Master Medical Plan Document and Summary Plan Description (SPD) For ALLIANCE HEALTHCARE, INC

ALLIANCE HEALTH CARE

Amended & Restated August 1st, 2026

For assistance in a non-English language, please call 844-660-2451.
Para obtener asistencia en Español, por favor llame al número arriba

Table of Contents

Introduction 3
General Information 4
Schedule of Benefits 7
Eligibility 9
Termination 12
Covered Services 13
Defined Terms 14
Prescription Drug Coverage 23
How to Submit a Claim 25
Appeals 28
Coordination of Benefits 33
Subrogation 33
Responsibilities of Plan Administrator 42
Plan Participants Rights under ERISA 43
Important Notices 45
General Plan Information & Establishment of the Plan 48

Introduction

INTRODUCTION
Welcome to the ALLIANCE HEALTHCARE, INC MEC Medical Plan.

This Master Plan Document and Summary Plan Description ("Plan Document" or "SPD") explains the operation of Your health plan and describes the terms for payment of covered medical and prescription charges.

You should read this document in its entirety. Many of its provisions are interrelated, and reading any one provision on its own may give You incomplete information about Your rights, responsibilities, and coverage under the Plan. Please call 844-660-2451 if You have any questions.

PLAN SPONSOR/PLAN ADMINISTRATOR
ALLIANCE HEALTHCARE, INC is the Plan Sponsor and the Plan Administrator. The Plan Sponsor has established the Plan for the benefit of its Employees to help offset the financial impact of an Injury or Sickness. Contact information for the Plan Sponsor is available in the "General Plan Information" section, below.

APPLICABLE LAW
This Plan is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). To the extent not preempted by federal law, the Plan shall be governed by the laws of the state where the Plan Sponsor maintains its principal place of business.

TYPE OF ADMINISTRATION
The Plan is a self-funded group health plan, which is funded by the general assets of the Plan Sponsor. HealthEZ has been appointed by the Plan Administrator to serve as the third-party claims administrator for the Plan.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR
The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD. The Plan Administrator also has full discretionary authority to determine all questions relating to eligibility to participate in the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals, committees, or third-parties, but will retain sole authority and responsibility to review and make final decisions on all Claims for benefits, along with any other decisions made by its third-party delegates.

NAMED FIDUCIARY
The Plan Administrator is the named fiduciary of the Plan.

LEGAL ENTITY; SERVICE OF PROCESS
The Plan is a legal entity separate from the Plan Administrator. Legal process may be served on the Plan Administrator at the address provided in the "General Plan Information" section below. You must exhaust Your appeal rights (other than external review) before bringing legal action.

PLAN CONTRIBUTIONS AND FUNDING
The Plan is self-funded by the general assets of the Plan Sponsor, which may include contributions from employees. The Plan Sponsor determines the level of Employee contributions, if any, and the method of payment. Plan Participants do not have any legal rights to rebates, if any, received by the Plan Sponsor, and, such rebates, if any, are not considered in calculating any Deductible, Copay, or Coinsurance under the plan. Contact the Plan Sponsor with any questions.

General Information

This section explains some of the general rules related to the administration of Your Plan.

Call 844-839-6747 to verify eligibility for benefits before the charge is incurred.

COSTS

You must pay for certain portions of the cost of Covered Services under the Plan, which may include any Deductible, Copay, or Coinsurance, up to the Out-of-Pocket Maximum set by the Plan. Review the Schedule of Benefits for details about these costs.

Reimbursement from the Plan may be reduced or denied due to the provisions in the Plan, such as coordination of benefits, subrogation, or Medical Necessity.

The Plan may have different Deductibles, Copays, Coinsurance, and Out-of-Pocket Maximum levels for In Network and Out-of-Network services. Review the Schedule of Benefits for details.

MAXIMUM ALLOWABLE CHARGE LIMITATION

The Plan has a fiduciary obligation to Plan Participants to preserve Plan assets against charges that exceed the Maximum Allowable Charge, which is the maximum benefit payable for a Covered Services under the Plan. The Plan only pays benefits based on the Maximum Allowable Charge rather than billed charges. If a Provider charges more than the Maximum Allowable Charge (as determined by the Plan), the Plan Participant may be responsible for the amount in excess of the Maximum Allowable Charge, unless prohibited by applicable law. Any excess amount charged to the Plan Participant is not counted toward satisfaction of the Deductible, and it is not paid by the Plan even after satisfaction of the Deductible or reaching the Out-of-Pocket Maximum for a Plan Year.

The Maximum Allowable Charge will not include charges for Unbundling, as defined by this Plan Document, which includes any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

For Claims subject to the No Surprises Act, if the Plan and an Out-of-Network Provider disagree over the payment amount for certain charges and cannot resolve the matter using an open negotiation process, they may invoke the federal independent dispute resolution process. Under the independent dispute resolution process, a Certified IDR Entity makes a binding determination that establishes the payment amount.

BALANCE BILLING

In the event that a Claim submitted by a Network Provider or Out-of-Network Provider is repriced because of billing errors, overcharges, and/or because it exceeds the Maximum Allowable Charge, it is the Plan's position that the Plan Participant should have no responsibility for payment of these changes and that a Provider should not balance bill a Plan Participant for this difference. It is the Plan's position that these Excess Charges are clearly excessive and exorbitant.

In addition, with respect to any services rendered by a Network Provider paid by the Plan at the negotiated rate, it is the Plan's position that the Plan Participant should have no responsibility for the difference between the amount billed by the Network Provider and the applicable negotiated rate determined to be payable by the Plan Administrator and that a Provider should not balance bill a Plan Participant for this difference.

Notwithstanding the foregoing, the Plan Participant acknowledges that the Plan has no control over any Provider action, including balance billing.

PROVIDER NETWORK

This Plan has entered into an agreement with a Provider Network. Your Provider Network name, phone number and website are displayed on Your ID card.

In-network Providers have agreed to charge reduced fees to Plan Participants. Out-of-Network Providers have not agreed to charge reduced fees to Plan Participants. Choices You make about seeing an In-network Provider or an Out-of-Network Provider can affect what You pay out of pocket under the Plan.

The Plan may pay for Out-of-Network services at the In-Network benefit level if:

- A Plan Participant has no In-Network Providers in the necessary specialty within the PPO service area; or
- A Plan Participant unavoidably receives services from an Out-of-Network Provider at an In-Network facility.

If a Provider is removed from the Provider Network, the Plan will notify Plan Participants who are receiving care from the Provider under a continuing care relationship that the Provider is no longer in the Provider Network and that the Plan Participant has the right to elect to continue receiving transitional care from the Provider under the same terms and conditions that would have applied had the Provider remained in-network for up to a 90-day period from when the notice was furnished to the Plan Participant.

Notwithstanding the Plan's agreements with any Provider or Provider Network, You have a free choice of any Provider (i.e. In-Network or Out-of-Network) and You, together with Your Provider, are 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.

NO SURPRISES ACT

Pursuant to the No Surprises Act, the Plan shall provide for Out-of-Network services at the In-Network benefit level if:

- A Plan Participant receives Emergency Services from an Out-of-Network Provider or emergency facility;
- A Plan Participant receives Non-Emergency Services from an Out-of-Network Provider at an In-Network facility, unless the Provider furnishes notice to the Plan Participant, beneficiary, or authorized representative and receives consent from the individual in compliance with the No Surprises Act; or
- A Plan Participant receives air ambulance services furnished by an Out-of-Network Provider.

Additional information about this option, as well as a list of In-Network Providers, will be made available to a Plan Participant upon request and without charge.

IMPORTANT NOTICE: BENEFITS AVAILABLE FOR PAYMENT OF COVERED SERVICES RENDERED BY PROVIDERS ARE LIMITED BY THE TERMS OF THIS PLAN. IF A PROVIDER SUBMITS CHARGES THAT: (i) EXCEED THE COVERED EXPENSES UNDER THE PLAN; (ii) ARE FOR SERVICES OR SUPPLIES FOR WHICH ARE NOT ELIGIBLE SERVICES; OR (iii) ARE FOR SERVICES OR SUPPLIES THAT ARE EXCLUDED FROM COVERAGE BY THE TERMS AND CONDITIONS OF THIS PLAN, BENEFITS WILL NOT BE PAID. BENEFITS WILL AT ALL TIMES BE PAID IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THIS PLAN, AND THE TERMS OF THIS PLAN DOCUMENT TAKE PRECEDENCE OVER THE TERMS OF ANY CONFLICTING LANGUAGE CONTAINED IN ANY OTHER MEDICAL OR SERVICE PROVIDER CONTRACT.

