January - December

Community Connections, Inc.
721 Stedman Street
Ketchikan AK 99901

Dental / Vision Plan

Effective January 1, 2024

SUMMARY PLAN DESCRIPTION

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CONTACT INFORMATION

How to Reach Your Claims Administrator
Rehn & Associates 1322 N. Post Street Spokane, Washington 99201 Telephone: (509) 534-0600 Toll Free: (800) 872-8979 Fax: (509) 535-7883 Website: www.commconnect.rehnonline.com
Office Hours:
8:00 a.m. to 5:00 p.m. Monday through Thursday 8:00 a.m. to 4:00 p.m. Friday *All times are Pacific Standard Time* *Messages may be left on voice mail after hours*
How to Reach Your Pharmacy Benefit Manager
Elixir Customer Service: (800) 361-4542 Website: www.elixirsolutions.com

MONEY SAVING TIPS FOR PARTIALLY SELF-INSURED HEALTH PLANS

- **Carry Your Card** with you and show it to all health care providers and pharmacies. Your card has important information your doctor, dentist, pharmacist or provider needs in order to file your claim.
- Please note this plan does have exclusions, limitations and benefits that require preauthorization. Make yourself familiar with these benefits in order to utilize your plan effectively.
- Cut the cost of your prescriptions. If possible, get your doctor to prescribe you **generic drugs.**
- Take advantage of the **preventive care benefits** your plan offers.
- **Practice healthy living.** One of the easiest ways to lower your medical expenses over the long term is to establish and maintain a healthy lifestyle.
- **Never assume** anything about your health insurance. Get your information up front and BEFORE you need it.

ABOUT THIS BOOKLET

This booklet describes Community Connections, Inc. Dental and Vision Plan as of January 1st, for eligible Plan participants.

The Community Connections, Inc. Dental and Vision Plan was established January 1st, 2016, to provide dental and vision coverage for members and their families.

We encourage you to become familiar with your benefits and the valuable protection they offer. This booklet will also help you understand what services are and are not covered and any special steps you need to take to get the highest level of coverage.

It's important for all Plan participants to use these benefits wisely, which starts with understanding them. Carefully read and keep this booklet for future reference, so you understand how to make the Plan work best for you.

If you have questions about your coverage or eligibility, please contact your Claim's Administrator, Rehn & Associates.

INTRODUCTION

This Summary Plan Description has been prepared for the Employees and their Dependents of Community Connections, Inc. (Employer) effective January 1st, 2016.

This document, Community Connections, Inc. Dental and Vision Summary Plan Description, contains the Plan document for the benefits program required by ERISA §102. This document does not constitute an employment contract or guarantee to continue employment for any period of time. In addition, dental and vision benefits are not vested. Community Connections, Inc. may delegate some or all of its responsibilities to other entities such as insurance companies and claims payers. Community Connections, Inc. reserves the right to amend or delete any of the Plans or Plan provisions described herein at any time.

Please review this benefit booklet carefully. It contains a schedule of benefits and all the general provisions of the Plan. To receive the maximum benefits of this Plan, a Preferred Provider must provide health care services. Affiliate Networks have contracted with physicians, specialists, hospitals, and other health care professionals in your service area in order to offer you a network of Providers from which you may choose to receive your health care services.

This document is a description of the Community Connections, Inc. Dental and Vision Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic dental and vision expenses. Coverage under the Plan will take effect for an eligible employee and designated dependents when the employee and such dependents satisfy all of the eligibility requirements of the Plan, including any applicable waiting periods. Members are responsible for any copay, deductible and coinsurance amounts, as well as any non-covered services and amounts in excess of the allowed charge when a Non-Preferred Provider provides services. Amounts in excess of the member's copay, deductible, coinsurance, and the payment by Rehn & Associates for covered services rendered by a Preferred Provider shall be considered to be contractual adjustments and shall not be billed to the member.

Rehn & Associates will act as the third party administrator and claims processing fiduciary for this partially self-funded plan. Community Connections, Inc. as a partially self-funded employer is the Plan Administrator with discretionary authority to determine eligibility for benefits, and to construe and interpret the terms of the Plan, except as delegated to Rehn & Associates under Plan processes.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason, with or without notice. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, coinsurance, maximums, copayments, exclusions, limitations, definitions, eligibility and the like at any time with or without notice.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections and payment, utilization review or other cost management requirements, lack of medical necessity, lack of timely filing of claims or lack of coverage. Failure to provide Coordination of Benefits information may result in delay of coverage or temporary termination of coverage until information is received. Fraudulent use of Coordination of Benefits rules will result in automatic termination of eligibility.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage is terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for service or supply is incurred on the date it is furnished. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment or elimination.

DENTAL OVERVIEW

Annual Maximum	$2,000
Annual Deductible – Individual	$50
Annual Deductible – Family	$150

Deductible *is the amount of charges, up to the Allowed Charge, for Covered Services payable by a Member to a Provider who is recognized for payment under this Plan before the Plan will assume any liability for all or part of the remaining Covered Services. Benefits, except as otherwise specified, shall apply only after the deductible has been met. Charges for services payable by the Member due to a reduction in benefits, denial of benefits, or amounts charged in excess of Allowed Charge are the financial responsibility of the Member and shall not be considered as an eligible expense for application towards the deductible amount.*

DENTAL PRE-TREATMENT ESTIMATE

If before beginning a Dental treatment program, the member may wish to have an estimate of the benefits that will be available by the plan. The dentist should complete a "Pre-treatment Estimate" on the standard claim form. This completed form should be sent to Rehn & Associates for review and a written estimate of covered services will be sent to the patient/subscriber and the dentist.

USUAL, CUSTOMARY & REASONABLE (UCR)

Some medical services may be paid at Usual, Customary & Reasonable (UCR) charges.

UCR schedule *represent the average or most common amount charged by providers for a particular service, treatment, or supply in the same geographic area. Information on rates for procedures is compiled into a national data bank and updated twice per year. When a claim is submitted for payment that hits the UCR benefit, before making the claim payment, rates are reviewed and double checked to make sure that hospitals and doctors are not billing excessively for the particular service or procedure.*

ALTERNATIVE TREATMENT

Alternative Treatment clause *limits the Plan's payment to the most cost effective treatment of a dental condition that provides a professionally acceptable result as determined by national standards of dental practice. If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Plan's payment will be based on the treatment that provides professionally satisfactory results at the most cost-effective level.*

DENTAL BENEFITS

Class I - Diagnostic and Preventive Services

Diagnostic services are necessary procedures to assist the dentist in evaluating existing conditions to determine the required dental treatment. Preventive services are necessary procedures to prevent the occurrence of oral disease.

Emergency Treatment

Emergency services which; (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this plan. Maximum benefit is limited to one (1) per calendar year.

Dental Provider: Covered at 100% of the UCR schedule

Fluoride Treatments, Child

Fluoride absorbs into the enamel of the teeth making them more resistant to acid producing bacteria. Fluoride Treatments for a child through age eighteen (18). Maximum benefit is limited to two (2) treatments per calendar year for covered persons under 20 years of age.

Dental Provider: Covered at 100% of the UCR schedule

Prophylaxis (Routine Cleaning)

Scaling and polishing procedure performed to remove coronal plaque, calculus and stains. Maximum benefit is limited to two (2) service(s) per plan year.

Dental Provider: Covered at 100% of the UCR schedule

Routine Examinations

An evaluation and recording of the patient's dental health. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, occlusal relationships, conditions, hard and soft tissue anomalies, oral cancer screening, etc. Maximum benefit is limited to two (2) service(s) per plan year.

Dental Provider: Covered at 100% of the UCR schedule

Sealants, Child

Plastic coating applied to grooves of teeth to prevent decay. Sealants for a child through age eighteen (18).

Dental Provider: Covered at 100% of the UCR schedule

Space Maintainers

Dental device that holds the space lost through loss of teeth. Maximum benefit is limited to covered persons under 20 years of age.

Dental Provider: Covered at 100% of the UCR schedule

X-Rays, Bitewings

An x-ray is a non-invasive method of identifying and monitoring diseases or injuries via the generation of images representing the internal anatomic structures of the patient's body. An x-ray of the crown of the tooth. Maximum benefit of one (1) service(s) per plan year.

Dental Provider: Covered at 100% of the UCR schedule

X-Rays, Full Mouth or Panorex

An x-ray of the full mouth or an x-ray of the outside of the mouth, on which the upper and lower jaw are depicted on a single film. Maximum benefit limited to one (1) service per 36 month period.

Dental Provider: Covered at 100% of the UCR schedule

X-Rays, Other X-Rays
Any other necessary x-ray administered by a dental professional.

Dental Provider: Covered at 100% of the UCR schedule

Class II - Basic Dental Services
Dental procedures concerned with the repair or restoration of individual teeth due to decay, trauma, impaired function, attrition, abrasion, or erosion.

Anesthesia Services
Partial or complete elimination of pain sensation; numbing a tooth is an example of local anesthesia; general anesthesia produces partial or complete unconsciousness.

If a dental procedure requires hospitalization due to a medical condition, pre-authorization is required for coverage of the facility and anesthesia charges under the medical plan.

Dental Provider: Deductible, then covered at 80% of the UCR schedule

Fillings/Restorations (other than gold)
Composite fillings, tooth colored fillings (composite) molars; reduce benefit to silver colored fillings (amalgam). Maximum benefit limited to each tooth/surface once every twenty-four (24) months.

Dental Provider: Deductible, then covered at 80% of the UCR schedule

Oral Surgery
Dental specialty concerned with the surgical procedures in and about the mouth and jaw. Limited to extractions, preparation of the mouth for dentures (alveoloplasty) and removal of Small benign cysts.

Dental Provider: Deductible, then covered at 80% of the UCR schedule

Periodontal Maintenance
Dental specialty concerned with diseases of the gums and other supportive structures of the teeth. After an active treatment, maximum benefit is limited to four (4) visits per calendar year.

Dental Provider: Deductible, then covered at 80% of the UCR schedule

Surgical Extractions
Used when a simple extraction is not feasible. A surgical extraction follows the guidelines of general surgery and can be done using local or general anesthesia.

Dental Provider: Deductible, then covered at 80% of the UCR schedule

Class III - Major Dental Services
Replacement of an appliance or dental prosthesis must be at least five (5) years old (5 Year Replacement Clause); or it is due to loss of natural teeth or damaged while in the covered person's mouth.

