HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC.
WELFARE BENEFIT PLAN

Established as of April 01, 1988
Amended and Restated as of April 01, 2019

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TABLE OF CONTENTS

ARTICLE 1. INTRODUCTION & DEFINITIONS

Hocking Athens Perry Community Action Agency, Inc. (the "Plan Sponsor") hereby adopts and maintains this Hocking Athens Perry Community Action Agency, Inc. Welfare Benefit Plan (the "Plan") to provide health and welfare benefits to its eligible employees and their dependents. The Plan number is 501. The Plan is effective as of the Effective Date.

This Plan is intended to comply with the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and will be administered in accordance with that intent. The Plan includes this document and any Subsidiary Contracts incorporated herein by reference.

DEFINITIONS

Company means
the Plan Sponsor and any other entity that adopts the Plan with the consent of the Plan Sponsor. Participating Companies are identified in a joinder agreement, which may be amended by the Plan Sponsor from time to time without amending the Plan.

Eligible Employee means
an employee of the Company who is eligible to participate in one or more Subsidiary Contracts.

Effective Date means
April 01, 2019.

Participant means
an employee of the Company, spouse, or dependent who is enrolled in one or more Subsidiary Contracts.

Plan means
this Hocking Athens Perry Community Action Agency, Inc. Welfare Benefit Plan, as may be amended from time to time.

Plan Administrator means
the Plan Sponsor, unless the Subsidiary Contract names another person or entity as its plan administrator.

Plan Year means
the 12-consecutive month period ending on: March 31.

Subsidiary Contract means
any agreement, writing, contract, plan, or arrangement between the Company and a welfare benefit provider where the benefits provided are subject to ERISA. In addition, any statements of coverage provided by the Plan Administrator setting forth a description of the scope of coverage under the Plan as well as the options, terms, conditions and limitations

related thereto are herein incorporated as part of the Subsidiary Contracts. Subsidiary Contract includes all welfare benefits of the Plan Sponsor that are subject to ERISA and are incorporated herein by reference.

ARTICLE 2. ELIGIBILITY & BENEFITS

Section 2.01 ELIGIBILITY

Eligibility for benefits under the Subsidiary Contracts will be determined by the Subsidiary Contracts. The terms of eligibility need not be identical or similar among Subsidiary Contracts. An individual will cease participation in a Subsidiary Contract in accordance with the terms of the Subsidiary Contract.

Section 2.02 BENEFITS

The terms and conditions of benefits offered under this Plan are contained in the Subsidiary Contracts, which are incorporated herein by reference as if fully recited herein.

ARTICLE 3. PLAN ADMINISTRATION

Section 3.01 PLAN ADMINISTRATOR

(a) Designation. If a committee is designated as the Plan Administrator (the "Committee"), the Committee will consist of one or more individuals appointed by the Plan Sponsor. The Committee may adopt such rules and procedures as it deems desirable to discharge its duties under the Plan. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf. If no Committee has been designated as the Plan Administrator, the Plan Sponsor will be the Plan Administrator.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator will be the "administrator" as such term is defined in section 3(16)(A) of ERISA and will be the "named fiduciary" of the Plan and, as such, will have total and complete discretionary power and authority:

(1) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation, or application of the Plan by the Plan Administrator will be final, conclusive, and binding;

(2) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 5;

(3) to determine the amount and manner of any allocations hereunder;

(4) to maintain and preserve records relating to the Plan;

(5) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;
(6) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;
(7) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;
(8) to determine all questions of the eligibility of employees and of the status of rights of Participants under the Plan;
(9) to determine the validity of any judicial order;
(10) to retain records on elections and waivers by Participants;
(11) to supply such information to any person as may be required;
(12) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator will be entitled to rely upon information furnished to it. The Plan Administrator's decisions will be final, binding, and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of its duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator will serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder will be paid or reimbursed by the Company.

Section 3.02 INDEMNIFICATION

The Company will indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) and any employees of the Plan Administrator from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA.

ARTICLE 4. FUNDING

Section 4.01 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Company to provide benefits hereunder will remain part of the general assets of the Company and all payments of benefits under the Plan will be made from the general assets of the Company or the Subsidiary Contracts.
(b) The Company will have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Company may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making benefit payments under this Plan.
(c) No person will have any rights to, or interest in, any account other than as expressly authorized in the Plan.

Section 4.02 FUNDING POLICY

The Company will have the right to enter into a contract with one or more Subsidiary Contract providers for the purposes of providing any benefits under the Plan and to replace any of such Subsidiary Contracts. Any dividends, retroactive rate adjustments, rebates, or other refunds of any type that may become payable under any such Subsidiary Contract or in connection with a Subsidiary Contract will not be assets of the Plan but will be the property of, and will be retained by, the Company unless otherwise mandated by law. The Company will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan. Such limitation will include, but not be limited to, losses or obligations that pertain to the following:

(a) Once a Subsidiary Contract is applied for or obtained, the Company will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Company;
(b) To the extent premium notices are received by the Company, the Company's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which result from such failure;
(c) When employment ends, the Company will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan. The Company will not be liable or responsible for the payment of any premium with respect to periods after employment ends.