SUPPLEMENTAL INFORMATION AND RECORDS REQUESTS

The Plan Administrator or its delegate may require additional information to make a benefit determination. The Plan Participant or Provider must send this information in the timeframe requested. Failure to send such requested information may result in denial of payment.

CLAIMS REVIEW AND INDEPENDENT BILL REVIEW

The Plan Administrator or its delegate may use its discretionary authority to utilize an independent bill review and/or Claim audit program or service. Such review may be conducted pre- or post-payment. The Plan Administrator has the sole discretion to determine which Claims will be subject to review and audit, and not every Claim for Covered Services may be reviewed.

Notwithstanding the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge in accordance with the terms of this SPD.

Schedule of Benefits

Minimum Essential Coverage Plan

	In Network	Out of Network
DEDUCTIBLE & OUT-OF-POCKET MAXIMUM		
Individual Coverage	N/A	N/A
Family Coverage	N/A	N/A

Plan Year	Grandfathered Status	Coinsurance/Copay
August 1 – July 31	Non Grandfathered	Indicates Plan Participant responsibility.

PREVENTIVE CARE SERVICES		
Preventive Care – Children to age 18 See Preventive and Wellness Care for Adults and Children in Covered Services for more information.	No Charge	No Coverage
Preventive Care – All Adults See Preventive and Wellness Care for Adults and Children in Covered Services for more information.	No Charge	No Coverage
Routine Prenatal Care See Preventive and Wellness Care for Adults and Children in Covered Services for more information.	No Charge	No Coverage
Routine Immunizations See Preventive and Wellness Care for Adults and Children in Covered Services for more information.	No Charge	No Coverage
Breast Feeding Equipment Limit to one pump per pregnancy with a $350 limit for reimbursement unless otherwise precluded by applicable law.	No Charge	
Any other preventive care services required by the Affordable Care Act.	No Charge	No Coverage

PRESCRIPTION DRUG SERVICES		
	Retail (per 30-day supply)	**Mail Order (per 90-day Supply)**
Preventive	No Charge	
Generic	No Coverage	
Preferred Brand		
Brand Non-Formulary		

Specialty Drugs	

Eligibility

You are eligible to enroll in the Plan if You meet the eligibility requirements set forth below. Eligibility requirements are determined by the Plan Sponsor. If You have any questions regarding eligibility, contact the Plan Sponsor.

Employee	
Waiting Period	The coverage Effective Date for an Employee is the first day of the month following 30 days of employment.
Eligible Dependent	1. An Employee's Spouse; 2. An Employee's Child who is less than 26 years of age, without regard to the child's student or marital status or whether the child is the Employee's financial dependent; 3. An Employee's Child, regardless of age, who became Disabled prior to the end of the month in which the Child attained 26 years of age. For purposes of this section, a Child is considered "disabled" if he or she is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. The Plan reserves the right to require documentation to establish a Dependent relationship, including, but not limited to, written proof of disability from a physician.
Coverage Termination	Coverage under the Plan terminates on the last day of the month once the Employee and/or Dependent is no longer eligible.
Rehired Employees	If an Employee is rehired within 13 weeks of the Employee's termination of employment, then the Employee is eligible for participation in the Plan no later than first day of the month following rehire.
Employee	30 hours per week or 130 hours per month

ENROLLMENT

An Employee must enroll for coverage with the Plan Sponsor within 31 days after the Employee becomes eligible to participate in the Plan. After this period, the enrollment decision cannot be changed or dropped during the Plan Year without a qualifying life event. During Open Enrollment, Employees will be able to elect, change, or discontinue coverage.

SPECIAL ENROLLMENT RIGHTS- QUALIFYING LIFE EVENT

Usually, You may only make coverage changes during Open Enrollment. However, federal law allows a special enrollment period if You experience certain qualifying life events. In these cases, coverage will be effective on the date of the qualifying life event, provided a request for enrollment is made within 31 days of the qualifying life event, unless a longer time is provided in this Plan Document or required by law. An Employee or Eligible Dependent who is already enrolled in the Plan at the time of the qualifying life event may also make changes to their enrollment at this time.

The following are considered qualifying life events under the Plan for purpose of this special enrollment right:

- Loss of other health coverage:
  - Losing eligibility for existing health coverage, including job-based, individual, and student plans.
  - Losing eligibility for Medicaid or CHIP or becoming eligible for a state premium assistance subsidy under Medicaid or CHIP.

    If an Employee has declined enrollment in the Plan for themselves or Dependents because of coverage under Medicaid or CHIP and loses that coverage or becomes eligible for a state premium assistance subsidy under Medicaid or CHIP, there is a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the Medicaid or CHIP coverage ends or after becoming eligible for a state premium subsidy under Medicaid or CHIP.
- Changes in household:
  - Acquisition of a new spouse due to marriage.
  - Acquisition of a new Dependent through marriage, birth, adoption, or placement for adoption.

IMPORTANT NOTICE: IF YOUR OTHER HEALTH PLAN COVERAGE WAS LOST BECAUSE OF A FAILURE TO PAY COVERAGE PREMIUMS OR OTHER REQUIRED CONTRIBUTIONS, YOU DO NOT HAVE SPECIAL ENROLLMENT RIGHTS BASED ON THE LOSS OF THAT COVERAGE.

COVERAGE DURING DISABILITY OR LEAVE OF ABSENCE

A Plan Participant may remain eligible under the Plan for a limited time if disabled or during a leave of absence, such as FMLA leave. You may request further information from your Employer.

EMPLOYEES ON MILITARY LEAVE

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), if an Employee is absent from work because of service in the uniformed services, the Employee can continue health coverage for the Employee and the Employee's covered Dependents. If the Employee or the Employee's covered Dependents choose coverage under USERRA, then the Employee or the Dependents must pay monthly premiums for coverage.

During a military leave that is expected to be 30 days or less, the Employee's current employee coverage will continue without interruption, assuming the Employee pays the normal share of premiums for the coverage.

While on paid military service leave (for up to two years), the Employee may maintain the health benefits for which the Employee was enrolled before military service leave by paying the Employee's normal share of premiums for coverage.

For Employees who continue coverage while in military service, coverage will terminate at the earliest of these dates:

- The 24-month period beginning on the date absence begins; or
- The date the Employee fails to return to work as required.

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, unless on active duty for 30 days or less.

A Waiting Period may not be imposed upon reemployment if one would not have been imposed had coverage not been terminated because of military 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 active military service.

After your paid military service leave ends, the Employee may elect continuation coverage for up to 24 months 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. Dependents do not have any independent right to elect USERRA health plan continuation.

Termination

You and/or Your Eligible Dependents may be terminated from participation in the Plan as set forth below. Termination of coverage is determined by the Plan Sponsor. If You have any questions regarding termination, contact the Plan Sponsor.

TERMINATION OF COVERAGE

Your coverage will automatically terminate on the earliest of these events, unless a COBRA continuation coverage right exists (see the COBRA Continuation Coverage Rights section below for more details):

- The last day of the month in which the You cease to be eligible to participate in the Plan; or
- The date the Plan is terminated or amended such that You lose coverage under the Plan.

RECISSION OF COVERAGE FOR CAUSE AND FRAUD

The Plan Sponsor also has the right to rescind any coverage for cause, including in response to a Plan Participant taking actions that constitute fraud. The following actions by a Plan Participant or a Plan Participant's knowledge of such actions being taken by another, constitute fraud and will result in immediate, indefinite and permanent termination of all coverage under this Plan for the entire Family unit of which the Plan Participant is a member:

- Attempting to submit a Claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Participant in the Plan;
- Attempting to file a Claim for a Plan Participant for services that were not rendered or Drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the Plan;
- Providing any false or misleading information to the Plan; or
- Providing any false or misleading information to the alternate funding programs that it identifies.

In addition to being considered fraud on the Plan and an intentional misrepresentation, enrolling ineligible Dependents or maintaining coverage for a person who no longer satisfies the Dependent eligibility rules violates ALLIANCE HEALTHCARE, INC policy. If ALLIANCE HEALTHCARE, INC determines that an ineligible Dependent has been enrolled, coverage may be canceled retroactively. ALLIANCE HEALTHCARE, INC reserves the right to recover any and all benefit payments made for services received by ineligible Dependents and to terminate the Employee's employment.

RETROACTIVE TERMINATIONS

Except in cases where You and/or Your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage unless You and/or Your covered Dependents (or a person seeking coverage on behalf of You and/or Your covered Dependents) performs an act, practice, or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to You or Your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where the required Employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Covered Services

Covered Services are listed in the Schedule of Benefits.

NOTE: All Covered Services are subject to the Maximum Allowable Charge as determined by HealthEZ.