Bridges (Installation and Repair)
One or more artificial teeth attached, usually on both sides, by crowns to adjacent teeth. It is used to maintain space and function for missing teeth. 5 year replacement clause

Dental Provider: Deductible, then covered at 50% of the UCR schedule

Crowns (Installation and Repair)
A crown or a cap is a cover for a decayed or damaged tooth made of porcelain and/or metal. 5 year replacement clause

Dental Provider: Deductible, then covered at 50% of the UCR schedule

Dentures (Full/Removable Partial)
An artificial substitute for natural teeth and adjacent tissues. 5 year replacement clause

Dental Provider: Deductible, then covered at 50% of the UCR schedule

Dentures (Treatment)
Adjustment, repair, reline, rebase, or tissue conditioning of an artificial substitute for natural teeth and adjacent tissues. Not covered for the first six (6) month after delivery.

Dental Provider: Deductible, then covered at 50% of the UCR schedule

Endodontics (Root Canal Treatment)
Dental specialty concerned with the treatment of diseases of the nerves, blood vessels, etc. within the tooth.

Dental Provider: Deductible, then covered at 50% of the UCR schedule

Full Mouth Debridement
The removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures. Maximum benefit limited to once per three (3) calendar years.

Dental Provider: Deductible, then covered at 50% of the UCR schedule

Implants/Implant Related Services
A surgical component that interfaces with the bone of the jaw or skull to support a dental prosthesis such as a crown, bridge, denture, facial prosthesis or to act as an orthodontic anchor. 5 year replacement clause.

Dental Provider: Deductible, then covered at 50% of the UCR schedule

Periodontal Scaling and Root Planing
The process of removing or eliminating the etiologic agents – dental plaque, its products, and calculus – which cause inflammation, thus helping to establish a periodontium that is free of disease. Maximum benefit limited to each quad once every two (2) calendar years.

Dental Provider: Deductible, then covered at 50% of the UCR schedule

Periodontal Surgery
A plastic (reshaping) surgical procedure designed to restore and regenerate normal form and function to lost and damaged periodontal structures which support the teeth (the gum tissue, periodontal ligament and bone).

Dental Provider: Deductible, then covered at 50% of the UCR schedule

Recementing
Recementing of bridges, crowns, dentures, bridgework onlays or inlays.

Dental Provider: Deductible, then covered at 50% of the UCR schedule

DENTAL EXCLUSIONS

Act of War: any Injury, Illness, or physical disability resulting from any act of war or from explosion of atomic or similar fissionable materials in war (declared or undeclared), armed invasion, or aggression, national disaster, or from any Illness or Injury contracted or incurred during military service, including any complications or recurrences thereof.

Administrative Fees: for telephone consultations, missed appointments, claim form completion, interest charges, legal services, obtaining and/or copying medical records, or Provider travel and/or lodging expenses.

American Dental Association: Expenses that do not meet the standards of dental practices accepted by the American Dental Association will not be considered eligible.

Armed Services: Any condition for which the Veterans Administration or any of the armed services is responsible or to the extent benefits are provided or covered by any governmental agency, except as otherwise provided by law.

Athletic Mouth Guards: Expenses for athletic mouth guards will not be considered eligible**.**

Automobile Coverage: Services and supplies to the extent that benefits are payable under the terms of an automobile medical, automobile no-fault, automobile uninsured motorist and/or underinsured motorist, personal injury protection (PIP), commercial liability, or homeowner's policy, or similar contract or insurance when such contract or insurance is issued to or provides benefits for any Member. Any benefits paid by the Employer contrary to this exclusion are provided solely to assist the Member. By providing such benefits, the Employer is not waiving any right to reimbursement or to subrogation as provided in this Plan.

Complication for Non-Covered Services: No benefits shall be provided for services, supplies, or charges which result from the treatment of any direct or indirect complication of any Injury, Illness, physical disability, or condition for which coverage is not or was not provided.

Congenital Defect: Treatment or services provided to correct any congenital defect or developmental malformation which does not interfere with function.

Cosmetic: Treatments performed to enhance appearance; not a recognized specialty.

Coverage not in effect: Expenses incurred solely because coverage exists or for which the patient has no legal obligation to pay, and expenses incurred prior to the period this Plan was effective.

Criminal or Illegal Act: charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior or by participating in a riot or public disturbance.

Duplicate Devices

Employment: Any Injury or Illness which arises out of and/or in the course of employment for which the Member is covered under the provisions of State or self-insured Industrial Insurance, Worker's Compensation, or any federal act or similar law. Including, but not limited to, DOT licensing fees, pre-employment screenings and evaluations, or vision exams in connection with employment, etc.

Experimental/Investigational: any service or supply which is determined to be Experimental or Investigational on the date furnished. Experimental/Investigational services include, but are not limited to: cloning, gene therapy, genetic testing and other similar services.

Foreign Travel: care, treatment, or supplies received outside of the United States if travel is for the sole purpose of obtaining medical services or care. If medical emergency while traveling please see Other Plan Provisions section 4.

Fraudulent or Misrepresented Charges: Expenses related in any way to billings or statements containing fraudulent information or misrepresentations.

Habit-Breaking Appliances

Hospital Expenses: Expenses for Hospital expenses will not be considered eligible.

Installation or Replacement: Expenses for installation, replacement or alteration of or addition to, dentures and fixed bridgework will not be considered eligible, except as shown in Eligible Dental Expenses.

Insurance Coverage: Any and all services, supplies and benefits that result from or arise out of an accident, occurrence or incident for which there exists any first party medical payment coverage or first party medical reimbursement coverage or any third party liability coverage, to include but not limited to, medical payment coverage, automobile medical, automobile

no-fault coverage, automobile uninsured motorist and/or underinsured motorist coverage, personal injury protection (PIP), automobile bodily injury coverage, automobile liability insurance policy, third-party automobile liability coverage, commercial liability coverage, homeowner's liability coverage, a personal liability umbrella policy or any other similar contract, coverage or insurance policy when such contract or insurance is issued to or provides benefits for any Member. Any benefits which may be paid by the Employer contrary to this exclusion are provided solely to assist the Member in the form of an "advance." By providing such benefits, the Employer is not waiving any right to reimbursement or to subrogation as provided in this Plan.

Integration with Medical Benefits: In the event benefits are available for the same expenses under both the medical and dental provisions of this Plan, such charges will first be considered for payment as a medical expense. The charges will be considered under the dental expenses only if the amount normally paid under the dental expenses exceeds the amount paid under the medical expenses and only up to the excess amount.

Late fees

Medical Services: Services that, to any extent, are payable under any medical expense benefits of the Plan.

No listing: Services which are not included in the list of covered dental services.

Not Performed By a Dentist: Expenses for treatment by other than a Dentist or Physician will not be considered eligible, except charges for treatment performed under the supervision and direction of a Dentist or Physician by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations.

Not Prescribed by a Dentist: Expenses for services not prescribed as necessary by a Physician or Dentist will not be considered eligible.

Occlusion: Expenses for restorations or procedures to splint, change vertical dimension or restore occlusion will not be considered eligible, except as shown in Eligible Dental Expenses.

Oral Hygiene Instruction: Instruction in the process of maintaining cleanliness of the teeth and related structures.

Orthodontic Services - Adult: Orthodontic services for an adult age nineteen (19) and over.

Orthodontic Services - Child: Orthodontic services for a child through age eighteen (18).

Orthognathic Surgery: Surgery performed on the bones of the jaws to change their positions.

Personalization: Expenses for personalization of dentures will not be considered eligible.

Porcelain or acrylic veneers: A thin layer of porcelain or acrylic bonded to a natural tooth to replace lost tooth structure, close spaces, and straighten teeth or change color and/or shape.

Reasonable and Customary: Charges made that are not medically necessary or are in excess of reasonable and customary charges as determined by industry standards.

Replacement: Expenses for replacement of lost or stolen appliances will not be considered eligible.

Services and Supplies: (1) for which a Member is not required to make payment, (2) that are made only because benefits are available under this Plan, or (3) for which a Member would have no legal obligation to pay in the absence of this or any similar coverage.

Services by Relation: Services and supplies furnished by a person who is related by blood, marriage, adoption, or who lives in the Member's home.

Splinting: An appliance used to prevent motion of teeth.

Take-Home Items

Temporary Prosthesis: Expenses for a temporary full prosthesis or for adjustment or relining of a prosthesis within 6 months after the prosthesis is initially furnished will not be considered eligible.

Temporomandibular Joint Dysfunction (TMJ): a condition of facial pain causing muscle spasms in the jaw, dental misalignment, and/or difficulty chewing or swallowing.

Third Party Liability: Services and supplies to the extent that benefits are payable by a liable third party. Any benefits paid by the Employer contrary to this exclusion are provided solely to assist the Member in the form of an "advance." By providing such benefits, the Employer is not waiving any right to reimbursement or to subrogation as provided in this Plan.

Veneers: Expenses for Cosmetic veneers will not be considered eligible.

VISION OVERVIEW

AFFILIATE NETWORKS

Preferred Provider Network
Wrap National Network
First Choice Health Network
Multiplan

Affiliate Networks *are provider networks with whom Rehn & Associates has contracted to ensure that Members have access to Preferred Providers. Please see member identification card(s) for list of Affiliate Networks. These Networks are also referred to as Preferred Provider Organizations (PPO).*

VISION BENEFITS

Examination
Routine vision examinations are a series of tests performed by an ophthalmologist or optometrist (eye doctor) that measure the refraction and visual acuity of the eye and test for disease. Maximum benefit limited to one (1) visit per calendar year.

Preferred Provider:	100% of allowed charges
Non-Preferred Provider:	100% of allowed charges

Hardware
Supplies which correct or improve function of the eye. Maximum benefit of $300 per calendar year combined for all vision hardware.

Preferred Provider:	100% of allowed charges
Non-Preferred Provider:	100% of allowed charges

Contacts
A thin curved glass or plastic lens designed to fit over the cornea in order to correct vision or to deliver medication.

Frames
A supporting structure for your prescription lenses.

Lenses, Bifocals
Eyeglasses incorporating two different powers in each lens, usually for near and distant corrections.

Lenses, Lenticular
A more complex lens, usually for post-cataract vision issues.

Lenses, Progressive Lenses
Progressive, or no-line, lenses have no dividing line as focus changes from top to bottom.

Lenses, Single Vision
Eyeglasses for those who are either farsighted or nearsighted.