ARTICLE 5. CLAIMS PROCEDURES

Section 5.01 CLAIMS PROCEDURES

(a) This Section 5.01 will apply for any claim for benefits under a Subsidiary Contract unless the Subsidiary Contract for the benefit has a claims procedure that is compliant with ERISA section 503. If the applicable Subsidiary Contract has a claims procedure that is compliant with ERISA section 503, the claims procedure of the Subsidiary Contract will apply.

A request for benefits is a "claim" subject to these procedures only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan and any procedures provided by the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" for purposes of this Section 5.01. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" for purposes of this Section 5.01, unless it is determined by the Plan Administrator in its sole discretion that the inquiry is an attempt to file a claim. If the Plan Administrator or its delegate receives a claim, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information.

Participants may designate an authorized representative by providing to the Plan Administrator or its delegate written notice of such designation and identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the Participant's medical condition may act as an authorized representative with or without prior notice. A "health care professional" is a physician or other health care professional licensed, accredited, or certified to perform specified health services, consistent with state law.

(b) Timing of Notice of Claim. The Plan Administrator will notify the Claimant of an adverse benefit determination within a reasonable period of time, but not later than the time frame below, depending on the type of benefit being provided under the Subsidiary Contract under which the claim for benefits arises. An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan, and including, with respect to a group health plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(1) In General. The Plan Administrator (or its delegate) will provide notice of an adverse benefit determination within 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(2) Group Health Plan Claims.

(A) Urgent Care Claims. An "urgent care" claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the

Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an "urgent care" claim is determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the Participant's medical condition determines is an "urgent care" claim will be treated as an "urgent care" claim by the Plan.

If the Participant or the Participant's authorized representative fails to follow the Plan's procedures for filing an urgent care claim, the Plan Administrator (or its delegate) will notify the Participant of the failure as soon as possible, but not later than 24 hours following the failure and of the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Participant or authorized representative. This paragraph (A) applies only to a communication by a Participant or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify the Participant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Participant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the plan administrator will notify the Participant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Participant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, or (2) the end of the period afforded the Participant to provide the specified additional information.

(B) Pre-Service Claims. A "pre-service" claim is any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. If the Participant or the Participant's authorized representative fails to follow the Plan's procedures for filing a pre-service claim, the Plan Administrator (or its delegate) will notify the Participant of the failure as soon as possible, but not later than 5 days following the failure and of the proper procedures to be followed in filing a claim for benefits. Notification may be oral,

unless written notification is requested by the Participant or authorized representative. This paragraph (B) applies only to a communication by a Participant or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify the Participant of the Plan's determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(C) Post-Service Claims. A post-service claim is any claim for a benefit under the plan that is not a pre-service claim. In the case of a post-service claim, the Plan Administrator will notify the Participant of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(D) Concurrent Care Claims. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Plan Administrator will notify the Participant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a

determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by a Participant to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify the Participant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Notwithstanding anything herein to the contrary, the timeframe for benefit determinations under group health plans will be determined as provided under DOL Reg. section 2560.503-1(f)(2). For purposes of this Section 5.01, group health plan means a group health plan as defined in DOL Reg. section 2560.503-1(m)(6).

(3) Disability Benefit Claims. The Plan Administrator will provide notice of an adverse benefits determination to the Participant within 45 days after receipt of the claim. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if Plan Administrator notifies the Participant prior to the expiration of the first 30-day extension period the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section will explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Participant will be afforded at least 45 days within which to provide the specified information.

(c) Content of Notice of Adverse Benefit Determination.

(1) If a claim is wholly or partially denied, the Plan Administrator will provide the Participant with a written notice identifying (1) the reason or reasons for such denial; (2) the pertinent Plan provisions on which the denial is based; (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary; and (4) an explanation of the steps that the Participant must take if he wishes to appeal the denial including a statement that the Participant may bring a civil action under ERISA.

(2) In addition, if the wholly or partially denied claim is for a group health plan or disability benefit under the Plan, the following information must also be included in the written notice: (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a

statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) If the denied claim is for a disability benefit under the Plan, the Plan Administrator will also provide the Participant the following information in the written notice: (1) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration regarding the Participant presented by the Participant to the Plan; (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request; (3) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and (4) a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for disability benefits.

(4) In the case of a wholly or partially denied urgent care claim by a group health plan under the Plan, the notice must include a description of the expedited review process applicable to such claims. In addition, the information described in this Section 5.01(c) may be provided orally within the timeframe required under Section 5.01(b) provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

(d) Appeal of Adverse Benefit Determination.

(1) A Participant may appeal the denial of a claim by filing a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied (the 180th day for claims involving a group health plan or disability benefits). If the denial involves a claim for disability benefits, a denial includes a cancellation or discontinuance of coverage that has retroactive effect (unless it is due to the Participant's failure to pay required premiums). The written appeal will identify both the grounds and specific Plan provisions upon which

the appeal is based. The Participant will lose the right to appeal if the appeal is not timely made.

The Plan will provide the Participant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefit. The Participant may submit written comments, documents, records, and other information relating to the claim for benefits. The Plan will take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan Administrator will consider the merits of the Participant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant.