1. **Contraceptives.** The charges for all FDA approved contraceptive methods are covered in accordance with Health Resources and Services Administration (HRSA) guidelines.

2. **Pregnancy.** Routine Prenatal Care is covered under as Preventative Care. Includes one lactation consultation per pregnancy.

3. **Preventive and Wellness Care for Adults and Children**. For services below, benefits are available at the age and frequency listed.

    - Colonoscopy – 1 every 5 Deductible Years for any individual over the age of 45
    - Cologuard – 1 every Deductible Year for any individual over the age of 45
    - Cervical Cancer Screening – 1 every 3 Deductible Years for women over age 21
    - Lung Cancer Screening – 1 per Deductible year for adults over the age of 50
    - Osteoporosis Screening (Bone Density Scan) – 1 per Deductible Year for women of all ages

    In accordance with Federal Law, benefits are available for evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendat…)

    Immunizations that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

    Routine Prenatal Care includes periodic office visits, lab work, and ultrasounds. Other Prenatal care may include additional tests, office visits, and covered services described elsewhere in the Schedule of Benefits.

4. **Preventive Breast Imaging and Dense Breast Tissue.** The Plan covers breast cancer screening and additional imaging services as preventive care in accordance with clinical guidelines. These services are considered preventive for women over age 40 once per Deductible Year.

    Covered services include:

    - Screening mammography (bilateral, digital or film) once annually.
    - Follow-up diagnostic mammography, breast ultrasound, or breast MRI when performed due to dense breast tissue, inconclusive or abnormal mammogram results, or when clinically indicated for adequate screening.
    - 3D tomosynthesis (digital breast tomosynthesis/DBT) when used as part of a screening or diagnostic mammogram.

5. **Smoking Cessation.** To the extent required by law and when under the treatment of a Physician.

6. **Sterilization.** To the extent required by the Patient Protection and Affordable Care Act (PPACA).

Defined Terms

This Plan Document contains several capitalized terms that have a specific meaning. This section defines those terms. These definitions are not intended to, and specifically do not, identify whether charges associated with a particular service or supply are entitled for payment under the Plan. Please refer to the appropriate sections of this SPD for coverage information.

1. **Adverse Benefit Determination.** Adverse Benefit Determination shall mean any of the following:

    - A denial in benefits;
    - A reduction in benefits;
    - A rescission of coverage, even if the rescission does not impact a current Claim for benefits under the Plan;
    - A termination of benefits;
    - A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan;
    - A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for , a benefit resulting from the application of any utilization review procedure described in this Plan Document;
    - A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental, Investigational, not Medically Necessary or appropriate, or subject to any other exclusion provided in this Plan Document.

2. **Allowable Expenses.** The dollar amount considered payment in full by an insurance plan. The allowable charge is a discounted rate rather than the actual charge.

3. **Approved Clinical Trial**. means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

    The Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

    A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

    "Routine patient costs" include all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's network area unless out of network benefits are otherwise provided under the Plan.

4. **Center of Excellence.** Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the best outcomes in performing transplant procedures and the best survival rates. The Plan Administrator or its delegate shall determine what network Centers of Excellence are to be used.

5. **Certified IDR Entity.** An entity that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury to be responsible for conducting determinations under the No Surprises Act.

6. **Child.** Employee's own blood descendant of the first degree, a stepchild, a child in a legal guardianship relationship with the Employee or the Employee's Spouse, lawfully adopted Child, or a Child placed with a covered Employee in anticipation of legal adoption, and/or a covered Employee's Child who is an alternate recipient under a "Qualified Medical Child Support Order" required by law.

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

8. **Claim**. A request for payment that You or Your health care provider submits to the Plan when You receive items, services, or supplies that You wish to have considered for coverage under the Plan**.**

9. **Claimant.** A Plan Participant, or an entity acting on behalf of a Plan Participant, authorized to submit Claims to the Plan for processing and/or appeal of an Adverse Benefit Determination.

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

11. **Coinsurance.** A fixed percentage of the Covered Services that You are responsible for paying for Covered Services. The amount You pay for Coinsurance is determined after You pay any applicable Copays and after the Deductible is met.

    Coinsurance payments accrue toward the Out-of-Pocket Maximum, but not toward the Deductible.

12. **Copay.** A flat fee that You pay each time You incur certain Covered Services. If the Copay is less than the Covered Expense, the Plan will pay the difference. If the Copay is more than the Covered Expense, You are only responsible for paying the Covered Expense.

    Copayments accrue toward the Out-of-Pocket Maximum, but not toward the Deductible.

13. **Covered Expense**. An Expense payable for a Covered Service. The Plan will pay for all Covered Services that exceed Your Co-pay, Coinsurance, and/or Deductible.

14. **Covered Service(s).** A service, treatment, supply, or other item that is eligible for coverage in this Plan.

15. **Custodial Care.** Services that are rendered for assistance in daily living that can be provided safely and reasonably by individuals who are neither skilled nor licensed medical personnel.

16. **Deductible.** The Deductible is the amount You must pay in a Plan Year for Covered Services before benefits will be paid by the Plan. The Deductible amount for the Plan is shown in the Schedule of Benefits.

17. **Dependent.** A non-Employee who is eligible for coverage under the Eligibility section of the Plan.

18. **Emergency.** A serious, unexpected, or dangerous situation requiring immediate medical attention.

19. **Emergency Medical Condition.** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

20. **Emergency Services.** Emergency Services means, with respect to an Emergency Medical Condition, the following:

    - 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
    - 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).

21. **Employee.** A person who is employed by the Plan Sponsor and eligible for coverage.

22. **Effective Date**. The first day of coverage.

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

24. **Errors.** Charges based on billing mistakes, improprieties, or illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services 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. It is in the Plan Administrator's sole discretion to determine what constitutes an error under the terms of this Plan.

25. **Experimental and/or Investigational.** Services or treatments that are not United States Food and Drug Administration (FDA) approved. Services or treatments which are not widely used or accepted by most practitioners or lack credible evidence, and that are not the subject of, or related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment.

26. **Family.** The covered Employee and the Dependents who are covered under the Plan.

27. **FMLA.** Family and Medical Leave Act of 1993, as amended.

28. **FMLA Leave** is a leave of absence, which the Employer is required to extend to certain Employees under FMLA, during which time group health benefits may be maintained.

29. **Formulary.** A list of covered prescription medications compiled by the Pharmacy Benefit Manager.

30. **Generic Drug**. A Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration.

31. **GINA**. The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

32. **HIPAA**. The Health Insurance Portability and Accountability Act of 1996, as amended.

33. **Home Health Care Agency.** An organization whose main function is to provide Home Health Care Services and Supplies; The agency must be federally certified and licensed by the state in which it is operating.

34. **Home Health Care Plan**. A formal written plan made by the patient's attending Physician; which states the diagnosis and specifies the type and extent of Home Health Care required.

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

36. **Hospice Care Plan**. A plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

37. **Hospice Care Services and Supplies.** Those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, and home care. See the Schedule of Benefits to determine whether this includes family counseling during the bereavement period.

38. **Hospital.** An institution which is engaged primarily in providing medical care is accredited as a Hospital by The Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program or is approved by Medicare as a Hospital. The definition of "Hospital" shall be expanded to include the following: A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

39. **Illness.** A bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

40. **Incurred**. A Covered Expense is “Incurred” on the date the Covered Service is rendered, or the supply is obtained.

41. **Independent Freestanding Emergency Department.** 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.

    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.

42. **Infertility.** Incapable of producing offspring.

43. **Injury.** A physical Injury to the body caused by unexpected or external means.

44. **In-Network.** Providers who have a contract with the Plan to provide Services to its Plan Participants at a pre-negotiated rate.

45. **Intensive Care Unit.** A department of a hospital of which patients who are dangerously ill are kept under constant observation.

46. **Legal Guardian.** 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 an individual.

47. **Maximum Allowable Charge.** The benefit payable for a Covered Service in the Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists. If no negotiated rate exists, the Maximum Allowable Charge will be the lesser of: (i) the Usual and Customary rate, as determined by the Plan; or (ii) billed charges. The Maximum Allowable Charge must be Reasonable.

    Note: The Plan Administrator has the discretionary authority to decide if a charge is Reasonable and Medically Necessary. The Plan will reimburse out of network charges at the billed rate if it is less than the Reasonable amount. The Maximum Allowable Charge will not include any billing mistakes including, up-coding, duplicate charges, and services not performed. The Maximum Allowable Charge may be equal to or less than the contract rate set forth in a Provider agreement.