Lenses, Trifocals
Eyeglasses incorporating two or more different powers in each lens.

Other Vision Hardware
Additional vision hardware services including scratch resistant coating, tinting, etc.

ELIGIBILITY REQUIREMENTS

1. The Plan Administrator has the discretionary authority to determine eligibility for benefits, to construe the terms used in The Plan Administrator has the discretionary authority to determine eligibility for benefits, to construe the terms used in this Plan and to interpret the terms of the benefit Plan, except as provided under Plan Processes. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all.

2. In order for an applicant to become entitled to or a member to continue the benefits of this Plan, the following qualifications must be met:

   2.1 An enrolled employee hereunder is any employee as to whom each and all of the following qualification exists:

   - The employee must be in a benefit eligible position working one hundred thirty (130) or more hours per month and;
   - The employee must have completed the one (1) month orientation period as well as the sixty (60) day waiting period.
   - The employee must be a U.S. citizen or legally authorized to work in the United States;
   - The employee must be actively at work or on an approved benefit eligible leave or receiving salary continuation; and
   - The employee must submit all enrollment paperwork completed and on schedule. Newly eligible employees must submit their paperwork to the Benefits Office in Human Resources within 60 days from date of hire.

   2.2 An enrolled dependent hereunder is any dependent as to whom the following qualifications exist:

   - The legal spouse of the Subscriber; or
   - Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1, 2016. For more information contact your Human Resources Department.
   - Enrolled dependent children through eighteen (18) years of age.
   - Overage dependent if they are between the ages of nineteen (19) through age twenty-five (25); further a dependent child must be one of the following:
     - A natural, step, or adopted child of the Subscriber, a child placed for adoption;
     - A legally placed ward in the Subscriber's home;
     - A child of a divorced Subscriber if the child is not self-supporting; or
     - A foster child is not eligible.
     - Dependent child(ren) whose coverage must continue pursuant to a state court's medical child support order (Qualified Medical Child Support Order, (QMCSO)).

3. Subscribers and their dependents may, without special or late enrollment status, apply for coverage when they initially become eligible. Annually thereafter, members must participate in the Employer Group open enrollment process. All rules regarding mid-year changes are according to IRS regulations.

4. If a family status change occurs such as marriage, divorce, legal separation, birth, death, change in spouse's employment that affects health care coverage, the Subscriber must contact the Human Resource office within sixty (60) days of the event. Newborn Children or children placed for the purpose of adoption may be added within sixty (60) days of the event, coverage will be effective the date of the birth/adoption. New enrollment due to marriage will be effective the first of the month following the date of marriage. Premiums may apply from the effective date of eligibility.

5. Prior to legal finalization of an adoption, the coverage provided herein shall continue until the first of the following events occurs: (1) the date the child is removed permanently from placement, or (2) the date the Subscriber rescinds, in writing, the agreement of adoption and the agreement assuming financial responsibility. If one of the foregoing events occurs, coverage shall terminate on the last day of the month in accordance with the Plan rules and practices.

6. Any unmarried child enrolled who is, or becomes incapable of self-sustaining employment by reason of developmental disability or physical handicap prior to reaching his or her twenty-sixth (26th) birthday and who is primarily dependent upon the Subscriber for support and maintenance, shall not be terminated so long as this Plan remains in force and the dependent remains in such condition, provided the Subscriber maintains coverage under this Plan, if the Subscriber has, within thirty-one (31) days of such dependent's reaching age twenty-six (26), submitted proof of such dependent's incapacity as herein described. The Plan will require subsequent proof of the dependent's disability and dependency.
7. In the absence of fraud, all statements made by applicants or Members shall be deemed representations and not warranties. No statement made for the purpose of effecting coverage shall void such coverage or reduce benefits unless such statement is contained in a written instrument signed by the Subscriber.

Leave of Absence

Coverage for Subscribers and enrolled Dependents may be continued during an employer approved leave of absence, provided the Subscriber submits the appropriate monthly contribution amount. Refer to the companies Personnel Policies for information concerning the employee's Leave of Absence or Family Medical Leave Act. To continue dependent coverage during a benefit eligible leave, the Subscriber must make monthly premium contributions directly to your Employer.

Termination

Your eligibility for Plan benefits terminates on the date of termination in which employment is terminated. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you or your dependents submit false claims, or fail to submit Coordination of Benefits information in a timely manner after enrollment, etc. Coverage for your spouse and dependents terminates when your coverage terminates. Their coverage will also cease for other reasons, such as divorce, the dependent child attaining the overage limit, etc. Benefits will also cease for employees, spouses and dependents on the termination date of the Plan. Depending on the reason why coverage was terminated, you and your covered spouse and dependents might have the right to continue coverage temporarily under COBRA. See the "Continuation of Coverage - COBRA" section of this booklet.

ENROLLMENT

Annual Enrollment

Each year during annual enrollment, the member may choose the benefit options the member wants by completing a new enrollment form. The member may change options or add coverage for the member's family during the annual enrollment period. Most selections the member makes are in effect for one calendar year. However, the employer reserves the right to amend, delete or terminate any of the plans or plan provisions described at any time, with or without notice. The time period for enrolling is limited.

Special Enrollment

Special enrollment rules apply to the member's medical benefits. Under these rules, if the member declined medical coverage for themselves or eligible family members because the member had other coverage, the member may be able to enroll themselves and the member's dependents in the Health Care Plan within a thirty (30) day special enrollment period after other coverage ends.

To be eligible for special enrollment, the loss of coverage must have been due to loss of eligibility (for example, resulting from divorce, death, termination of employment or reduction of hours of employment) or termination of employer contributions toward the coverage.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), effective 4/1/09, amends the Internal Revenue Code to require a group health plan to permit an employee who is eligible, but not enrolled, for coverage under the plan to enroll if either of the following conditions are met: (1) the employee or dependent covered under Medicaid or CHIP has coverage terminated as a result of loss of eligibility, and the employee requests coverage under the group health plan within 60 days after such termination; or (2) the employee or dependent becomes eligible for Medicaid or CHIP assistance if the employee requests coverage within 60 days after the eligibility determination date.

Change in Status

Except for special enrollment, you may only change your medical coverage elections once per year during the annual open enrollment. Elections made during that time apply for the entire Plan Year. Please refer to above Eligibility section regarding time frames for status changes.

A change in status includes:

- Marriage, divorce, or legal separation
- Death of your spouse or dependent
- Birth, adoption, or placement for adoption of a child
- Employment status, such as the beginning or ending of employment.
- Work schedule, such as a switch between part-time and full-time or a strike or lockout, or commencement or return from an unpaid leave of absence that results in a gain or loss of coverage eligibility.
- Changes in your member's dependent's age status or other factor affecting his or her eligibility.
- Open Enrollment of spouse's employer.

Any changes made in elections must be consistent with the change in status.

COORDINATION OF BENEFITS

All of the benefits under this Plan are subject to these provisions:

1. Your "Certificate of Continuing Coverage" or "HIPAA Certificate" is required when coverage under the Plan other than your Employer Plan begins or ends. Failure to provide Coordination of Benefits information may result in delay of coverage or temporary termination of coverage until information is received.
2. Benefits shall be provided under this Plan to the extent that the Member could not have received benefits for the same services under any other Plan had a claim been made. If the other Plan has a coordination of benefits provision and if the benefits provided under this Plan and all other Plans under which the Member is covered would exceed the Allowed expense for the claim being processed, then this coordination of benefits provision will apply. This means that the benefits under this Plan and all other Plans under which the Member is covered will be reduced so that the sum of the benefits of all Plans shall not exceed the lesser of the other Plan Allowed Charge or Rehn & Associates Allowed Charge for that claim. If the benefits of this Plan are reduced because of this coordination of benefits provision, each claim during that Plan Year will be processed as it is received by Rehn & Associates and previous benefit reductions during that Plan Year will be taken into consideration in determining the amount to be paid. The benefits of the other Plan shall include all benefits that would have been payable had the claim been duly made therefore.
3. If both this Plan and the other Plan provide that the benefits of this Plan must first be exhausted, the other Plan may be ignored in determining benefits under this Plan; but otherwise the following rules shall establish the order of benefit payment under this Plan and the other Plan:
    - 3.1 The benefits of a Plan that cover the Member other than as a dependent shall be exhausted first.
    - 3.2 The benefits of a Plan that cover the Member as the Dependent of the parent whose birthday (day and month only) falls earlier in a year are determined before those of the parent whose birthday falls later in that year. If the other Plan does not have this rule and the two Plans do not agree on the order of benefits, the rule in this Plan will be administered as if the other plan contained this rule. If such Member is a Dependent child whose parents are separated or divorced, the following rules shall apply:
        - 3.2.1 If the parent with custody has not remarried, the benefits of the Plan of the parent with custody will be exhausted before the Plan of the parent without custody.
        - 3.2.2 If the parent with custody has remarried, the benefits of the Plan that cover the child will be exhausted in the following order:
            - 3.2.2.1 Plan of the parent with custody
            - 3.2.2.2 Plan of the spouse of the parent with custody
            - 3.2.2.3 Plan of the parent without custody
            - 3.2.2.4 Plan of the spouse of the parent without custody
        - 3.2.3 Notwithstanding, if there is a court decree that established financial responsibility for the health care of the child, the benefits of the Plan that covers the child as the dependent of the parent with such financial responsibility shall be exhausted first.
        - 3.2.4 When rules 1 and 2 above do not establish an order of benefit determination, the benefits of a Plan that

has covered the individual receiving services for the longer period of time shall be applied before the benefits of a Plan that has covered such individual the shorter period of time. In the event the individual receiving services has been covered for the same period of time under both Plans, the benefits of the Plan which has covered the Subscriber for the longer period of time shall be applied before the benefits of the Plan which has covered the Subscriber for the shorter period of time, provided that:

3.2.4.1 The benefits of a Plan covering the person on whose expenses claim is based as a laid off or retired employee, or Dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid off or retired employee, or Dependent of such person; and

3.2.4.1 If either Plan does not have a provision regarding laid off or retired employees, which results in each Plan determining its benefits after the other, then the provisions of (1) of this subsection shall not apply.

Eligibility and Plan Verification

Rehn & Associates shall provide a contact person, available during normal business hours, for Providers to further verify the eligibility, plan benefits, and obtain billing information for Members. Providers shall be entitled to rely on Rehn & Associates verification of a Member's eligibility under the Plan.

