALENDAR YEAR		
Self-only	$2,750	Not applicable
Family Coverage	$5,500	Not applicable
No benefits will be paid for any member of a Family Unit until the Family Unit Deductible has been met regardless of the number of participants it takes to meet the family Deductible.		