(2) If the claim is for group health plan or disability benefits, the following will apply:

(A) the review will not afford deference to the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

(C) the Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) in the case of an urgent care claim, the Plan will expedite review of the claim such that a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Participant and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Participant by telephone, facsimile, or other available similarly expeditious method.

(3) If the claim is for disability benefits under the Plan, the following will also apply:

(A) Before the Plan issues any adverse benefit determination, the Plan Administrator will provide the Participant, free of charge, with any new

or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan) in connection with the claim, and any new or additional rationale must be provided to the Participant as soon as possible and sufficiently in advance of the date on which the Plan must provide the Participant with the notice of final adverse benefit determination so that the Participant has a reasonable opportunity to respond prior to that date.

(B) If the determination is based on a new or additional rationale, the Participant will be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give the Participant a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it in time for the Participant to have a reasonable opportunity to respond, the Plan's deadline for providing a notice of final adverse benefit determination will be delayed until the Participant has had reasonable opportunity to respond. After the Participant responds, or has a reasonable opportunity to respond but fails to do so, the Plan Administrator will notify the Participant of the Plan's benefit determination as soon as a Plan Administrator acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

(4) The Plan Administrator will ordinarily rule on an appeal of an adverse benefit determination within 60 days following receipt of the claim. However, if special circumstances require an extension and the Plan Administrator furnishes the Participant with a written extension notice during the initial period, the Plan Administrator may extend this period of time by 60 days if written notice of the extension is furnished to the Participant prior to the termination of the initial 60-day period.

If a Committee designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, the Committee will instead make a benefit determination no later than the date of the meeting of the Committee that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the Committee following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator will provide the Participant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of

the extension. The Plan Administrator will notify the Participant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(5) If the claim is for group health plan benefits, the Plan Administrator will notify the Participant of the Plan's benefit determination on review as follows:

(A) Urgent Care Claims. The Plan Administrator will notify the Participant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Participant's request for review of an adverse benefit determination by the Plan.

(B) Pre-Service Claims. The plan administrator will notify the Participant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of the Participant's request for review of an adverse benefit determination.

(C) Post-Service Claims. The Plan Administrator will notify the Participant of the Plan's benefit determination on review within a reasonable period of time, but no later than 60 days after receipt by the Plan of the Participant's request for review of an adverse benefit determination.

(6) If the claim is for disability benefits, the Plan Administrator will ordinarily rule on an appeal of a claim denial within 45 days following receipt of the claim. However, if special circumstances require an extension and the Plan Administrator furnishes the Participant with a written extension notice during the initial period, the Plan Administrator may extend this period of time by 45 days if written notice of the extension is furnished prior to the termination of the initial 45-day period.

(7) The period of time within which a benefit determination on review is required to be made will begin at the time an appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review will be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

(8) All claims and appeals involving disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will be made based upon the likelihood that the individual will support the denial of benefits.

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator will provide the Participant with a notice identifying (1) the reason or reasons for such denial; (2) the Plan provisions on which the denial is based; (3) a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the

Participant's claim for benefits; and (4) a statement describing the Participant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator will be binding upon all parties.

(1) In the case of a group health plan or a plan providing disability benefits, the notice will also include:
   (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request;
   (B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
   (C) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(2) In the case of a claim involving disability benefits, the notice will also include:
   (A) any applicable contractual limitations period that applies to the Participant's right to bring an action under section 502(a) of ERISA, including the calendar date that the contractual limitations period expires for the claim;
   (B) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration regarding the Participant presented by the Participant to the Plan;
   (C) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
   (D) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse

determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

(f) Exhaustion of Remedies. A Participant must exhaust all internal remedies before a claim or lawsuit can be filed in court.

(g) Additional Claims Processes.

(1) Applicability. This Subsection will apply to benefit under (1) a plan that constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the plan is subject to HIPAA portability rules, and (2) the plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(2) Internal Claims Process. The claims requirements set forth in Section 5.01 above will apply as the internal claims process, except that

(A) an "adverse benefit determination" will also include any cancellation or discontinuance of coverage under the applicable plan that has retroactive effect;

(B) the Plan will provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to the Participant to give the Participant a reasonable opportunity to respond prior to that date;

(C) before the Plan can issue a final internal adverse benefit determination based on a new or additional rationale, the Participant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the Participant a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it to the Participant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the Participant has a reasonable opportunity to respond. After the Participant responds, or has a reasonable opportunity to respond but fails to do so, the Plan Administrator will notify the Participant of the Plan's benefit determination as soon as a Plan Administrator acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies;

(D) the Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits;

(E) the Plan must provide notice to Participants, in a culturally and linguistically appropriate manner;

(F) the Plan must ensure that any notice of adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(G) the Plan must provide to Participants, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review;

(H) the Plan must ensure that the reason or reasons for the adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision;

(I) the Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(J) the Plan must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist Participant's with the internal claims and appeals and external review processes; and

(K) the Plan will continue to provide continued coverage under the Plan as required by DOL Reg. section 2590.715-2719(b)(2)(iii) pending the outcome of an appeal.

(h) External Claims Process.

(1) State Process. To the extent the Plan is required pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the Plan will comply with the state external claims process of DOL Reg. section 2590.715-2719(c).