STANDARD PLAN PROVISIONS

Information You Need To Know

1. Rehn & Associates has contracted with Preferred Provider Organizations (PPO) nationwide to offer Providers from which you may access your health care services. To receive the maximum benefits of this Plan, a PPO Provider must provide such services.

2. Rehn & Associates will act as third party administrator and claims processing fiduciary for this self-funded plan. Community Connections, Inc., as a self-funded employer, is the Plan Administrator with discretionary authority to determine eligibility for benefits, and to construe and interpret the terms of the Plan, except as delegated to Rehn & Associates under Plan Processes.

3. The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason, with or without notice. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility, etc.

4. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan. Members are responsible for any copay, coinsurance and deductible amounts as defined in this Plan, as well as Non-Covered Services and amounts in excess of Rehn & Associates allowed charge when services are provided by a Non-Preferred Provider. Amounts in excess of the Member's copay, coinsurance, deductible and the payment by Rehn & Associates for covered services rendered by a Preferred Provider shall be considered to be contractual adjustments and shall not be billed to the Member.

5. The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage begins or after coverage is terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force, except as outlined in the current Employer Payer Agreement. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment or elimination.

Other Plan Provisions

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

coverage until information is received. Fraudulent use of Coordination of Benefits rules will result in automatic termination of eligibility. See the "Coordination of Benefits" section of this booklet.

2. If there is not a Preferred Provider within twenty-five (25) miles of your home, benefits for services will be reimbursed as if a Preferred Provider provided the services.
3. Non-emergency care at an emergency room will not be covered.
4. If you are traveling outside of the United States of America and require treatment for an injury or medical emergency, any payments you make for medical treatment may be reimbursed, provided the following guidelines are met:
   - The Plan must have authorized Rehn & Associates to reimburse Plan Members for emergency treatment incurred outside of the United States. If authorization has not been given, the following procedures do not apply.
   - Members must pay for medical services at the time of service.
   - Upon returning to the United States, submit an itemized statement of charges that includes diagnosis, and all charges paid. The exchange rate for foreign currency must also be noted on submitted forms.
   - Charges submitted must be for a serious injury medical emergency.
   - Claims in a foreign language must be submitted in English.
   - Claims will not be reimbursed for non-covered services or for services that are determined to be not medically necessary.

Preferred and Non-Preferred Providers

A Preferred Provider is a Physician, Hospital, or other Provider, as herein defined, who or which has contracted with a PPO to provide covered services to Members and to accept the Member's Deductible, Copay, and Coinsurance, plus the benefit payment as payment in full.

A Non-Preferred Provider is defined as a Provider which does not have a current contract with a Preferred Provider Organization (PPO). Services provided by a Non-Preferred Provider shall be reimbursed according to the plan's Non-Preferred Provider benefit level. Any balance remaining after the admistrator's payment shall be the responsibility of the Member.

Plan Processes

Rehn & Associates as the claims processing fiduciary is responsible for evaluating all benefit claims and is vested with full discretionary authority to approve or deny claims and appeals, and to interpret the Plan as necessary to do so, including for example determining whether treatment is "medically necessary" or "experimental." Rehn & Associates may delegate certain administrative or claims processing tasks to subcontractors for review.

Claims Filing

Claims for services will be submitted for you. For office visits and prescriptions, you will pay either a copay or coinsurance at the time of service. For other types of services, you will typically receive a bill from your provider for the balance you owe after the Plan has paid its portion of your claim.

Occasionally, you may need to file a claim directly to Rehn & Associates. Here's how to file a claim:

1. Obtain a Rehn & Associates claim form from your Human Resources office or download one at the Community Connections, Inc. website.
2. Complete and sign the form.
3. Attach the itemized doctor, hospital or other health care provider bill to your completed claim form. Rehn & Associates will accept any form that contains all of the itemized information necessary to process and pay benefits.
4. Submit the completed Statement of Claim form and attached bills within 90 days after the date of service to:

Community Connections, Inc.
Health Care Plan
PO Box 5433
Spokane, WA 99205

If all coverage and eligibility requirements are met, the benefit payment will be sent directly to the patient, or to the Assigned Provider of Services (your hospital, doctor, clinic, etc.) The deadline for submitting benefit claims is one year from the date of service: Claims submitted more than 12 months after the date of service will not be paid.

If all coverage and eligibility requirements are met, the benefit payment will be sent directly to the patient, or to the Assigned Provider of Services (your hospital, doctor, clinic, etc.) The deadline for submitting benefit claims is one year from the date of service: Claims submitted more than 12 months after the date of service will not be paid.

Clean Claim Submission

No benefits shall be provided for any claim submitted more than twelve (12) months from the date services were rendered. If your claim is denied, you may appeal to Rehn & Associates for a review of the denied claim. Your appeal will be decided in accordance with reasonable claims procedures, as required by ERISA. See the "Appeal Process" section of this booklet.

APPEAL PROCESS

Procedure for Disputed Claims

In the event that a claim for benefits is denied, the following is the procedure for you to appeal a claim;

If your claim is denied in whole or in part, the third-party administrator (TPA) shall notify you of the denial and will include the specific reasons for the denial and specific plan provisions or IRS rules or regulations upon which the denial is based and a description of any material necessary for your claim to be processed. Within 15 days from the date your request for claim was received, the TPA may extend the period by which it expects to render its decision on your claim to a period not to exceed 60 days and shall notify you in writing of the extension.

If your claim is denied, you or your authorized representative may appeal the denial in writing to the Plan Sponsor. You have 180 days from the date you receive the written notification of your denial to make your appeal. You will have the right to review pertinent documents and submit written issues and comments concerning your claim request to the Plan Sponsor.

After the Plan Sponsor receives your request of an appeal by you or your authorized representative, the Plan Sponsor shall consider your appeal within 60 days from the time that your request for review was received.

In special circumstances, the Plan Sponsor may request a 60-day extension to review the decision. The Plan Sponsor’s decision shall be furnished to you and shall include specific reasons for their decision and specific references to pertinent plan provisions or IRS rules or regulations on which the decision was based.

The Plan Sponsor may determine that a hearing is required to properly consider a claim that has been requested for review. In that event, if the Plan Sponsor determines such a hearing is required, such determination shall constitute special circumstances permitting an extension of time in which to consider the claim that is requested for review.

APPLICABLE FEDERAL LAW

Compliance with Law and Court Orders

Rehn & Associates processes claims in compliance with applicable Washington State and Federal law. In the event a court of competent jurisdiction enters a Qualified Medical Child Support Order (QMCSO) or other order regarding enrollment of or payment of medical expenses for a dependent child or alternate recipient, a copy of such order must be provided to the member's employer. Rehn & Associates shall comply, as directed, with any such order to the extent required by law. For more information see the "Qualified Medical Child Support Orders" section of this booklet.

Family Medical Leave Act

This Plan shall be administered to accommodate the specific requirements of the Family and Medical Leave Act of 1993 (Public Law 103-3), the Act. Any term or provision of this Plan relating to eligibility for coverage that contradicts or conflicts with the express terms of the Act is hereby declared invalid. The Policyholder shall keep Rehn & Associates advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by the Act.

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn

earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Mental Health Parity Act

The Mental Health Parity Act (MHPA), signed into law on September 26, 1996, requires that annual dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan.

MHPA applies to group health plans for plan years beginning on or after January 1, 1998. The original sunset provision (providing that the parity requirements would not apply to benefits for services furnished on or after September 30, 2001) has been extended several times. If you have questions about the sunset provision, contact the EBSA office nearest you.

The law:

- Generally requires parity of mental health benefits with medical/surgical benefits with respect to the application of aggregate annual dollar limits under a group health plan
- Provides that employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity)

The law, however, does not apply to benefits for substance abuse or chemical dependency.

The law also contains the following two exemptions:

- Small employer exemption. MHPA does not apply to any group health plan or coverage of any employer who employed an average of between 2 and 50 employees on business days during the preceding calendar year, and who employs at least 2 employees on the first day of the plan year
- Increased cost exemption. MHPA does not apply to a group health plan or group health insurance coverage if the application of the parity provisions results in an increase in the cost under the plan or coverage of at least one percent

Qualified Medical Child Support Orders

The Employee Retirement Income Security Act of 1974 (ERISA) and the Child Support Performance and Incentive Act of 1998 (CSPIA) require the Employer to take certain actions to help enforce state administrative and court orders for medical child support.

The Employer adopts the following procedures under ERISA to determine whether medical child support orders qualify with ERISA's requirements and thus are to be carried out. The Employer may modify or terminate these procedures to satisfy legal requirements.

A qualified medical child support order (QMCSO) establishes a child's right to receive benefits for which a plan participant or qualified beneficiary for continuation of coverage is eligible, and which the Plan has determined meets the requirements to be a qualified medical child support order.

A medical child support order must:

- Specify the name and last known mailing address of the participant and the name and mailing address of each child covered by the order; and,
- Include a reasonable description of the type of coverage to be provided by the Plan to each child, or the manner in which such type of coverage is to be determined; and,
- Specify each period to which such order applies; and,
- Specify each plan to which such order applies.

A QMCSO must not require the Plan to provide any type or form of benefit or any option not otherwise provided under the Plan, except to meet requirements of Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

Upon receiving a medical child support order from a court of law, Rehn & Associates shall:

- Promptly notify in writing the Participant, each child covered by the order, and each representative for these parties of the receipt of the medical child support order. The notice shall include a copy of the order and these QMCSO

procedures for determining if the order is qualified;
- Permit the child to designate a representative to receive copies of notices sent to the alternate recipient regarding the medical child support order;
- Within a reasonable time after receiving a medical child support order, determine if it is qualified and notify the participant and child(ren) subject of the order; and

Once the order is determined to be qualified, ensure the child is enrolled according to plan terms and the order and is otherwise treated by the Plan as a covered beneficiary for ERISA reporting and disclosure purposes. As such, the plan will distribute to the child a copy of the Summary Plan Description (SPD) and any subsequent material modifications adopted by the plan sponsor.

In the event the Plan receives a state administrative or court medical child support order under CSPIA requiring the Employer to withhold employee contributions for group health coverage for a child, the Employer will determine whether the employee is covered or eligible under the plan, and whether the child may be eligible under the plan.