    When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

    With respect to non-contracted Emergency Services, the Maximum Allowable Charge will be an amount equal to the greatest of the following three amounts, as applicable:

    - The median of the amount negotiated with contracted Providers for Emergency Services without regard to copayments and coinsurance (if no per-service amount is negotiated, this amount is disregarded);
    - The amount the plan generally pays for out of network services, such as usual, customary and reasonable (UCR) amount, but without regard to in-network copayments or coinsurance and without reduction for the plan's usual cost-sharing generally applicable to out of network services; or
    - The amount that would be paid under Medicare Parts A and B, without regard to copayments and coinsurance.

48. **Medical Necessity/Medically Necessary.** Health care services ordered by a licensed Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition. To be considered Medically Necessary, the services:

    1. Must not be maintenance therapy or maintenance treatment;
    2. Purpose must be to restore health;
    3. Must not be primarily custodial in nature; and
    4. Must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Plan Participant is receiving or the severity of the Plan Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the FDA and other medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

49. **Medical Equipment.** Equipment and supplies ordered by a healthcare Provider for everyday or extended use.

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

51. **Mental Disorder.** A disease or condition is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

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

53. **No-Fault Coverage.** The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

54. **No Surprises Act.** The No Surprises Act of the 2021 Consolidated Appropriations Act, as amended.

55. **Open Enrollment**. The yearly period when employees can enroll in benefits.

56. **Out-of-Network.** Providers who are not In-Network Providers.

57. **Out-of-Pocket Maximum.** The Out-of-Pocket Maximum is the Plan's overall limit on the amount You will pay for Covered Services for the Plan Year. Once the Out-of-Pocket Maximum is reached, the Plan will pay for all Covered Services for the remainder of the Plan Year.

58. **Outpatient Services.** Medical procedures or tests that can be done in a medical center without an overnight stay.

59. **Partial Hospitalization.** A structured program of outpatient psychiatric or substance abuse services. This treatment is provided during the day and does not require an overnight stay.

60. **Participating Health Care Facility.** A Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. 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.

61. **Pharmacy.** An establishment where covered Prescription Drugs are filled and dispensed by a licensed pharmacist.

62. **Physician**. A Doctor of Medicine (M.D.), Osteopathy (D.O.), Podiatric Medicine (D.P.M.), Chiropractic (D.C.), Dental Surgery (D.D.S), or Optometry (O.D). Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Licensed Professional Occupational Therapist, Psychiatrist, Psychologist (Ph.D.), or Licensed Professional Speech Language Pathologist. All physicians must be practicing within the scope of their license.

63. **Plan.** ALLIANCE HEALTHCARE, INC MEC Medical Plan, which is a group health plan for eligible Employees.

64. **Plan Participant or Participant.** An Employee or Dependent who is covered under this Plan.

65. **Plan Sponsor.** ALLIANCE HEALTHCARE, INC

66. **Provider**. A health professional who provides health care services.

67. **Prenatal.** Existing or occurring before birth.

68. **Prescription Drug.** A pharmaceutical drug that legally requires a medical prescription to be dispensed.

69. **Preventive Care**. Routine healthcare that includes screenings, check-ups, and patient counseling to prevent Illnesses, disease, or other health problems.

70. **Qualified Beneficiary.** An employee who was covered by the Plan on the day before a Qualifying Event occurred or that employee's spouse, former spouse, or Dependent child.

71. **Qualifying Event.** Certain events that would cause an individual to lose health coverage under the Plan that would entitled the individual to continuation coverage under COBRA.

72. **Qualifying Payment Amount.** The median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning less than three) contracted rates available to determine a Qualifying Payment Amount, the amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

73. **Reasonable** and/or **Reasonableness.** In the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator or its delegate.

    This determination will consider the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) the U.S. Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information

presented to it or its delegate. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

74. **Rehabilitative.** The process of helping a person who has suffered an Illness or Injury, restore lost skills and regain maximum self-sufficiency.

75. **Routine Prenatal Care.** Routine Prenatal Care includes regular medical care provided to a pregnant person related to the pregnancy and provided from the time of a positive pregnancy test until delivery. Services include, but are not necessarily limited to, health check-ups, diagnostic screenings, labs, ultrasounds, and counseling on health practices, as well as any other prenatal services classified as preventative care under the ACA.

76. **Sickness.** A person's Illness, disease or Pregnancy (including complications).

77. **Skilled Nursing Facility.** A facility that fully meets all of these tests: (i) services are provided for compensation and under the full-time supervision of a Physician; (ii) provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse; (iii) maintains a complete medical record on each patient; (iv) has an effective utilization review plan; (v) has ability to store and dispense Prescription Drugs; and, (vi) is approved and licensed by Medicare. This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

78. **Special Enrollment Period**. A time outside the yearly Open Enrollment Period when You can enroll in benefits. You qualify for a Special Enrollment Period if You've had certain qualifying life events.

79. **Special Enrollment Rights.** A right granted by federal law to enroll in the Plan during a Special Enrollment Period.

80. **Spouse.** An individual who is lawfully married to an Employee under the law of the state where the Employee resides.

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

    - Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home
    - Recurrent substance use in situations in which it is physically hazardous
    - Craving or a strong desire or urge to use a substance;
    - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

82. **Substance Abuse Treatment Center.** A facility operating primarily for the treatment of Substance Abuse if it meets these tests: (i) maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; (ii) has a Physician in regular attendance; (iii) continuously provides 24-hour a day nursing service by a registered nurse (R.N.); (iv) has a full-time psychiatrist or psychologist on the staff; and (v) is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse. This Institution must be: affiliated with a Hospital under a contractual agreement with an established system for patient referral; accredited as such a facility by The Joint Commission on Accreditation of Hospitals; or licensed, certified, or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

83. **Temporomandibular Joint (TMJ) Syndrome**. Jaw joint disorders, including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular joint.

84. **Unbundling.** Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

85. **Urgent Care Clinic.** A health care facility whose primary purposes is to offer and provide immediate, short-term medical care for minor immediate medical conditions not on a regular or routine basis.

86. **Usual and Customary.** The Usual and Customary Charge (U&C) represents the maximum allowable amount used to calculate payments for certain Covered Services. It is based by taking into consideration the fee(s) which providers most frequently charge patients for the same or similar medical service in a geographic area and the Medicare reimbursement rates. Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

87. **You, Your.** When used in this Plan Document, You or Your means the Employee and/or Dependent enrolled in coverage under the Plan.

Prescription Drug Coverage

GENERAL INFORMATION

Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. Contact Your Pharmacy Benefit Manager ("PBM") for more information. The name of Your PBM is located on Your ID card.

If a drug is purchased from a pharmacy that does not participate in Your PBM's program, or when You do not use Your ID card at the point of sale, the total amount eligible for benefits under the Plan will be the ingredient cost and the dispensing fee.

PRIOR AUTHORIZATION

Certain prescription drugs require prior authorization. This means the Plan and/or PBM will review a medication prescribed before the Plan will cover its cost. A prior authorization may be required for drugs listed or not listed on the PBM's formulary. Contact Your PBM for more details.

NOT COVERED EXPENSES

Notwithstanding any other provision of this Plan Document, the following items are not Covered Expenses under the Plan, and the Plan will not cover any of the associated costs or charges.

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

2. **Brand Name Drugs.**

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

4. **Experimental, Investigational, or non-FDA Approved.**

5. **Generic Drugs.**

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

7. **Impotence.** A charge for impotence medication.

8. **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

9. **Inpatient medication.** A drug or medicine that is to be taken while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises. Instead, inpatient medication may be covered by the Plan's medical coverage.

10. **Medical exclusions.** A charge excluded under the medical plan.

11. **Copay Assistance.** A charge for Prescription Drugs which may be properly received without charge under local, state, or federal programs.

12. **Off-Label drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

13. **No prescription.** A drug or medicine that can legally be bought without a written prescription.

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

15. Specialty Drugs.

How to Submit a Claim

GENERAL INFORMATION

This section sets forth the process for submitting Claims for reimbursement as a Covered Expense under the Plan.

CLAIM SUBMISSION

In general, if You receive Covered Services from an In-network Provider, the Provider will submit Claims to the Plan on Your behalf and the Plan will pay its portion of the Covered Services directly to the Provider. You remain individually responsible for submission of payment for any Deductible, Copay, or Coinsurance.

If You have an Out-of-Network Claim to submit for consideration, You must submit the Claim to HealthEZ. This submission must include the following information:

- Subscriber number
- Employee's name
- Patient's Name
- Name, address, tax ID, NPI, and telephone number of the Provider of care
- Type of services rendered, with diagnosis and procedure codes
- Date of service(s)
- Any receipt

The Claim should be sent to HealthEZ through one of the following methods:

Mail – PO Box 211186, Eagan, MN 55121
Email – claimsubmission@healthez.com

You have the right to appoint authorized representatives to act on Your behalf in connection with an initial Claim, an appeal of an Adverse Benefit Determination, or both.