(2) Federal Process. To the extent the Plan is not required pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with the State external claims process, then the Plan will comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d).

Section 5.02 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the individual's legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a

parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment will fully discharge the Plan Administrator and the Company from further liability on account thereof.

Section 5.03 MISSING PAYEE

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person will be forfeited one year after the date any such payment first became due.

ARTICLE 6. AMENDMENT OR TERMINATION OF PLAN

Section 6.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor.

Section 6.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will continue indefinitely. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) Each entity constituting the Company reserves the right to terminate its participation in this Plan. In addition, each such entity constituting the Company will be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Company, (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Company, or (iii) it at any time is not under common control with the Plan Sponsor pursuant to Section 3(37)(B) of ERISA.

(c) Upon termination, any assets remaining in the Plan will be used to pay outstanding benefit claims. After all claims and Plan liabilities have been paid, any surplus will revert to the Company, unless the Plan Sponsor determines that the assets will be refunded to Participants and the Subsidiary Contracts do not provide otherwise.

ARTICLE 7. GENERAL PROVISIONS

Section 7.01 INTERPRETATION

Each separate Subsidiary Contract, as amended or subsequently replaced, is hereby incorporated by reference. In the event of a conflict between the Subsidiary Contracts and this Plan, the Subsidiary Contracts will govern.

Section 7.02 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator will notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and of the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period of receiving the medical child support order, the Plan Administrator will determine whether the order is a qualified medical child support order and will notify the Participant and alternate recipient of such determination.

Section 7.03 FMLA and USERRA

The Plan Administrator will permit Participants to continue Participation in the Plan as required under the Family Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act and will provide such reinstatement rights as required by law. The Plan Administrator will also permit Participants to continue to participate in the Plan as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

Section 7.04 COBRA

To the extent the Plan is subject to the Consolidated Omnibus Budget Reconciliation Act of 1988, as amended (COBRA), a Participant will be entitled to COBRA continuation coverage to the extent required under Code section 4980B (and the regulations thereunder). A Participant will be entitled to continuation coverage under the Plan as required by applicable state law to the extent that such law is not pre-empted by federal law.

Section 7.05 THIRD PARTY RECOVERY/REIMBURSEMENT

(a) The Plan Administrator may, but is not required to, utilize the provisions of this subsection to the extent not inconsistent with the provisions of any applicable Subsidiary Contract, in which case the provisions of the Subsidiary Contract will control.

(b) In General. When a Participant receives Plan benefits that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related expenses that arise through an act or omission

of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Plan will be entitled to reimbursement by the Participant or her or her representatives of benefits paid from the Plan.

(c) Specific Requirements and Plan Rights. Because the Plan is entitled to reimbursement, the Plan will be fully subrogated to any and all rights, recovery or causes of actions or claims that a Participant may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount, or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if the Participant has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery will not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring the Participant to assert a claim to any of the benefits to which the Participant may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Company.

If the Plan should become aware that a Participant has received a third-party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and any covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Participant.

(d) Participant Duties and Actions. By participating in the Plan each Participant consents and agrees that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien, or equitable lien by agreement, each Participant agrees to cooperate with the Plan in reimbursing the Plan for costs and expenses.

Once a Participant has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. At that time, the Participant (and the Participant's attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount, or recovery from a third party.

If a Participant fails or refuses to execute the required subrogation/ reimbursement agreement, the Plan may deny payment of any benefits to the Participant until the agreement is signed. Alternatively, if a Participant fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Participant, the Participant's acceptance of such benefits will constitute agreement to the Plan's right to subrogation or reimbursement.

Each Participant consents and agrees that they will not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

This Section 7.05 will apply even after an individual is no longer a Participant in the Plan. The Plan Administrator has the authority and discretion to resolve all disputes regarding the interpretation of these subrogation and reimbursement rights and to make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Section 7.06 NONALIENATION OF BENEFITS

No Participant will have the right to alienate, anticipate, commute, pledge, encumber, or assign any of the benefits or payments which he may expect to receive, contingently or otherwise, under the Plan.

Section 7.07 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan will be construed as a contract of employment between the Company and any Participant, or as a right of any employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its employees, with or without cause.

Section 7.08 GOVERNING LAW

(a) The Plan will be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.
(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 7.09 TAX EFFECT

The Company does not represent or guarantee that any particular federal, state, or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 7.10 SEVERABILITY OF PROVISIONS

If any provision of the Plan will be held invalid or unenforceable, such invalidity or unenforceability will not affect any other provisions hereof, and the Plan will be construed and enforced as if such provisions had not been included.

Section 7.11 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, will not be considered part of the Plan, and will not be employed in the construction of the Plan.

Section 7.12 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter will include the feminine and the neuter, the singular will include the plural, and vice-versa.

Section 7.13 EFFECT OF MISTAKE

In the event of a mistake as to the eligibility or participation of any individual, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator will, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Company from Compensation paid by the Company.

ARTICLE 8. HIPAA

This Section 8 applies to those benefits under the Plan that are subject to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") as set forth below.