After the Employer determines the employee is subject to income withholding to pay for the child's coverage, the Employer and/or Rehn & Associates, shall notify the employee, the child and the child's custodial parent (when that is not the employee) that coverage is or will become available. The Employer and/or Rehn & Associates will furnish the custodial parent a description of the coverage available, the effective date of the coverage and any forms, documents or other information needed to put such coverage into effect, as well as information needed to submit claims for benefits.

The Employer will determine whether employee contributions are available to pay for the child(ren)'s coverage. If such funds are available, the Employer will withhold such contributions from the employee's income and notify the employee to that effect.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are on voluntary or involuntary duty with certain uniformed services (e.g. the U.S. Armed Forces, National Guard, or commissioned members of the Public Health Service), coverage under your medical plan remains in effect for you and your enrolled dependents for the lesser of the period of your leave or twenty-four (24) months, as long as you pay your portion of the premium. Active duty includes: active duty, active duty for training, inactive duty training, full-time National Guard duty, and an absence for the purpose of determining your fitness to perform any of these types of duties.

If your leave is thirty (30) days or less, you are required to pay the same amount to maintain coverage as an active employee. If your leave is for thirty-one (31) days or longer, you are required to pay 102% of the full cost of coverage (employer and employee contributions) as described in the COBRA section of this document.

STATEMENT OF YOUR RIGHTS UNDER ERISA

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants may be entitled to:

- Examine, without charge, at the Trust Administrative Office and at all local union offices upon 10 days written request, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon 10 days written request to the Employer. The Employer may impose a reasonable charge for the copies. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies.
- Receive a summary of the Plan's annual financial report. The Employer is required by law to furnish each participant with a copy of this summary annual report. This requirement is applicable to groups of one hundred (100) members or more.
- File suit in a federal court if any materials requested are not received within 30 days of a participant's request, unless the materials were not sent because of matters beyond the control of the administrator. The court may require the Employer to pay up to $110 for each day's delay until the materials are received.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the employee benefits plan. These persons are referred to as “fiduciaries” of the Plan. Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of their Plan duties.

In the event Plan fiduciaries misuse the assets of the Plan, you may request assistance from the U.S. Department of Labor or sue in federal court, which may award you costs of suit, including your attorney fees if you are successful. If you are not successful, the court may award you with the Trust attorney fees.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D. C. 20210.

All questions with respect to Plan participation, eligibility for benefits or the nature and amount of benefits, or with respect to any matter of Plan administration, should be referred to the office of:

Rehn & Associates
PO Box 5433
Spokane, WA 99205
(509) 534-0600 / (800) 872-8979

IMPORTANT STATEMENTS

Access to Service

Failure to satisfy Plan requirements or meet criteria does not deny access to service. It does, however, result in reduced payment or denial of payment for non-authorized services. Charges for those services will be the financial responsibility of the member.

Authorization as to Medical Information

Members, for themselves, their heirs, executors, administrators, and assigns, do hereby expressly authorize any Provider to fully impart to Rehn & Associates any and all medical information or knowledge acquired by such Provider with reference to such member, by means of examination or otherwise, either prior to or subsequent to the effective date of this Plan, and further authorize Rehn & Associates to examine all professional and institutional records pertaining to such member's physical and/or mental condition.

Hold Harmless

Members are responsible for applicable Deductibles, Copays and Coinsurance amounts for Covered Services, as identified in this Plan under the schedule of benefits. Any balances remaining after such amounts, and Rehn & Associates benefit payment for Covered Services, shall be treated as contractual adjustments by PPO Providers and shall not be billed to the Member. Any balances after Rehn & Associates payment to Non-Preferred Providers shall be the responsibility of the Member. The Member is one hundred percent (100%) responsible for non-covered services as billed by any provider.

Limitations of Liability

Providers rendering services to Members are as to Rehn & Associates solely independent contractors and are not agents of Rehn & Associates for any purpose hereunder. Rehn & Associates shall have no liability whatsoever for any negligence, act, failure to act, or omission on the part of any such Provider, employees of such Provider or any other person. Rehn & Associates shall not be liable to any person or entity for the inability or failure to procure or provide the benefits of this Plan by reason of epidemic, disaster, provider terminations, or other cause or condition beyond the control of Rehn & Associates.

Member Rights and Responsibilities

Failure to satisfy plan requirements or meet criteria does NOT deny access to service. It does, however, result in reduced payment or denial of payment for non-authorized services or services not rendered by a specific provider. Charges for those services will be your responsibility.

By taking part in the responsibility for your care you are entitled to certain rights:

- You have the right to be informed. Be sure you understand the features and requirements of this Plan. This booklet is designed to provide you with details of your coverage including covered services as well as exclusions, limitations, and other terms and conditions.
- You have a right to expect considerate courteous treatment with respect to your privacy and dignity. Information regarding your health care will be kept confidential, unless you have given written permission to release information

or if information is required by law.

- You have a right to ask questions and participate in making decisions involving your health and medical care. You have the right to refuse treatment and be informed of the possible consequences for refusing treatment.
- You have the right to receive information about your medical conditions, health status, the recommended course of treatment, choices, and risks involved. You have the right to a second opinion.
- It is your responsibility to present your identification (ID) card to Providers at the time service is performed.

It is your responsibility to give accurate and complete medical information to all Providers, follow medical advice and ask questions if you do not understand or need an explanation.

Non-Assignability

The benefits hereunder shall not, by the Member or any person entitled thereto, be pledged, hypothecated, encumbered, or assigned.

Payment of Monthly Contribution by Subscriber in Event of Suspension of Compensation due to Labor Dispute

If there is a suspension of compensation because of a lockout, strike or other labor dispute, a Subscriber may make payment of monthly contribution directly to the employer for a period not exceeding six (6) months. It is the responsibility of the employer to immediately notify the Subscriber of his or her right to make payments when such Subscriber's compensation is suspended or terminated.

Vesting of Policies

Under no circumstances does a Member acquire a vested interest in continued receipt of a particular benefit or level of benefits. If benefits for a service or supply are eliminated or modified for a new Plan Year, or during the Plan Year, benefits shall not be provided for those services or supplies rendered after the effective date of the elimination or modification. There will be no grandfathering of benefits. No oral or written statements or representations given in good faith by any person, including employers, agents, or representatives of Rehn & Associates or the self-funded employer, can change, alter, delete, add, or otherwise modify the expressed written terms of this Plan or a validly executed endorsement to this Plan, even if the statements or representations are misleading or incorrect.

Wrongful Payment

Should Rehn & Associates make any incorrect payments or overpayments for services or supplies provided to a Member or ineligible person, the Plan shall be fully reimbursed by the reprocessing of those incorrectly processed claims.

SUBROGATION

If a Member (Subscriber or Dependent) receives benefits under this Plan for treatment of Injuries resulting from the act or omission of another person, firm, or corporation (or, "third party"), the Plan shall be subrogated to all of the rights of the Member or the personal representative of a deceased Member to recover compensation or damages to the extent of all payments made by the Plan.

The Member or his or her personal representative shall notify Rehn & Associates in writing of the facts of the accident or occurrence and the name and address of the party who may be responsible. The Member shall do nothing to prejudice the Plan's subrogation rights and shall cooperate fully with Rehn & Associates including providing advice as to the status of the Member's claim and prior notification of any proposed litigation or settlement.

Expenses that are the responsibility of a third party are excluded under this Plan. Rehn & Associates and the self-funded employer shall have no liability for claims paid by any third party. Please see the Exclusions "Automobile Coverage" and "Third Party Liability." The Plan may "advance" benefits pending a recovery sum which will reimburse the self-funded employer for claims paid. The Member or personal representative of the Member will be asked to sign a reimbursement agreement before benefits are advanced on behalf of the Member. There is no waiver of rights by the employer if an "advance" of benefits is made without a signed agreement.

If reasonable collection costs and reasonable legal expenses have been incurred by the Member or his or her personal representative in recovering medical expenses which have been previously paid by the Plan, whether by an action for damages or otherwise, the amount of the subrogation claim of the Plan shall be proportionately reduced to no less than two-thirds (2/3) of the total amount paid by the Plan in connection with Injuries related to such accident. However, the Plan

does not pay for, nor is it responsible for the payment of participants' attorney's fees. Attorney's fees are to be paid solely by the participant.

The Plan is entitled to recovery:

- As a first priority claim.
- Regardless of the characterization of the settlement or judgment.
- Even if the participant is not "made whole." As medical expenses are considered damages, when a third party is liable. This agreement requires the good faith cooperation of all parties involved.

The Member shall cooperate by reimbursing the Plan from any recovery received.

The Member shall not interfere with the Plan's right to recover. Neither will the Plan interfere with the Member's right to receive a settlement.

The Member shall consult with the Plan before taking any steps to recover. If a third-party recovery is being considered, please call Rehn & Associates and ask to speak to the Claims Coordinator concerning third-party liability.

The Member shall keep the Plan informed of all developments in their recovery efforts.

Motor Vehicle Coverage

Most motor vehicle insurance policies provide medical expense coverage and uninsured and/or underinsured motorist insurance. The term motor vehicle insurance includes medical expense coverage, personal injury protection coverage, uninsured motorist coverage, underinsured motorist coverage, or any coverage similar to any of the coverages listed prior. Benefits for health care expenses are excluded under this Plan to the extent that you or your enrolled dependent receives payments from medical expense coverage, personal injury protection coverage, uninsured motorist coverage, or underinsured motorist coverage.

Here are some rules which apply with regard to motor vehicle insurance coverage:

1. If a claim for health care expenses arising out of a motor vehicle accident is filed with the Plan and motor vehicle insurance has not yet paid, benefits for covered expenses under the Plan may be advanced as long as you or your enrolled dependent agrees in writing:
    - To give Rehn & Associates information about any motor vehicle insurance coverage which may be available to you or your enrolled dependents; and
    - To otherwise secure the Plan's rights and you or your enrolled dependent's rights.
2. If the Plan has paid benefits before motor vehicle insurance has paid, the Plan is entitled to reimbursement of the benefits it has paid out of any subsequent motor vehicle insurance recovery or payment made to or on behalf of you or your enrolled dependent.
3. If you or your enrolled dependent incurs health care expenses for treatment of the illness or injury arising out of a motor vehicle accident after receiving a recovery from uninsured or underinsured motor vehicle coverage, benefits for otherwise covered expenses under the Plan will be excluded until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount (as defined in the "Third Party Liability" section of this booklet).
4. You or your enrolled dependent who was involved in a motor vehicle accident may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the "Third Party Liability" provision in this booklet apply. However, double reimbursement will not be sought.