WHEN CLAIMS SHOULD BE FILED

Claims must be filed within 180 days from the date of service or they will be denied as untimely. Benefits are applied based on the date of service.

HealthEZ reserves the right to request more information from the Plan Participant or Provider. If more information is requested, the request will include an explanation of why the additional information is necessary to process the Claim.

TIMEFRAMES

The following timeframes apply to Claims submitted for review:

The following timetable applies to post-service claims:	
Notification to Plan Participant of an Adverse Benefit Determination	30 calendar days
Extension due to matters beyond the control of the Plan	15 calendar days
Extension due to insufficient information on the Claim	15 calendar days
Response by the Plan Participant following notice of insufficient information	45 calendar days

Review of Adverse Benefit Determination	60 calendar days after benefit appeal
The following timetable applies to non-urgent pre-service Claims:	
Notification to Plan Participant of a benefit determination	15 calendar days
Notification to Plan Participant of failure to follow procedures	5 calendar days
Extension due to matters beyond the control of the Plan	15 calendar days
Extension due to insufficient information on the Claim	15 calendar days
Response by the Plan Participant following notice of insufficient information	45 calendar days
Review of Adverse Benefit Determination	30 calendar days after benefit appeal
The following timetable applies to post-service claims:	
Notification to Plan Participant of an Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by the Plan Participant following notice of insufficient information	45 days
Review of Adverse Benefit Determination	60 days after benefit appeal
The following timetable applies to non-urgent pre-service Claims:	
Notification to Plan Participant of a benefit determination	15 days
Notification to Plan Participant of failure to follow procedures	5 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by the Plan Participant following notice of insufficient information	45 days
Review of Adverse Benefit Determination	30 days after benefit appeal
The following timetable applies to urgent care Claims:	
Notification to Plan Participant of a benefit determination	72 hours from receipt of a complete Claim. If initial Claim was incomplete, 48 hours after the earlier of: (1) date Claimant provides requested information, or (2) end of the 48-hour period for Claimant to provide the information.
Notification to Plan Participant of failure to follow procedures	24 hours from receipt of a Claim
Notice of incomplete Claim	24 hours
Time for Claimant to provide requested information	48 hours
Review of Adverse Benefit Determination	72 hours
Deadline to notify Claimant of determination on request to extend treatment involving urgent care (concurrent care)	24 hours after receipt of Claim if Claim made at least 24 hours prior to expiration of treatment
The following timetable applies to concurrent care Claims:	

Notification to Claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow Claimant to appeal
Notification to Claimant of recission	30 days
Notification of determination on Appeal of Claims involving urgent care	24 hours (provided Claimant files appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for recission Claims	30 days
Notification to Claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow Claimant to appeal

NOTICE TO THE PLAN PARTICIPANTS OF ADVERSE BENEFIT DETERMINATIONS

If a Claim is denied, in whole or in part, the denial is considered an Adverse Benefit Determination. Except for urgent care claims, HealthEZ will provide written or electronic notification of the Adverse Benefit Determination. For urgent care claims, notification may be made orally and followed by written or electronic notification within three days of the oral notification. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the Claimant the following information:

- A reference to the specific portion(s) of the Plan upon which a denial is based;
- Specific reason(s) for the Adverse Benefit Determination;
- A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;
- If the Adverse Benefit Determination is based on a determination of Medical Necessity, Experimental treatment, or a similar exclusion or limit, the Adverse Benefit Determination will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- In the case of an Adverse Benefit Determination for an urgent care claim, a description of the expedited review process applicable to such Claims.

Appeals

APPEALS PROCESS

First Appeal

When a Plan Participant receives an Adverse Benefit Determination, the Plan Participant has 180 calendar days following receipt of the Explanation of Benefits (EOB) for the claims they want to appeal. A Plan Participant may submit written comments, documents, records, and other information relating to the Claim.

Upon request, a Plan Participant will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim under appeal. A document, record, or other information shall be considered relevant to a Claim if it:

- Was relied upon in making the Adverse Benefit Determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- Demonstrated compliance with the administrative processes and safeguards required and designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Claimants; or
- Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

Appeals should be submitted to:

HealthEZ
Attn: Appeals
P.O Box 211186
Eagan, MN 55121

Email – appeals@healthez.com

The appeal decision timeline begins at the time an appeal is filed without regard to whether all the necessary information accompanies the filing.

The review shall take into account all information submitted by the Plan Participant relating to the Claim. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by HealthEZ, through a person who is neither the individual who made the initial Adverse Benefit Determination nor a subordinate of that individual.

If the determination is based, in whole or in part, on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary, the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement. The Plan will identify the medical or vocational experts whose advice was obtained in connection with its review of the Adverse Benefit Determination, without regard to whether the advice was relied upon in making its final determination. The health care professional engaged for purposes of consultation will be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is subject to the appeal, nor the subordinate of any such individual.

In the case of a Claim involving Urgent Care, there is an expedited review process pursuant to which: (a) a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and (b) all necessary information, including the Plan's benefit determination on

review, shall be transmitted between the Plan and the Claimant by telephone, fax, or other available similarly expeditious method.

If the Appeal is denied, in whole or in part, the Claimant will be provided written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the Claimant, the following:

- The specific reason(s) for the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the Adverse Benefit Determination is based;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain information about such procedures;
- A statement of the Claimant's right to bring action under Section 502(a) of ERISA;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;
- If the Adverse Benefit Determination is based on a determination of Medical Necessity, Experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- The following statement: "You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency."

Second Appeal

If a Plan Participant's appeal is upheld, in whole or in part, the Plan Participant has 180 calendar days after receiving notice of the decision to provide notice of a second appeal. The second review will follow the same procedures as the first review and shall take into account all information submitted by the Plan Participant relating to the Claim. The review will not afford deference to the initial Adverse Benefit Determination nor the first appeal decision and will be conducted by HealthEZ, through a person who is neither the individuals who made the initial Adverse Benefit Determination or the first appeal review, nor anyone subordinate of those individuals.

EXTERNAL REVIEW PROCESS

If a Claimant receives a final Adverse Benefit Determination, then the Claimant may be eligible to request that the Claim be reviewed under the Plan's External Review Process. The Federal external review process applies only to:

- An Adverse Benefit Determination that involves medical judgment as determined by the external reviewer;
- Rescission; and
- An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth under the No Surprises Act.

Claims based on: (a) legal or contractual disputes; or (b) issues regarding Your eligibility are not eligible for external review.

Standard external review

1. **Request for external review.** A Plan Participant must file a request for external review within 4 months after the receipt of an Adverse Benefit Determination. The Plan Participant can only file a request for external review after an Appeal determination has been issued.

2. **Preliminary review.** Within 5 business days following the receipt of a request for external review, HealthEZ, as Claims administrator, will complete a preliminary review of the request to determine whether:
    - The Claimant is or was covered under the Plan at the time the service was provided or requested;
    - The Claimant is eligible for federal external review;
    - The Claimant has exhausted the Plan's Appeal process; and
    - The Claimant has provided all the information required to process an external review.

    HealthEZ will issue a notification to the Claimant within one business day of completion of the preliminary review. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification will describe the information needed to make the request complete and the Plan will allow a Claimant to amend the request for external review: (a) before the expiration of the four-month filing period; or (b) within 48-hour of receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization.** Once the Claimant's request is complete and HealthEZ has determined the Claim is eligible for external review, the Plan will assign an accredited independent review organization (IRO) to conduct the external review. HealthEZ will provide the IRO with the internal file and other materials considered during the internal appeals process within 5 days of the date of assignment of the IRO. The IRO will timely notify the Claimant in writing whether the request is eligible for external review, and this notice will include a statement that the Claimant has 10 business days to submit, in writing, any additional information for the IRO to consider during the external review process. The IRO will forward the information submitted by the Claimant to the Plan within 1 business day of receipt.

In addition to the documents and information provided, the IRO will consider the following in reaching a decision, to the extent such information and/or documents are available and considered appropriate in the independent judgment of the IRO:

- The Claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating Provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary its terms, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or coverage or with applicable law; and
- The opinion of the IRO's clinical reviewer.

The IRO will provide written notice of the final external review decision within 45 days after it receives the request for external review. The notice will contain a general description of the reason for the request for

external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

4. **Reversal of Plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination, the Plan will provide payment for the Claim without delay, regardless of whether the Plan intends to seek judicial review.