Section 8.01 DEFINITIONS

For purposes of this Article 8, the following terms have the following meanings:

(a) Business Associate means a person or entity who qualifies as a "business associate" as defined in Section 160.103 of the HIPAA Privacy Regulations, including but not limited to a vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and any subcontractor to whom a Business Associate delegates its obligations.

(b) Group Health Benefits means the health benefits, dental benefits, vision benefits, and employee assistance program benefits offered under the Plan.

(c) Individual means the Participant or the Participant's covered dependents enrolled in any of the Group Health Benefits under the Plan.

(d) Notice of Privacy Practices means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

(e) Plan Administration Functions means the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

(f) Protected Health Information (PHI) means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:

(1) is created or received by the Plan or the Plan Sponsor;

(2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and

(3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) Summary Health Information means information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:

(1) names;

(2) any geographic information which is more specific than a five-digit zip code;

(3) all elements of dates relating to a covered Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(5) facial photographs or biometric identifiers (e.g., finger prints); and

(6) any other unique identifying number, characteristic, or code.

Section 8.02 HIPAA PRIVACY COMPLIANCE

The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

(1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:

(A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;

(B) for auditing claims payments made by the Plan;

(C) to request proposals for services to be provided to or on behalf of the Plan; and

(D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.

(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

(3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.

(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.

(3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.

(5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.

(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.

(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

(8) The Plan Sponsor will make available its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.

(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

(10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum

necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.

(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor will, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

(f) Rights of Individuals.

(1) Notice of Privacy Practices. The Plan Sponsor will provide a Notice of Privacy Practices to the Participant in accordance with HIPAA.

(2) Right to Request Restrictions. Each Individual has the right to request that the Plan restrict its uses and disclosures of the Individual's PHI.

(3) Right to Access. Each Individual has the right to obtain and inspect its PHI held by the Plan.

(4) Right to Amend. Each Individual has the right to ask the Plan to amend its PHI.
(5) Right to an Accounting. Each Individual has the right to request an accounting of disclosures of PHI made by the Plan for purposes other than treatment, payment, or health care operations.

Section 8.03 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan
(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;
(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
(d) Report to the Plan any security incident of which it becomes aware.

Section 8.04 HIPAA COMPLIANCE FOR FULLY INSURED GROUP HEALTH BENEFITS

Notwithstanding the foregoing, to the extent any of the Plan's Group Health Benefits are fully insured, the Plan Sponsor has adopted a policy of not receiving, disclosing or using PHI or other health information (except for information described in 45 C.F.R. 164.530(k)(1)(ii)) regarding insured benefits for any purpose permitted under HIPAA, unless authorized by the Individual, when appropriate.

Execution Page

The undersigned agree to be bound by the terms of this Plan and acknowledge receipt of same. Hocking Athens Perry Community Action Agency, Inc. caused this Plan to be executed this _____ day of _____, 2018.

HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC.:

Signature:_____

Print Name: _____

Title/Position:_____

HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC.
WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

April 1, 2019

HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC.
WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

INTRODUCTION

Hocking Athens Perry Community Action Agency, Inc. (the "Employer") established the Hocking Athens Perry Community Action Agency, Inc. Welfare Benefit Plan (the "Plan") effective 04/01/1988 and the Plan has been amended and restated effective 04/01/2019. This summary describes the Plan and together with the incorporated documents, describes the benefits offered under the Plan (the "Included Benefits").

This Summary Plan Description supersedes any and all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document and Included Benefit Documents will prevail in the event of any inconsistency.

ADMINISTRATIVE INFORMATION

1. The Plan's name is Hocking Athens Perry Community Action Agency, Inc. Welfare Benefit Plan
   The Plan's number is 501
   The Plan Year End is the 12-month period ending on 03/31

   The Plan is an "employee welfare benefit plan" for purposes of ERISA that includes a group health plan, a group dental plan, a group vision plan, a disability plan, a group life insurance plan and a group accident plan.

   Note: "group health plan" may include a medical, EAP, wellness, expat medical, and Health FSA.
2. The Plan Sponsor is Hocking Athens Perry Community Action Agency, Inc.
   3 Cardaras Drive
   Glouster, OH, 45732
   Phone: 740-767-4500
   Fax: 740-767-2738
   Employer Identification Number: 31-0718322
3. The Plan Administrator is the Employer
   3 Cardaras Drive
   Glouster, OH, 45732
   Phone: 740-767-4500
   Fax: 740-767-2738
4. The agent for legal service is Executive Director
   3 Cardaras Drive
   Glouster, OH, 45732
   Phone: 740-767-4500

   Service of legal process may also be made upon the Plan Administrator.
5. The Plan is not funded by a trust.

6. Funding
   The cost of benefits offered under the Plan is either covered by contributions from the Company, contributions by you, or will be shared by you and the Company. Where you and the Company share the cost of coverage, the Company will contribute the difference between your premium and the amount required to pay benefits under the Plan.

   Any dividends, retroactive rate adjustments, rebates, or other refunds of any type that may become payable under any Included Benefit or in connection with an Included Benefit do not become assets of the Plan but are the property of, and will be retained by, the Company unless otherwise mandated by law.
7. The COBRA contact is the Plan Sponsor
   3 Cardaras Drive
   Glouster, OH, 45732
   Phone: 740-767-4500

ELIGIBILITY

Your eligibility for participation and for benefits under the Plan is described in the documents summarizing the Included Benefits. These documents are available from the Plan Administrator.