Third Party Liability

This provision applies when you or an enrolled dependent incurs health care expenses in connection with an illness or injury for which one or more third parties may be responsible. In that situation, benefits for otherwise covered expenses are excluded under this Plan to the extent you or your enrolled dependent receives a recovery from or on behalf of the responsible third party regardless of whether you or your enrolled dependent is made whole by recovery from the third party.

Here are some rules which apply in these third party liability situations:

1. If a claim for health care expense is filed under the Plan and you have not yet received recovery from the responsible person, benefits under the Plan may be advanced for covered expenses if you or your enrolled dependent agrees in

writing to hold any recovery in trust for the Plan up to the amount of benefits paid under the Plan. You or your enrolled dependent may be required to sign an agreement guaranteeing the plan's rights to full reimbursement before any benefits under the Plan are advanced.

2. If benefits under the Plan have already been paid, the Plan will be entitled to full reimbursement of the benefits it has paid from the proceeds of any recovery you or your enrolled dependent receives from or on behalf of the third party regardless of whether you or your enrolled dependents are made whole by recovery from the third party.
3. The Plan is entitled to full reimbursement of the benefits it has paid as explained previously regardless of whether:

   3.1 the recovery is the result of a court judgment, arbitration award, compromise settlement, or any other arrangement;

   3.2 the third party or the third party's insurer admits liability; or

   3.3 the health care expenses are itemized or expressly excluded in the third-party recovery.

The Plan will not pay any fees or costs associated with a claim/lawsuit by you or your enrolled dependent against the third party.

If you or your enrolled dependent incurs health care expenses for treatment of the illness or injury after receiving a recovery exceeding full compensation for the loss, benefits under the Plan for otherwise covered expenses will be excluded until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount.

The net recovery amount is:

- The amount of the recovery; plus
- The amount you or your enrolled dependent recovered from any other source such as other insurance as a result of the illness or injury; minus
- The difference between the total amount of related third-party health expenses incurred prior to the recovery and the benefits paid under the Plan before the recovery toward such expense; minus
- The amount you or your enrolled dependent reimbursed to the Plan or other insurers or lien holders out of the recovery for benefits paid under the Plan before the recovery; minus
- The total costs paid by you or your enrolled dependent or on your or your enrolled dependent's behalf in obtaining the recovery such as reasonable attorney fees and court costs.

Workers' Compensation

This provision applies if you or your enrolled dependent has filed or is entitled to file a claim for workers' compensation. Benefits for treatment of an illness or injury arising out of or in the course of employment or self-employment for wages or profit are excluded under this Plan. The only exception would be if you or your enrolled dependent is exempt from state or federal workers' compensation law.

Here are some rules which apply in situations where a workers' compensation claim has been filed:

1. You must notify Rehn & Associates in writing within ten days of filing a workers' compensation claim.
2. If the entity providing workers' compensation coverage has denied you or your enrolled dependent's claims and you have filed an appeal, benefits under the Plan for covered expenses may be advanced if you or your enrolled dependent agrees in writing to hold any recovery you or your enrolled dependent obtains from the entity providing workers' compensation coverage in trust for the Plan up to the amount of the benefits it has paid. You or your enrolled dependent may be required to sign an agreement guaranteeing the Plan's rights to reimbursement before any benefits are advanced.
3. If the benefits under the Plan have already been paid, the Plan will be entitled to reimbursement of the benefits it has paid from the proceeds of any recovery you or your enrolled dependent receives from or on behalf of the entity providing workers compensation coverage.
4. The Plan is entitled to full reimbursement of the benefits it has paid from the proceeds of any recovery you or your enrolled dependent received from or on behalf of the entity providing workers' compensation coverage. This is so regardless of whether:

   4.1 The recovery is the result of an arbitration award, compromise settlement, or any other arrangement;

4.2 The entity providing workers' compensation coverage admits liability; or

4.3 The health care expenses are itemized or expressly excluded in the recovery.

5. A deduction of a proportionate share the reasonable expenses of obtaining a recovery such as attorney fees and court costs will be allowed from the amount reimbursed to the plan.

6. If you or your enrolled dependent incurs health care expenses for treatment of the illness or injury after receiving a recovery, benefits under the plan for otherwise covered expenses will be excluded until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount, as defined in the "Third Party Liability" section of this booklet.

CONTINUATION OF COVERAGE - COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This outline is intended only to summarize your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires and this Notice should be construed accordingly.

The Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272 (COBRA) is a federal law that applies to employers of twenty (20) or more employees. This law gives enrolled Members the right, in certain circumstances, to continue coverage under their employer's health plan for a limited time beyond the date coverage would otherwise have been terminated. Continued coverage is not automatic. Under COBRA, a qualified individual must apply for continued coverage within a certain time period and may also have to pay the full cost for the coverage plus 2%.

References below to the "Plan Administrator" generally refer to your employer and references to the COBRA Administrator refer to Rehn & Associates.

Conditions for Continuation of Coverage under COBRA

1. For COBRA continuation coverage to become effective, all of the following requirements must be satisfied:
   - The qualified individual(s) must elect continued coverage no more than thirty (30) days after either the date coverage was to end because of a "qualifying event", or the date he or she is notified of the right to continue coverage, whichever is later.
   - The qualified individual(s) must send the initial required premium payment to the COBRA Administrator, not more than forty-five (45) days after the date he, she, or they have elected continued coverage.
   - Subsequent required premiums must be paid monthly to the COBRA Administrator.
2. A qualified individual must be notified of his or her rights under COBRA within forty-four (44) days of the date the Plan Administrator receives notice of the qualifying event.
3. The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan or COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the employer must notify the Plan Administrator of the qualifying event within sixty (60) days of any of these events.
4. For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan or COBRA Administrator. The Plan requires you to notify the Plan or COBRA Administrator within sixty (60) days after the qualifying event occurs.

Qualifying Events:

1. COBRA may be elected for up to eighteen (18) consecutive calendar months for an employee and his or her covered dependents if the "qualifying event" is that:
2. The employee's work hours are reduced resulting in a loss of eligibility for medical benefits; or,
3. The employee's employment terminates (voluntary or involuntary) for reasons other than gross misconduct.
4. If the individual continuing coverage is determined to be disabled (under Title II (OASDI), within sixty (60) days of the "qualifying event," or Title XVI (SSI) of the Social Security Act) on the date of the "qualifying event" identified above, he or she may elect COBRA for up to a total of twenty-nine (29) consecutive calendar months from the date of the "qualifying event." To be eligible for the extended continuation period, the individual must present a copy of the disability

determination to the COBRA Plan Administrator, during the initial eighteen (18) month period and no later than sixty (60) days after the individual receives the disability determination.

5. COBRA may be elected for up to thirty-six (36) consecutive calendar months for the covered spouse or dependent children if the qualifying event resulting in loss of medical coverage is:

6. The death of the employee;

7. The employee and spouse legally separate or divorce;

8. A child loses eligibility for dependent coverage (for example: age limitation or marriage)

9. In addition, the occurrence of one of these events during the initial eighteen (18) month period described above can extend that period for a continuing dependent up to 36 months.

COBRA Election Period

1. Once the Plan or COBRA Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

2. You (the employee) or your qualified beneficiaries must elect continuation coverage within sixty (60) days after Plan coverage ends, or, if later, 60 days after the Plan or COBRA Administrator sends you notice of the right to elect continuation coverage. If you or your family-member does not elect continuation coverage within this sixty (60) day election period, you will lose your right to elect continuation coverage. Your (or your qualified beneficiaries) election, if mailed, is effective on the day the election is sent (post-marked) to the COBRA Administrator.

3. Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only.

4. In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a sixty-three (63) day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Notices Required

1. The Plans provide that your spouse’s coverage terminates as of the last day of the month in which a divorce or legal separation occurs. A dependent child’s coverage terminates the last day of the month in which he or she ceases to be an eligible dependent under the Plans (for example, after attainment of a certain age). You (the employee) or a qualified beneficiary have the responsibility to notify the Plan or COBRA Administrator upon a divorce or legal separation, or a child losing dependent status within sixty (60) days after the later of the qualifying event or the date coverage is lost. If the qualifying event is a divorce or legal separation, you must present a copy of the divorce decree or proof of legal separation during the sixty (60) day notice period. If you or a family member fails to notify the Plan or COBRA Administrator during the sixty (60) day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family member fail to notify the Plan or COBRA Administrator, and contrary to Plan terms any claims are paid mistakenly for expenses incurred after the last day of the month of the divorce or legal separation or child losing dependent status, then you and your qualifying family members will be required to reimburse the Plans for any claims paid.

2. You (the employee) or your qualified beneficiaries must also notify the COBRA Administrator within thirty (30) days if, after electing COBRA coverage you or a qualified beneficiary becomes covered under another group health plan. Further, if you or a qualified beneficiary fails to notify the COBRA Administrator, and contrary to Plan terms any claims are paid

mistakenly for expenses incurred, then you and your qualified beneficiaries will be required to reimburse the Plans for any claims paid.

3. Once the Plan or COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, and pays the required premium, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.
4. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.
5. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

COBRA Payment Procedures

1. Once your COBRA Administrator, has received your correctly completed COBRA election (or enrollment) form, the selections chosen will confirm that you wish to continue coverage under the COBRA plan. Coverage is not activated until payment is received even if the election form is received within the election deadline. As stated above, COBRA payments are due within the first forty-five (45) days after your sixty (60) day election period.
2. Rehn & Associates is your COBRA Administrator, so the following procedures apply: Your COBRA payment is due (in full) the first (1st) of each month to the COBRA Administrator. Premium payments will have a thirty-one (31) day grace period. On the first (1st) day of each month, your eligibility status will be set as Terminated until your premium payment for that month is received. Once received, your eligibility status will be set as Effective retroactively back to the first (1st) day of that month and extending until the last day of that month. If your premium payment is not delivered or postmarked within the grace period, your coverage will be terminated back to the last day of the month for which we received a full premium payment. Payments by bounced checks indicating non-sufficient funds do not constitute payment. If funds are not made available by the end of the grace period, coverage will be terminated back to the last day of the month for which full payment was received.
3. COBRA premiums and benefits are subject to change at any time during the plan year. In the event of a premium or benefit change, you will be notified with new premiums and benefits. Upon yearly plan renewal, you will receive a letter listing updated premiums.