Expedited External Review

A Claimant may request an expedited external review when the Adverse Benefit Determination involves a medical condition for which the timeframe of a standard appeal would seriously jeopardize the health of the Claimant. The IRO will provide notice of the final external review decision as quickly as Your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

External Review – No Surprises Act

Notwithstanding the foregoing appeals process, all appeals related to Claims governed by the No Surprises Act must be resolved using the federal independent dispute resolution process. Under the federal independent dispute process, a Certified IDR Entity makes a binding determination that establishes the payment amount. Claims governed by the No Surprises Act include:

- Claims for Emergency Services from an Out-of-Network Provider or an emergency facility;
- Claims for non-emergency services from an Out-of-Network Provider at an In-Network Facility, unless the Provider furnishes notice to the Plan Participant, beneficiary, or authorized representative and receives consent form that individual in compliance with the No Surprises Act; and
- Air ambulance services furnished by an Out-of-Network Provider.

DEEMED EXHAUSTION OF INTERNAL CLAIMS PROCEDURES AND DE MINIMIS

A Plan Participant is normally required to exhaust the Plan's internal Claim and appeals procedures (other than external review) before suing. However, a Plan Participant will not be required to exhaust the internal appeals process if the Plan fails to adhere to the Claims procedures requirements. In this case, a Plan Participant may proceed immediately to the External Review Program or file a Claim in court. The Plan Participant will be required to follow the Plan's appeals process if:

- The Plan's violation of its Claim procedures is not likely to cause harm to the Plan Participant;
- The Plan demonstrates that its failure was for good cause or due to matters beyond its control;
- The violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Plan Participant; and
- The violation is not reflective of a pattern or practice of non-compliance.

If a Plan Participant believes the Plan has engaged in a violation of the Claims procedures and would like to pursue an immediate review, the Plan Participant may request that the Plan provide a written explanation of the violation and explain why violation should not result in a "deemed exhaustion" of the Claims procedures. The Plan will respond to this request within 10 days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis exception" described above, the Plan will provide the Plan Participant with notice of an opportunity to resubmit and pursue an internal appeal of the Claim.

DEADLINE TO SUE

A Plan Participant must commence any lawsuit under the Plan within the later of: (a) 2 years after the Plan Participant knew or reasonably should have known of the facts giving rise to the Claim; or (b) 6 months after completion of the internal appeals process.

VENUE

All litigation related to the Plan (including but not limited to any and all Claims brought under ERISA, such as Claims for benefits and Claims for breach of fiduciary duty) must be filed in the United States District Court siting in or otherwise having jurisdiction over where the Plan Sponsor maintains its principal place of business.

RECOVERY OF PAYMENT

Occasionally, benefits are paid in error. HealthEZ reserves the right to recover any erroneous payment directly from the entity or person who received it and/or from other payers and/or the Plan Participant on whose behalf the payment was made.

The Plan Administrator will have the sole discretion to choose who will repay an erroneous payment and whether such payment will be reimbursed in a lump sum. When an entity or person does not comply, HealthEZ will have the authority to deny payment of any Claims for benefits by the Plan Participant and to deny or reduce future benefits payable by the amount due.

Any payments made in accordance with the above provisions will be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against an entity to enforce the provisions of this Plan, then that entity or person will pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

PAYMENTS TO PROVIDERS AND ASSIGNMENT OF BENEFITS

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Plan Participant attempts to assign its right to seek and receive payment of eligible Plan benefits, less Deductible, Copays, and/or Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Plan Participant and are limited by the terms of this Plan Document.

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

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

Coordination of Benefits

Coordination of benefits sets out rules for the order of payment when You, as a Plan Participant, may be covered under more than one plan.

WHEN IS COORDINATION NEEDED

Coordination of benefits is needed when You and/or Your Dependents have coverage under:

- More than one employer-provided health plan;
- An individually purchased plan and an employer-sponsored health plan;
- A university-sponsored student plan and an employer-sponsored health plan;
- Medicare and an employer-sponsored health plan;
- Another insurance policy, such as an automobile policy, a worker's compensation policy, homeowners policy, general liability policy, or any other insurance or plan.

HOW COORDINATION OF BENEFITS WORKS

If a health care expense is covered by more than one plan, one plan is the "primary" plan and has first responsibility for the expense. When the primary plan has paid all of its covered benefits under its plan terms, the other plan, often called a "secondary" plan or an "excess" plan, may make an additional payment based on its plan terms.

When You or Your Dependents have coverage under two or more health plans, this Plan will pay Plan benefits according to the Order of Benefit Determination Rules described below.

IF THIS PLAN IS PRIMARY

When the Order of Benefit Determination Rules determine that this Plan is primary, this Plan's benefit payment will not be affected. The Plan pays full benefits according to the terms of this Plan Document. After You have received an explanation of benefits (EOB) from the Plan, You can submit any remaining expenses to the secondary/excess plan for consideration.

IF THIS PLAN IS SECONDARY/EXCESS

When the Order of Benefit Determination Rules determined that this Plan is secondary or an excess plan, this Plan will reduce its benefits so that the total benefits paid by all Plans covering You or Your Dependents are not more than the total Allowable Expense, as determined by the rules of this Plan. In determining the amount to be paid by this Plan, the Plan will calculate the benefits it would have paid in the absence of the other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary plan. This Plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total Allowable Expense for that claim.

ORDER OF BENEFIT DETERMINATION RULES

When two or more plans provide benefits for the same allowable charge, this Plan will follow these rules:

1. Plans that do not have a coordination provision will pay first.

2. Plans with a coordination provision will pay their benefits, with a maximum payment equal to the Maximum Allowable Charge, in this order:

    a. The benefits of the plan which covers the person directly ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

b. The benefits of a plan which covers a person as an Active Employee are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

c. The plan which covers a person as an Active Employee or a Dependent of an Employee is determined before those of a plan which covers the person as a COBRA beneficiary.

d. When a child's parents are married, these rules will apply:

i. The plan of the parent whose birthday falls earlier in the calendar year is determined first.

ii. If both parents have the same birthday, the plan which has covered the patient for the longer period is determined first.

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

i. When the parent with custody has not remarried, their plan will be considered first.

ii. When the parent with custody has remarried, their plan will be considered first. The plan of the stepparent will be considered next. The plan of the parent without custody will be considered last.

iii. A court decree state may overrule the above and state which parent is financially responsible for medical and dental benefits of the child.

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

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

3. When the Plan Participant is covered by Medicare and Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B in compliance with the Medicare coordination of benefits rules.

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

In all cases, and subject to all Plan exclusions, the Plan shall be excess to any of the following:

- The responsible party, its insurer, or any other source of recovery and/or payment on behalf of that party.
- Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage, or any similar policy, insurance, or coverage.
- Any policy of insurance from any insurance company or guarantor of a third party, including, but not limited to, an employer's policy.
- Workers' compensation or other liability insurance.
- Any other source of coverage, including, but not limited to:
  - Crime victim restitution funds
  - Civil restitution funds
  - No-fault restitution funds, such as vaccine Injury compensation Injury

- Any applicable medical, disability, or other benefit payment
- School insurance coverage
- Charity care funds or other hospital financial assistance

AUTOMOBILE LIMITATIONS

When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only**.**

END-STAGE RENAL DISEASE

When an individual is covered under this Plan, this Plan will reimburse treatment for End-Stage Renal Disease (ESRD) as required by Applicable Law. For Plan Participant's enrolled in Medicare, the coverage for ESRD or any other dialysis will continue for the initial 30 months.

Subrogation

Benefits payable by the Plan shall be limited in the following ways when the Injury or Sickness is the result of an act or omission of another (including a legal entity) and when You or Your Dependents pursue or have the right to pursue a recovery for such act or omission.

By accepting payment of benefits under the Plan, You agree to the following:

PAYMENT CONDITION

1. The Plan may elect to conditionally advance payment of benefits in situations 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 Coverage, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “Coverage”).

2. The Plan Participant, their attorney, and/or the 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 one hundred percent (100%) of the Plan’s conditional payment of benefits. The Plan will have an equitable lien on any funds received by the Plan Participant and/or their attorney from any source and said funds shall be held in trust until the obligations under this provision are fully satisfied. The Plan Participant agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

3. In the event a Plan Participant settles, recovers, or is reimbursed by any Coverage, they agree to reimburse the Plan for all benefits paid conditionally. If the Plan Participant fails to reimburse the Plan, they will be responsible for any expenses associated with the Plan’s attempt to recover the money.

4. If there is more than one party that is 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 is only one, are considered as an “identifiable” fund from which the Plan may seek reimbursement.