PAYMENTS FROM THIRD PARTIES

The Plan has a specific and first right of reimbursement from any payment, amount, or recovery you receive from a third party relating to expenses covered by the Plan. By accepting the benefits of the Plan, you agree to these rights of the Plan, which are described in the Plan document. Below is a summary of these rights. If the reimbursement provisions in this "Payments from Third Parties" provisions conflict with subrogation, right of recovery, or reimbursement provisions in an insurance contract or other document governing the Included Benefit at issue, the provisions in the other document will govern.

The Plan's share of the recovery will not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to the reduction. Further, the Plan's right to reimbursement will not be affected or reduced by any equitable defenses that may affect the Plan's right to reimbursement.

The Plan may enforce its rights by requiring you to assert a claim to any of the benefits to which you may be entitled. The Plan will not pay your attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Company.

If the Plan should become aware that a Participant has received a third-party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and any covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Participant.

By participating in the Plan, you consent and agree:

- that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party.
- to cooperate with the Plan in reimbursing the Plan for costs and expenses.
- to notify the Plan if you have any reason to believe that the Plan may be entitled to recovery from any third party and to sign an agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you payment, amount or recovery from a third party.
- to not assign your rights to settlement or recovery against a third person or party to any other party, including your attorney(s), without the Plan's consent.

If you fail or refuse to execute the required agreement, the Plan may deny payment of any benefits until the agreement is signed. Alternatively, if you fail or refuse to execute the required agreement and the Plan nevertheless pays benefits to you, your acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

The Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

These rights apply even after you are no longer a Participant in the Plan. The Plan Administrator has the authority and discretion to resolve all disputes regarding the Plan's subrogation and reimbursement rights and to make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

CONTINUATION RIGHTS/COBRA NOTICE

The right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review, the documents describing the Included Benefits, this Summary Plan Description, or contact the Plan Administrator.

If you are participating in an Included Benefit subject to COBRA and the Company is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs at least 20 employees, but you should contact the Plan Administrator who can inform you if the Company is a small employer not subject to COBRA and is not required to comply with these rules.

Should you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another

group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Except as set forth in an Included Benefit document, the following shall apply only to the Included Benefits subject to COBRA:

Qualifying Events

You have the right to continue your coverage under the Plan if any of the following events results in your loss of coverage under the Plan:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Plan if any of the following events results in their loss of coverage under the Plan:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."

If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Plan for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage. You will be provided notice of your right to elect COBRA continuation coverage.

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

Notice

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying

Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if he or she is not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of his or her COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Plan until the end of the Plan Year (or 18 months, please contact the COBRA contact for further information on the length of COBRA coverage) in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Plan;
- The date that you first become entitled to Medicare; or
- The date the Employer no longer provides a Plan to any of its employees.

AMENDMENT AND TERMINATION

The Company intends to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan or an Included Benefit, in whole or in part, at any time and for any reason. No participant or beneficiary has a vested right in or to any future Plan benefits.

INCLUDED BENEFIT DOCUMENTS INCORPORATED BY REFERENCE

This Plan incorporates the terms of all welfare benefit plans subject to ERISA sponsored by Employer and any affiliate who has adopted the Plan ("Included Benefits"). Certain documents describing these Included Benefits include information about eligibility, benefits, and

employee/employer contributions for each of the separate Included Benefits, which are incorporated by reference into this summary plan description. These documents may include summary plan descriptions for the Included Benefits, as well as summary benefit booklets, certificates of coverage, enrollment materials, etc. These documents, together with this document, constitute the entire summary plan description for the Plan.

CLAIMS PROCEDURES

In General

Unless the applicable Included Benefit specifies claims procedures, the following procedures will apply. In all cases, the Plan Administrator or Claims Administrator will administer claims in accordance with Section 503 of ERISA and the associated regulations.

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims may also be submitted to the Plan Administrator at the address specified at the beginning of this document.

Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file the claim in accordance with these procedures. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under this section. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" for purposes of this section, unless the Plan Administrator determines that the inquiry is an attempt to file a claim. If the Plan Administrator or its delegate receives a claim, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

You may designate an authorized representative by providing to the Plan Administrator with written notice of the designation. In the case of a claim for medical benefits involving urgent care, your health care professional with knowledge of your medical condition may act as your authorized representative.

Timing of Notice of Claim

The Plan Administrator will notify you of a claim denial within a reasonable period of time, but not later than the time frames below. The time frames will vary depending on the type of Included Benefit and may be extended for any period of time necessary for you to respond to a request for additional information.

Group Health Plan Claims

The following procedures apply to the Included Benefits that are "group health plans." These include any medical, health FSA, wellness, or employee assistance plans.

A. Urgent Care Claims.

An "urgent care" claim is any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If you fail to follow the Plan's procedures for filing an urgent care claim, the Plan Administrator will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 24 hours following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication from you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, or (2) the end of the period given to you to provide the specified additional information.