Premium Payments

1. Each qualified beneficiary will be required to pay the entire cost of continuation coverage. The premium you will be charged will not be more than 102% of the total cost of providing coverage. The premium for an extension of continuation coverage due to a disability can be as much as 150% of the cost of coverage for the 19th through 29th months of coverage.
2. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage to the COBRA Administrator, within forty-five (45) days after the date of your election. (This is the date the Election Notice is post-marked, if mailed). If you do not make your first payment for continuation coverage within those forty-five (45) days, you will lose all continuation coverage rights under the Plan.
3. Your first payment for continuation coverage must cover the cost of continuation coverage from the time your coverage under the Plans would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period.
4. All other premiums are due (in full) the first (1st) of each month. Premium payments will have a thirty-one (31) day grace period, which will not be extended for holidays or weekends. A premium payment is made on the date it is sent (post-marked). The Plans will not send periodic notices of payments due for these coverage periods.

The Trade Act

1. The Trade Act of 2002 amended ERISA. This amendment created a new tax credit for certain individuals who became eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualifying health insurance, including continuation

coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Service Center toll-free at (866) 626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/2002act_index.cfm.

2. The new second COBRA election period is intended to assist individuals who become TAA-eligible in taking advantage of a new tax credit, also created by the Trade Act of 2002. Under the new tax provisions, individuals who become eligible for TAA assistance can take a tax credit of premiums paid for qualified health insurance. The Trade Act of 2002 provides for advance payment of the tax credit to health insurers, beginning in 2003. COBRA continuation coverage is one of the types of health insurance that qualifies for the tax credit.

Maximum Length of COBRA Coverage

1. Thirty-six (36) Months: When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the plan, COBRA continuation coverage lasts for up to thirty-six (36) months.

2. Eighteen (18) Months: If you or your qualified beneficiaries lose group health coverage due to termination of employment (other than for gross misconduct) or reduction in hours of employment, coverage may be continued for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of eighteen (18) month period of continuation coverage

If you or your qualified beneficiaries covered under the Plans is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage, you and your family can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The Social Security Administration must formally determine under Title IX (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the twenty-nine (29) month continuation coverage period to apply, the qualified beneficiary must present the COBRA Administrator with a copy of the Social Security Determination of Disability within sixty (60) days of the date of the determination and before the end of the original eighteen (18) month period that applies to the qualifying event. If these procedures are not followed or if the notice is not provided to the Plan Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA Administrator of that fact within thirty (30) days of SSA's determination. Further, if you or a family member fails to notify the COBRA Administrator, and contrary to Plan terms any claims are paid mistakenly for expenses incurred, then you and your qualified beneficiaries will be required to reimburse the Plans for any claims paid.

Second qualifying event extension of eighteen (18) month period of continuation coverage

1. Eighteen (18) month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first eighteen (18) months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is thirty-six (36) months from the date of the initial termination of employment or reduction in hours. Such second qualifying events include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plans. You must notify the COBRA Administrator of the second qualifying event within sixty (60) days of the second qualifying event (see Notices Required). If these procedures are not followed or if the notice is not presented to the Plan Administrator within the required sixty (60) day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.

2. An event cannot be a 2nd qualifying event entitling a qualified beneficiary to extended COBRA coverage unless the event would have caused a loss of coverage under the plans.

3. In no event will continuation coverage last beyond thirty-six (36) months from the date of the original qualifying event. The thirty-six (36) months is counted from the date of the first qualifying event.

Children Born or Placed for Adoption after the Qualifying Event

If, during the period of continuation coverage, a child is born to the covered employee or is placed for adoption with the covered employee and the covered employee has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The covered employee or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The covered employee or a family member must notify the Plan Administrator within sixty (60) days of the birth, adoption or placement to enroll the

child on COBRA and COBRA coverage will last as long as it lasts for other family members of the employee. (The thirty (30) day period is the Plans normal enrollment window for newborn or adopted children.) If the covered employee or family member fails to notify the Plan Administrator in a timely fashion, the covered employee will NOT be offered the option to elect COBRA coverage for the newborn or adopted child.

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity to change their coverage option or add or drop dependents at open enrollment as similarly situated active employees. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and then later loses such coverage due to certain qualifying reasons. Except for children described above under Children Born or Placed for Adoption after the Qualifying Event, dependents that are added under HIPAA's special enrollment rights do not become qualified beneficiaries -their coverage will end at the same time coverage ends for the person who elected COBRA and later added them.

Termination of Continued Coverage (COBRA)

1. You and your qualified beneficiaries have the obligation to notify the COBRA Administrator within thirty (30) days after becoming covered under another group health plan. The Plan reserves the right to retroactively cancel COBRA coverage and to seek reimbursement of all benefits paid after that point in the event that you or any qualified beneficiary fails to notify the COBRA Administrator of the new coverage.
2. Continued coverage will end on the last day for which required contributions have been paid in the monthly period in which the first of the following occurs:
    - The applicable continuation period expires.
    - The next monthly required contribution is not paid when due or within the grace period.
    - For an individual whose coverage has been extended from eighteen (18) months to twenty-nine (29) months due to disability, continued coverage beyond eighteen (18) months ends if there is a final determination that the individual is no longer disabled under the Social Security Act. However, coverage will not end on the date indicated above, but on the last day for which required contributions have been paid in the first month that begins more than thirty (30) days after the date of the determination.
    - The individual subsequently becomes covered under another group health care program. If, however, the other group health care program contains exclusions or limits for benefits for pre-existing conditions that affect the individual's coverage, he or she may continue COBRA coverage for the shorter of the applicable COBRA term or until the pre-existing condition waiting period is satisfied. Note that under HIPAA, a federal law, exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other plan.
    - The employer no longer offers health coverage to any employee.
    - Occurrences of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses for a reason other than the COBRA coverage requirements of federal law.

Deadlines to Remember

1. You must notify the Plan or COBRA Administrator of a newborn child, or child placed for adoption in your home within thirty (30) days of the birth/placement or the child will not be offered the option to elect COBRA coverage.
2. You or your dependents must notify the Plan or COBRA Administrator of a divorce, legal separation, or a child's loss of dependent status within thirty-one (31) days of the event.
3. Upon termination of health plan coverage, immediately advise your Plan or COBRA Administrator if you desire continued coverage under COBRA. Complete instructions on how to elect continuation coverage will be given to you within fourteen (14) days of the date you provide the Plan or COBRA Administrator with timely notice of the "qualifying event." The person(s) eligible to continue coverage then has sixty (60) days in which to elect continuation.
4. After you elect COBRA continuation for you or your dependents, you have forty-five (45) days from the date of the election in which to pay the premium owed for continuous coverage during the period preceding the election (for

example: back to the time of the "qualifying event"). Premium payments should be paid to the COBRA Administrator.

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

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191 was enacted on August 21, 1996. HIPAA amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 (CODE) to provide for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with employment. Sections 102(c)(4), 101(g)(4) and 401 (c)(4) of HIPAA require the Secretaries of Health and Human Services, Labor and the Treasury each to issue regulations necessary to carry out these provisions.

The Law

- limits exclusions for preexisting medical conditions;
- provides credit for prior health coverage and a process for providing certificates concerning prior coverage to a new group health plan or issuer;
- provides new rights that allow individuals to enroll for health coverage when they lose other health coverage or add a new dependent;
- prohibits discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors;
- guarantees availability of health insurance coverage for small employers and renewability of health insurance coverage in both the small and large group markets; and,
- preserves the states' role in regulating health insurance, including the states' authority to provide greater protections.

HIPAA Rules

The Health Insurance Portability and Accountability Act (HIPAA) offers protection for millions of American workers that improve portability and continuity of health insurance coverage.

HIPAA Protects Workers and Their Families By

- Limiting exclusions for preexisting medical conditions (known as preexisting conditions).
- Providing credit against maximum preexisting condition exclusion periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer.
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent.
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors.
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers.
- Preserving the states’ role in regulating health insurance, including the states’ authority to provide greater protections than those available under federal law.

Rules published by the Departments of Labor, Health and Human Services, and the Treasury provide guidance to both employees and employers with respect to these HIPAA provisions in the following areas:

Creditable Coverage

- Includes prior coverage under another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan.

Certificates of Creditable Coverage

- Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage or exhausts COBRA

continuation coverage. A certificate must also be provided free of charge upon request while you have health coverage or anytime within 24 months after your coverage ends.

- Certificates of creditable coverage should contain information about the length of time you or your dependents had coverage as well as the length of any waiting period for coverage that applied to you or your dependents.
- For plan years beginning on or after July 1, 2005, certificates of creditable coverage should also include an educational statement that describes individuals' HIPAA portability rights. A new model certificate is available on EBSAs Web site.
- If a certificate is not received, or the information on the certificate is wrong, you should contact your prior plan or issuer. You have a right to show prior creditable coverage with other evidence — like pay stubs, explanation of benefits, letters from a doctor — if you cannot get a certificate.

Special Enrollment Rights

- Are provided for individuals who lose their coverage in certain situations, including on separation, divorce, death, termination of employment and reduction in hours. Special enrollment rights also are provided if employer contributions toward the other coverage terminates.
- Are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption.

Discrimination Prohibitions

- Ensure that individuals are not excluded from coverage, denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors.

HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Plan commitment to privacy:

The privacy of your personal health information is important to the Plan. To effectively manage your health benefits, the Plan must collect and share personal health information (PHI). PHI shall have the same definition as set forth in the Privacy Standards (45 CFR Part 164), but generally shall mean individually identifiable health information about the past, present or future physical or mental health condition of an individual, including information about treatment or payment for treatment. The Plan considers PHI private, and the Plan has policies and procedures in place to make sure that only the minimum amount of information necessary is shared with those parties who have a legitimate business need for the information. This notice provides you with important information about the Plan privacy policies including what types of PHI we collect, what types of PHI we may disclose and to whom we may disclose PHI.

What information does the Plan collect?

The Plan must collect personal health information about you and your dependents in order to provide health care services to you. This information may come to us in writing, in person, by telephone or electronically. This information may include:

1. Application information including items such as your name, address, social security number, birth date, and employment status. We may receive this information directly from you or through your health plan's sponsor.
2. Information regarding transactions that occur during your relationship with us, including medical claims information, clinical case management information, payment information, service inquiries and appeals information.
3. Health information about you relating to treatment, needed to obtain payment for treatment or for administrative purposes, or necessary to evaluate the quality of the care that you receive.

How does the Plan protect information?