Plan Participants assign the right to subrogate and pursue Claims that may arise against any individual, entity, or coverage to the Plan Administrator or its delegate. If a Plan Participant receives benefits or becomes entitled to receive benefits, from any party causing their Sickness or Injury, an automatic equitable lien attaches in favor of the Plan to any Claim the Plan Participant might have. The Plan (or its delegate, such as HealthEZ or one of HealthEZ’s subcontractors) may, at its discretion, in its own name or in the name of the Plan Participant, pursue such Claims.

ASSIGNMENT

As a condition to participating in and receiving benefits under this Plan, the Plan Participant 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 a right to any Coverage which the Plan Participant is entitled regardless of how classified or characterized, at the Plan's discretion. Plan Participant agrees to fully cooperate with the Plan to pursue a Claim and the recovery of all expenses.

RIGHT OF REIMBURSEMENT

1. The Plan will be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan will have an equitable lien which supersedes all common law or statutory laws of any State prohibiting assignment of rights which interferes with 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. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs or litigation expenses, including expert's fees, may be deducted from the Plan's recovery. In addition, 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, whether under any doctrine in law.

3. These rights of subrogation and reimbursement do not require a separate written acknowledgment from Plan Participant and will not limit any other remedies of the Plan provided by law.

SEPARATION OF FUNDS

Benefits paid, funds recovered, and funds over which the Plan has an equitable lien exist separately from the estate of the Plan Participant. The Death of or filing of bankruptcy by the Plan Participant will not affect the Plan's lien or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event a wrongful death or survivor Claim is asserted against a third party, the Plan's subrogation and reimbursement rights still apply.

OBLIGATIONS

It is the Plan Participant's obligation:

- To fully cooperate with the Plan, or any representative of the Plan, in protecting the Plan's rights, including discovery, attending depositions, and/or cooperating in trial;
- To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information, and any other requested additional information;
- To take all actions and execute any documents that the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment method is received;
- To notify the Plan or its authorized representative of any incident related to Claims or care which may not be identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;

- To notify the Plan or is authorized representative of any settlement prior to finalization of the settlement;
- To not settle or release any Claim without the prior consent of the Plan;
- 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;
- 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; and
- To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and the Plan Participant over the settlement funds is resolved.

If the Plan Participant or his or her attorney fail 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, judgement, or settlement received, the Plan Participant 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. The Plan's right to reimbursement and/or subrogation are in no way dependent upon the Plan Participant's cooperation or adherence to these terms.

MINOR STATUS

In the event the Plan Participant is a minor, the minor's parents or guardian will cooperate in all actions by the Plan to seek and obtain requisite court approval to bind the minor and their estate insofar as these subrogation and reimbursement provisions are concerned. If the minor's parents or guardian fail to take such action, the Plan will have no obligation to advance payment of medical benefits on behalf of the minor and any court costs or legal fees associated with obtaining such approval will be paid by the minor's parents or guardian.

OFFSET

If Plan Participant or their 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 refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant in an amount equivalent to what the Plan is owed.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and the Plan Document.

Continuation Coverage Rights Under COBRA

COBRA continuation coverage is the temporary extension of group health plan coverage due to a Qualifying Event. The right to enroll in continuation coverage is triggered by the loss of coverage under the terms of the Plan. The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event.

WHAT ARE COBRA QUALIFYING EVENTS?

A Qualifying Event is one that would cause an employee who had group health coverage to lose that coverage.

Qualifying Events for Employees

- Voluntary or involuntary termination of employment for any reason other than gross misconduct; or
- Reduction in the number of hours of employment such that the Employee is no longer eligible for participation in the Plan.

Qualifying Events for Spouses

- Voluntary or involuntary termination of the covered Employee's employment for any reason other than gross misconduct;
- Reduction in the number of hours worked by the covered Employee such that the Employee is no longer eligible for participation in the Plan;
- Covered Employee becomes entitled to Medicare;
- Divorce or legal separation; or
- Death of the Covered Employee.

Qualifying Events for Dependent Children

- Loss of Dependent status under the Plan rules;
- Voluntary or involuntary termination of the covered Employee's employment for any reason other than gross misconduct;
- Reduction in the number of hours worked by the covered Employee such that the Employee is no longer eligible for participation in the Plan;
- Covered Employee becomes entitled to Medicare;
- Divorce or legal separation; or
- Death of the Covered Employee.

FMLA qualified leaves do not constitute a Qualifying Event because coverage is not lost during such leave. However, if an Employee does not return to employment at the end of the FMLA leave, then that loss of coverage due to termination of employment or reduction in hours may be a Qualifying Event for COBRA.

Dropping coverage during open enrollment is not, on its own, a Qualifying Event, although doing so in conjunction with a Qualifying Event, such as divorce or legal separation, may create COBRA rights for certain individuals.

WHAT ARE THE ALTERNATIVES TO COBRA?

A Plan Participant has the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by their Spouse's employer) within 30 days after the coverage under this Plan ends. They will also have the same right at the end of COBRA coverage if they take COBRA for the maximum time available.

HOW LONG IS THE COBRA ELECTION PERIOD?

The election period begins on the day the Plan Participant would lose coverage and ends 60 days after the later of: (a) that date; or (b) the date the Plan Participant is provided notice of their right to elect COBRA.

WHEN MUST A COBRA ELECTION BE MADE?

The Employer is responsible for notifying the Plan Administrator within 30 days of the Qualifying Event when the Qualifying Event is one of the following:

- End of employment or reduction of hours;
- Death of Employee; or
- The Employee becoming entitled to Medicare benefits.

The Employee is responsible for notifying the Plan Administrator within 60 days of the Qualifying Event when the Qualifying Event is one of the following:

- Divorce;
- Legal separation; or
- Dependent Child's losing eligibility for coverage.

Each Qualified Beneficiary has an independent right to elect COBRA within the deadline stated in the COBRA election notice. Covered Employees may elect COBRA for their spouse, and parents may elect COBRA on behalf of their children.

QUALIFYING EVENT NOTICE PROCEDURES:

A Participant's notice of Qualifying Event must be ***in writing***. If mailed, the notice must be postmarked no later than the last day of the required notice period. The notice must state:

- The **name of the Plan** under which the Plan Participant lost coverage,
- The **name and address of the Employee** covered under the Plan,
- The **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- The **Qualifying Event** and the **date** it happened.

The Plan Administrator or its delegate reserves the right to request proof of the Qualifying Event.

CAN A COBRA WAIVER BE REVOKED?

If during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. However, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked).

IS COBRA AVAILABLE IF A QUALIFIED BENEFICIARY HAS OTHER COVERAGE?

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they are covered under another group health plan or are entitled to Medicare benefits. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, they become entitled to Medicare or become covered under other group health plan coverage.

WHAT ARE THE MAXIMUM COVERAGE PERIODS?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary:

1. If the Qualifying Event is a termination of employment or reduction of hours, the maximum coverage period is 18 months, or 29 months if there is a disability extension;
2. If an Employee is enrolled in Medicare before experiencing a termination of employment or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the Employee ends on the later of:
   i. 36 months after the date the Employee enrolled in the Medicare program; or
   ii. 18 months (29 months, if there is a disability extension) after the date of the Employee's termination of employment or reduction of hours;
3. In the case of any other Qualifying Event than that described above, the maximum coverage period is 36 months.

UNDER WHAT CIRCUMSTANCES CAN THE MAXIMUM COVERAGE PERIOD BE EXTENDED?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18-month or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be extended to more than 36 months.

HOW DOES A QUALIFIED BENEFICIARY BECOME ENTITLED TO A DISABILITY EXTENSION?

A disability extension will be granted if a Qualified Beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage. To qualify for the disability extension, the Qualified Beneficiary must provide the COBRA vendor or Plan Sponsor with notice of the disability determination within 60 days of the determination.

WHEN WILL COBRA BE TERMINATED?

COBRA will end on the earliest of the following dates:

- The last day of the maximum coverage period;
- The first day for which Timely Payment is not made;
- The date upon which the Employer ceases to provide any group health plan;
- The date, after election, that the Qualified Beneficiary first enrolls in Medicare, or
- In the case of a Qualified Beneficiary in a disability extension period, the first day of the month more than 30 days after the final determination that the Plan Participant is no longer disabled.

DOES THE PLAN REQUIRE PAYMENT FOR COBRA CONTINUATION COVERAGE?

Qualified Beneficiaries will pay 102% of the premium for the first 18 months and 150% of the premium if receiving a disability extension of COBRA.

WHAT IS TIMELY PAYMENT FOR COBRA CONTINUATION COVERAGE?

COBRA premiums are due on the first of the month. However, You will be allowed a grace period of 30 days.