B. Pre-Service Claims.

A "pre-service" claim is any claim where the Plan conditions receipt of the benefit on approval in advance of obtaining medical care. If you fail to follow the Plan's procedures for filing a pre-service claim, the Plan Administrator will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 5 days following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication by you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify you if its determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan Administrator for up to an additional 15 days. The Plan Administrator may only extend the deadline if they determine that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

C. Post-Service Claims.

A post-service claim is any claim for a benefit under the plan that is not a pre-service claim. In the case of a post-service claim, the Plan Administrator will notify you of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Plan Administrator for up to an additional 15 days. The Plan Administrator may only extend the deadline if they determine that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

D. Concurrent Care Claims.

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute claim denial. The Plan Administrator will notify you of the denial at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a review of that denial before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify you of the denial, whether adverse or not, within 24 hours after the Plan receives the claim, provided that the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Disability Benefit Claims

The Plan Administrator will provide you with notice of an adverse benefits determination within 45 days after receipt of the claim. This period may be extended for up to 30 days, provided that

the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if Plan Administrator notifies you prior to the expiration of the first 30-day extension period of the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section will explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

Non-Group Health Plan and Non-Disability Benefit Claims

For all other claims not described above, the Plan Administrator will provide you with a notice of claim denial within 90 days after receipt of the claim. This period may be extended one time by the Plan Administrator for up to an additional 90 days. The Plan Administrator may only extend the deadline if they determine that such an extension is necessary due to matters beyond the control of the Plan and they notify you of the extension prior to the expiration of the initial 90-day period.

Content of Notice of Adverse Benefit Determination

If your claim is denied, the Plan Administrator will provide you with a written notice identifying:

1. the reason(s) for the denial;
2. the Plan provisions on which the denial is based;
3. any material or information needed to grant the claim and an explanation of why the additional information is necessary; and
4. an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA.

In addition, if the denied claim is for a group health plan or disability benefit under the Plan, the following information will also be included in the written notice:

1. the specific rule, guideline, protocol, or other similar criterion, if any, that was relied upon in the denial; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or
2. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that the explanation will be provided free of charge to you upon request.

If the denied claim is for a disability benefit under the Plan, the following information will also be included in the written notice:

1. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the

covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration regarding you presented by you to the Plan.

2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.
3. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.
4. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for disability benefits.

If the denied claim is for a group health plan benefit under the Plan, the following information will also be included in the written notice:

1. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
3. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes.
4. The Plan must also:
    a. ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim; and
    b. provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In the case of a denied urgent care claim where the Included Benefit is a group health plan, the notice will include a description of the expedited review process applicable to such claims.

This information may be provided orally provided that a written or electronic notification is furnished to you not later than 3 days after the oral notification.

Appeal of Adverse Benefit Determination

You may appeal the denial of a claim (including a rescission of coverage) by filing a written appeal with the Plan Administrator on or before the 60th day after you receive the Plan Administrator's written notice that the claim has been denied. If the denial involves a claim under an Included Benefit that is a group health plan or disability plan, you may file a written appeal on or before the 180th day after your receive written notice of the denial.

If the denial involves a claim for disability benefits, a denial includes a cancellation or discontinuance of coverage that has retroactive effect (unless it is due to your failure to pay required premiums).

Your written appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will lose the right to appeal if your appeal is not timely made.

The Plan will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefit. You may submit written comments, documents, records, and other information relating to the claim for benefits. The Plan will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial claim. The Plan Administrator will consider the merits of your written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant.

If the claim is for group health plan or disability plan benefits the following will apply:

1. The review will not afford deference to the initial claim denial. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of that individual.
2. In deciding an appeal of any denial that is based on a medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the claim denial that is the subject of the appeal, nor the subordinate of any such individual.
3. The Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in the denial.
4. In the case of an urgent care claim, the Plan will expedite review of the claim and you may submit a request for an expedited appeal of a denial orally or in writing. All necessary information, including the Plan's benefit determination on review, will be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

If the claim is for disability benefits under the Plan, the following will apply:

1. Before the Plan issues any adverse benefit determination, the Plan Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan) in connection with the claim, and any new or additional rationale must be provided to you as soon as possible and sufficiently in advance of the date on which the Plan must provide you with the notice of final adverse benefit determination so that you have a reasonable opportunity to respond prior to that date.
2. If the determination is based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it in time for you to have a reasonable opportunity to respond, the Plan's deadline for providing a notice of final adverse benefit determination will be delayed until you have had reasonable opportunity to respond. After you respond, or had a reasonable opportunity to respond but failed to do so, the Plan Administrator will notify you of the Plan's benefit determination as soon as a Plan Administrator acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

The Plan Administrator will ordinarily rule on an appeal of a claim denial within 60 days following receipt of the claim. The time frame will begin at the time your appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, if special circumstances require an extension and the Plan Administrator furnishes you with a written extension notice during the initial period, the Plan Administrator may extend this period of time by 60 days if written notice of the extension is furnished to you prior to the termination of the initial 60-day period. In the event that the extension is due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will start on the date that you respond to the request for additional information.

If the claim is for group health plan benefits, the Plan Administrator will notify you of the Plan's benefit determination on review as follows:

1. Urgent Care Claims. The Plan Administrator will notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination by the Plan.
2. Pre-Service Claims. The plan administrator will notify you of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.
3. Post-Service Claims. The Plan Administrator will notify you of the Plan's benefit determination on review within a reasonable period of time, but no later than 60 days

after receipt by the Plan of your request for review of an adverse benefit determination.