Rehn & Associates is your health plan’s third party administrator. The Plan restricts access to PHI to those employees of Rehn & Associates who need the information to provide health plan services to you and your family. The Plan maintains the highest physical and electronic security safeguards to protect your information against unauthorized access. The Plan takes privacy very seriously. The Plan has a Privacy Committee whose responsibility is to develop procedures to support this endeavor, to educate the Plan staff and to test and enforce these mechanisms to protect privacy.

The Plan is required by law to maintain the privacy of protected health information and to provide affected individuals with

notice of its legal duties and privacy practices with respect to PHI. The Plan does not disclose PHI, except as permitted by law. The Plan will disclose information during normal health plan operations to help ensure that you receive the care that you need, or as required to secure payments for the services or benefits you receive. When the Plan is required to disclose information, specific policies and practices are followed to ensure that the party the Plan releases information to be whom they say they are and that they have a legitimate need for that information. Then only the minimum amount of information required is released. Any party with whom the Plan shares your information is required to keep this information confidential as required by law. Information that is publicly available or that is reported in aggregate (a summary across a population that cannot identify individuals) is not considered PHI.

To whom is PHI disclosed, and why?

The Plan is permitted to use and disclose protected health information without your authorization for treatment, payment and health care operations. Examples of when the Plan is permitted to use and disclose PHI and the data shared with a third party include:

For Treatment, Payment and Health Care Operations, the Plan may use and disclose protected health information for treatment, payment and health care operation activities. The Plan may disclose protected health information for the treatment activities of any health care provider, payment activities of any health care provider, or the health care operations of a health care provider if both health care Providers have or had a relationship with you and the protected health information pertains to the relationship.

1. For Treatment. Treatment is the provision, coordination or management of health care and related services for an individual by one or more health care Providers. The Plan may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, pharmacist or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care Providers to determine what treatment you should receive. Health care Providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.
2. For Payment. The Plan may use and disclose your health information to others for purposes of processing payment for treatment and services that you receive. “Payment” generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for healthcare. The information on a bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment. This includes the management of your health benefits and the authorization of payments for health care may require that the Plan release information to Providers, provider network organizations, or an excess loss insurance company. This exchange usually includes benefit information and / or PHI history that the Plan has on file. The Plan will always work to ensure that the information released is limited to what is needed for the current inquiry, that it facilitates your care or your benefits and that it is not used for any other purpose.
3. For Health Care Operations. The Plan may use and disclose health information about you for operational purposes. For example, your health information may be disclosed for:
    - Quality assessment and improvement activities, including case management and care coordination.
    - Competency assurance activities, including provider or health plan performance evaluation, credentialing and accreditation
    - Conducting or arranging for medical reviews, audits or legal services, including fraud and abuse detection and compliance programs
    - Specified insurance functions, such as underwriting, risk rating and reinsuring risk
    - Business planning, development, management and administration
    - Performing utilization review or for structuring wellness and disease management programs. Educational materials and screening reminders may be sent to Plan members. The Plan may also perform risk assessments and identify and contact those who may benefit from disease management programs.
    - Licensing, auditing and / or quality assurance programs may require the release of randomly selected records to an audit or accreditation organization or a federal or state agency.

- For Public Interest and Benefit Activities. The Privacy rule permits use and disclosure of protected health information, without an individual's authorization or permission, for 12 national priority purposes. These disclosures are permitted, although not required, by the Rule in recognition of the important uses made of health information outside the health care context. Specific conditions or limitations apply to each public interest purpose, striking the balance between the individual privacy interest and the public interest need for this information.
- As Required by Law. The Plan may use and disclose information about you as required by law.
- Cadaveric Organ, Eye or Tissue Donation. The Plan may use or disclose protected health information to facilitate the donation and transplantation of cadaveric organs, eyes and tissue.
- Decedents. The Plan may disclose protected health information to funeral directors as needed, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions authorized by law.
- Essential Government Functions. Your health information may be disclosed for specialized government functions such a protection of public officials or reporting to various branches of the armed services.
- For a Serious Threat to Health or Safety. The Plan may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclose is made to someone they believe can prevent or lessen the threat (including the target of the threat). Covered entities may also disclose the law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.
- For judicial and administrative proceedings pursuant to legal authority;
- Health oversight activities. To report to health oversight agencies for purposes or legally authorized audits and investigations necessary for oversight of the health care system.
- Law Enforcement Purposes. The Plan may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, of the covered entity suspects that criminal activity caused the death; (5) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and (6) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.
- Public Health Activities. The Plan may disclose protected health information to: (1) public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability and to public health or other government authorities authorized to receive reports of child abuse and neglect; (2) entities subject to FDA regulation regarding FDA regulated products or actives for purposes such as adverse event reporting, tracking of products, product recalls, and post-marketing surveillance; (3) individuals who may have contracted or been exposed to a communicable disease when notification is authorized by law; and (4) employers, regarding employees, when requested by employers for information concerning a work-related illness or injury or workplace related medical surveillance, because such information is needed by the employer to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MHSA) or similar state law.
- Research. The Plan may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.
- Victims of abuse, neglect or domestic violence. In certain circumstances, the Plan may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.
- Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.
- Other uses:
    - Enrollment information; such as your name, address, plan name and coverage dates may be released to your

pharmacy benefits carrier or other organizations responsible for delivering or administering a portion of your health care.

- The Plan may also share information to facilitate the change over or acquisition of your health plan to another insurer or Third Party Administrator (TPA).
- If the Plan uses or discloses your PHI for any reason other than treatment, payment or healthcare operation, as defined in the Privacy Standard, it must first obtain your written authorization. Once you provide the authorization, you may revoke it at any time.

What does this mean to me?

Every effort is made to protect your PHI and the trust you have placed in the Plan. You should be aware, however, that in the course of administering your health benefits, PHI must be disclosed. Disclosure is permitted only when required or allowed by law. The Plan considers the activities described in the previous section key for the management of your health plan. The Plan also recognizes that many people do not want to receive marketing materials based upon their health plan participation or health history. The Plan does not participate in this type of activity and would seek your special consent before disclosing your information.

HEALTH INFORMATION RIGHTS

You have the right to:

1. Request a restriction on certain uses and disclosures of your PHI. However, the Plan is not required to agree to a requested restriction.
2. Inspect and copy your PHI that is held by the Plan.
3. Amend your PHI, if appropriate.
4. Obtain a paper copy of the notice of information practices upon request.
5. Request an accounting of the disclosures of their protected health information by the Plan. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The Privacy Rule does not require accounting for disclosures:

   For treatment, payment, or health care operations. This includes

   - To the individual or the individual's personal representative
   - For notification or of to persons involved in an individual's health care or payment for health care
   - For national security or intelligence purposes
   - To correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody, or
   - Incident to an otherwise permitted or required uses or disclosures.
6. Disclosure of information regarding members who are no longer enrolled in the health plan;
   - The Plan policies, for the protection of PHI, remain in effect even after you terminate from the Plan. The Plan will retain your records and administer your benefits retroactively for as long as required by law.

What if I believe this Privacy Policy is violated?

Your privacy is important to the Plan. The Plan has systems and policies in place to prevent the unlawful or accidental disclosure of your information. If you believe that this policy has been violated or if you believe there has been an inappropriate or unauthorized disclosure of your PHI, please let the Plan know. You will not be retaliated against for filing a complaint. Please submit your complaint in writing to the Plan. You may also call in, or call to request additional information. Complaints can also be submitted to the Secretary of Health and Human Services. Please direct any concerns or complaints to the Plan Privacy Officer. Please see the General Information section located at the end of this document.

Changes or Updates to this Privacy Notice

This notice reflects our current privacy policies and practices. The Plan is required to abide by the terms of the notice currently in affect. However, the Plan reserves the right to amend this notice and make the new policy provisions effective for

all protected health information that it maintains. Any material change in the information collected or disclosed will result in a revised notice. As a member, you will receive an updated notice regarding our privacy policies annually or at the time of any significant change. The original effective date of this Notice was December 1, 2008. If you have any questions or wish to receive any additional information regarding the Privacy Policy, please contact the Plan Privacy Officer.

GENERAL PLAN INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the following information be furnished to you.

Name of Plan
Community Connections, Inc. Dental and Vision Plan.

Employer Identification Number "EIN":
92-0112719

Original Effective Date:
January 1, 2016

Type of Plan
This Plan can be described as a health care plan that provides dental and vision benefits for a health plan document.

Type of Administrator
Administered by the Plan sponsor in accordance with the summary plan description, administrative agreement and business associate agreements. Claims to be processed for benefits are sent to Rehn & Associates, Inc. The Plan sponsor (not Rehn & Associates, Inc.) is responsible for paying claims.

Source of Contribution
The plan is funded through employer and employee contributions.

Funding Medium
Claims are paid in part by the employer's general assets and in part by employees' payroll deductions.

Calendar Year
The Calendar Year for this plan ends December 31st each year. Each twelve (12) month period commencing on January 1st, consists of an entire Calendar Year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

Contact Information of Plan Administrator/Sponsor/Fiduciary
Community Connections Inc.
721 Stedman Street
Ketchikan, AK 99901

Agent for Services of Legal Process
The Health Care Plan Administrator may be served with process. Please serve legal process (e.g., subpoena) to:

Community Connections Inc.
721 Stedman Street
Ketchikan, AK 99901

Cobra Administrator
Community Connections Inc.
721 Stedman Street
Ketchikan, AK 99901

Third Party Administrator
Rehn & Associates, Inc.
1322 N Post
Spokane. WA 99201
Phone (509) 534-0600
Toll Free (800) 872-8979
Website: www.rehnonline.com

Hours of operation (Pacific Standard Time):
Monday through Thursday from 8:00 a.m. to 5:00 p.m.
Friday 8:00 a.m. to 4:00 p.m.

Appeals Department
Rehn & Associates, Inc.
1322 N Post

Spokane. WA 99201
Phone (509) 534-0600
Toll Free (800) 872-8979
Website: www.rehnonline.com
Hours of operation (Pacific Standard Time):
Monday through Thursday from 8:00 a.m. to 5:00 p.m.
Friday 8:00 a.m. to 4:00 p.m.

The Plan Privacy Officer
Rehn & Associates, Inc.
1322 N Post
Spokane. WA 99201
Phone (509) 534-0600
Toll Free (800) 872-8979
Website: www.rehnonline.com
Hours of operation (Pacific Standard Time):
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