Notwithstanding the above paragraph, the Plan does not require payment earlier than 45 days after the election of COBRA.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect Your family's rights, please keep HealthEZ informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to HealthEZ.

ADDITIONAL RESOURCES

For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Responsibilities of Plan Administrator

PLAN ADMINISTRATOR

ALLIANCE HEALTHCARE, INC is the Plan Administrator. The Plan Administrator has legal discretionary authority to interpret the Plan and to decide any disputes which may arise. The decisions of the Plan Administrator or its delegate will be final and binding on all interested parties.

CLERICAL ERROR

Any clerical error in making any changes in eligibility will not invalidate coverage or continue coverage validly terminated. In the case of clerical error that results in overpayment, the Plan requires reimbursement.

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 reserves the right, at any time and for any reason, to amend, suspend, or terminate the Plan.

SUMMARY OF MATERIAL MODIFICATION (SMM)

A Summary of Material Modification reports changes in the Summary Plan Description.

The Plan Sponsor will notify all Plan Participants of any plan amendment considered a Summary of Material Modifications, no later than 210 days after the close of the Plan Year in which the changes became effective.

The Plan Sponsor will notify all Plan Participants of any plan amendment considered a material reduction in coverage, no later than 60 days after adoption.

If a Plan's Material Modifications are not reflected in the most recent Summary of Benefits and Coverage (SBC) then the Plan will provide written notice to Plan Participants at least 60 days before the effective date of the modification.

Plan Participants Rights under ERISA

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a Claim for benefits which is denied or ignored, in whole or in part, You may file suit in Federal court after You have exhausted the Plan's Claims procedures. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your Claim is frivolous.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for Yourself, Your spouse, or Your Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or Your Dependents may have to pay for

such coverage. Review this SPD and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

ASSISTANCE WITH YOUR QUESTIONS

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

Important Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) NOTICE

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of mastectomy, including lymphedemas.

These benefits are subject to the same Deductibles and Coinsurance requirements as other procedures covered by the Plan.

GINA NOTICE

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233) (GINA), prohibits discrimination on the basis of Genetic Information. GINA expands on HIPAA in several ways:

- Group health plans and health insurers cannot base premiums on Genetic Information;
- Plans and insurers are prohibited from requesting or requiring an individual to undergo a genetic test; and
- Plans and insurers are prohibited from collecting Genetic Information (including family history) prior to or in connection with enrollment, or for underwriting purposes.

NOTICE OF RIGHTS UNDER THE MOTHERS & NEWBORNS HEALTH PROTECTION ACT

Under Federal law, group health plans offering group health insurance coverage generally may not 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, the Plan may pay for a shorter stay if the attending Provider (*e.g., Y*our physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan may not, under Federal law, require that a physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Your Plan Administrator.

MENTAL HEALTH PARITY

The Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (together, "Mental Health Parity Laws"), and regulations thereunder, generally intend to ensure parity in aggregate lifetime and annual dollar limits, financial requirements, quantitative treatment limitations, and nonquantitative treatment limitations between (i) mental health and substance use disorder benefits and (ii) medical/surgical benefits. This Plan complies with the Mental Health Parity Laws and applicable regulations, including performing and documenting comparative analyses of the design

and application of nonquantitative treatment limitations within the Plan and making such comparative analyses available to required parties, such as governmental authorities and Plan Participants.

COMPLIANCE WITH HIPAA PRIVACY REQUIREMENTS

This Plan provides each Plan Participant with a separate Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. This Notice describes how the Plan uses and discloses Your personal health information. It also describes certain rights You have regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by contacting the HIPAA Compliance Officer(s).

HIPAA Compliance Officer(s): Brianna Bokman, Ph: 651-895-8030

MICHELLE'S LAW NOTICE

Under a Federal law known as "Michelle's Law," the Plan cannot terminate coverage for a Dependent child whose enrollment in a plan requires student status at a postsecondary educational institution if the student status is lost because of a medically necessary leave of absence. In this situation, the Plan will continue the Dependent's coverage until the earlier of: (a) the date that is one year after the first day of the medically necessary leave of absence or (b) the date on which the Dependent's coverage would otherwise end under the Plan's terms. The Dependent must provide written certification from the Dependent's treating physician to the Plan.

NOTICE REGARDING COVERAGE FOR OBSTETRIC OR GYNECOLOGICAL CARE

You do not need prior authorization from the Plan or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in Your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

NOTICE REGARDING DESIGNATION OF PRIMARY CARE PROVIDERS

The Plan generally allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in Your network and who is available to accept You and Your family members.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

Please contact 844-660-2451 to obtain, without charge, a copy of the written procedures used by HealthEZ to determine the status of QMCSOs.

MEDICARE PART D PRESCRIPTION DRUG CREDITABLE COVERAGE

If You or a covered Dependent are eligible for prescription drug coverage under the Plan and are also eligible for Medicare, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the employer to provide You with an annual notice addressing whether the Plan's prescription drug coverage is creditable or non-creditable. You should receive the notice each year by October 15.

Creditable means that the Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard prescription drug benefit under Medicare Part D will pay. You do not need to enroll in coverage under Medicare Part D if Your coverage under the Plan is creditable.

If Your coverage under the Plan is non-creditable, You may pay higher Medicare Part D premiums if You have a break in creditable coverage of 63 days or more and then enroll in Medicare Part D prescription drug coverage.

Additional information about Your prescription drug coverage under the Plan is available in the notice that You receive. The notice is intended to help You decide between Medicare Part D prescription drug coverage and employer-provided coverage, if available. You can request a copy of the notice by contacting the Plan Administrator.

NO SURPRISES ACT

The No Surprises Act of the 2021 Consolidated Appropriations Act prohibits "surprise billing" or "balance billing" for:

- emergency care at an Out-of-Network Hospital;
- post-stabilization services provided in a Hospital following an emergency visit at an Out-of-Network Hospital;
- care received from an Out-of-Network Provider while at an In Network Hospital or certain other facilities; or
- air ambulance services from an Out-of-Network Provider.

The Plan must cover Emergency Services without requiring prior authorization and must cover Emergency Services even if the services are provided by Providers who are outside of the Plan's network. Any required cost sharing (Copays, Coinsurance, or Deductibles) for emergency care received from an Out-of-Network Provider or facility must be the same as the cost sharing for emergency care received from a Provider or facility in the group health plan's network.

For Claims subject to the No Surprises Act, if the Plan and an Out-of-Network Provider disagree over the payment amount for certain charges and cannot resolve the matter using an open negotiation process, they may invoke the federal independent dispute resolution process. Under the independent dispute resolution process, a Certified IDR Entity makes a binding determination that establishes the payment amount.

RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator and/or HealthEZ may, without the consent of or notice to any person, and consistent with the privacy rights and obligations under HIPAA, release or obtain any information necessary to determine acceptability of any applicant or Plan Participant in and/or benefits from this Plan. In so acting, the Plan Administrator and/or HealthEZ shall be free from any liability that may arise related to such action. Any Plan Participant claiming benefits under this Plan shall furnish to the Plan Administrator and/or HealthEZ such information as may be necessary to implement this provision.

CONTINUITY OF CARE

The Plan complies with federal continuity of care requirements under which Plan Participants and beneficiaries may seek extended care from their current Provider when the Provider is no longer part of the Plan's Network. Plan Participants and beneficiaries will be notified that the Provider is no longer part of the Plan's Network and permitted to receive transitional care from the Provider for up to 90 days after the Plan's notice is furnished.

General Plan Information & Establishment of the Plan

Name of Plan:	ALLIANCE HEALTHCARE, INC. Medical Plan
Plan Sponsor:	ALLIANCE HEALTHCARE, INC. 2260 Cliff Road Eagan, MN 55122
Plan Administrator (Named Fiduciary):	ALLIANCE HEALTHCARE, INC. 2260 Cliff Road Eagan, MN 55122
Plan Sponsor EIN:	41-1678327
Source of Funding:	Self-Funded
Applicable Law:	ERISA
Plan Year:	August 1st – July 31st
Plan Number:	501
Plan Status:	Non-Grandfathered
Plan Type:	Group health plan providing medical and prescription drug benefits
Third-Party Administrator and Claims Administrator	America's TPA dba HealthEZ P.O. Box 211186 Eagan, Minnesota 55121
Agent for Service of Process:	ALLIANCE HEALTHCARE, INC. 2260 Cliff Road Eagan, MN 55122

Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this non-grandfathered Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

ALLIANCE HEALTHCARE, INC

By: Brianna Bokman

Name: Brianna Bokman

Title: Human Resources Manager

Date: 7/21/2026