If the claim is for disability benefits, the Plan Administrator will ordinarily rule on an appeal of a claim denial within 45 days following receipt of the claim. The time frame will begin at the time your appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, if special circumstances require an extension and the Plan Administrator furnishes you with a written extension notice during the initial period, the Plan Administrator may extend this period of time by 45 days if written notice of the extension is furnished to you prior to the termination of the initial 45-day period. In the event that the extension is due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will start on the date that you respond to the request for additional information.

All claims and appeals involving group health plan benefits and disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will be made based upon the likelihood that the individual will support the denial of benefits.

The following applies to any claim for group health plan benefits (or appeal of a claim for group health plan benefits):

1. the Plan must ensure that any notice of adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. the Plan must provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review;
3. the Plan must ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of final adverse benefit determination, this description must include a discussion of the decision;
4. the Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
5. the Plan must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes.

Denial of Appeal

If an appeal is wholly or partially denied, the Plan Administrator will provide you with a notice identifying:

1. the reason or reasons for such denial;
2. the Plan provisions on which the denial is based;
3. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
4. a statement describing your right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator will be binding upon all parties.

If the denied claim is for a group health plan benefit under the Plan, the following information will also be included in the written notice:

1. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
3. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes; and
4. The Plan must also:
    a. ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim and a discussion of the decision if the notice is a final adverse benefit determination; and
    b. provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In the case of a group health plan or a plan providing disability benefits, the notice will also include:

1. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
2. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or

clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

3. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

In the case of a claim involving disability benefits, the notice will also include:

1. Any applicable contractual limitations period that applies to your right to bring an action under section 502(a) of ERISA, including the calendar date that the contractual limitations period expires for the claim.
2. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration regarding you presented by you to the Plan.
3. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.
4. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

External Claims Process

State Process. To the extent the Plan is required pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the Plan will comply with the state external claims process of DOL Reg. section 2590.715-2719(c).

Federal Process. To the extent the Plan is not required pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with the State external claims process, then the Plan will comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d).

REFUNDS/INDEMNIFICATION

You must immediately repay any excess payments/reimbursements. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or

reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

MILITARY SERVICE

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

YOUR RIGHTS UNDER ERISA

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right to:

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

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

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

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

To the extent required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this Plan provides coverage for all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan or coverage. Written notice of the availability of such coverage shall be delivered to Participants upon enrollment and annually thereafter. Contact the Plan Administrator for more information.

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 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under

Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

LOSS OF BENEFIT

You may lose all or part of any payment due to you if we cannot locate you when your benefit becomes payable to you.

NON-ALIENATION

You may not alienate, anticipate, commute, pledge, encumber, or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

PLAN ADMINISTRATOR DISCRETION

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation, or application of the Plan by the Plan Administrator is final, conclusive, and binding on all parties.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES FOR HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC. GROUP HEALTH PLAN BENEFITS

What is a Qualified Medical Child Support Order (QMCSO)?

A "QMCSO" is a medical child support order (from a court or administrative agency) that creates or recognizes the right of an "alternate recipient" to receive benefits for which a participant or beneficiary is eligible under a group health plan. The medical child support order may be a judgment, decree, or order (including approval of a settlement agreement) that (1) provides for child support with respect to a child of a participant under a group health plan, (2) provides for health benefit coverage is made pursuant to a State domestic relations law (including a community property law), or (3) is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act.

A medical child support order becomes a QMCSO when it is recognized by the group health plan as meeting certain requirements under applicable law.

Who can be an "alternate recipient"?

Any child of a participant in a group health plan who is recognized under a medical child support order as having a right to enrollment under the group health plan with respect to such participant is an alternate recipient. Eligible children include children adopted by, or placed for adoption with, plan participants.

Why does it matter if a medical child support order is "qualified"?

An alternative recipient under a qualified medical child support order is entitled to certain rights under the group health plan that are not available if the medical child support order is not qualified.

What information must a medical child support order contain to be "qualified" by the group health plan?

A medical child support order must contain the following information to be qualified by the group health plan:

- The name and last known mailing address of the participant and each alternate recipient. The order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined); and
- The period to which the order applies
- An order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of certain State laws.

Is a National Medical Support Notice a QMCSO?

Yes, a National Medical Support Notice is a qualified medical support notice if it includes the information required above.

PROCEDURES

Upon receiving a document providing for coverage of a child under the group health plan, the Plan Administrator will:

1. Determine if the document applies to employee benefits subject to Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

2. If the Plan Administrator determines that the document pertains to benefits subject to Section 609(a) of ERISA, determine if the document is a National Medical Support Notice or a medical child support order as described above.

3. If the Plan Administrator determines that the document is a medical child support order or National Medical Support Notice, notify the participant, each alternate recipient and the issuing court or agency in the case of a National Medical Support Notice of the receipt of the order and provide a copy of these procedures.

4. Review the employment status of the affected employee/parent and review the plan provisions to determine which, if any, group health plan benefits are available to the alternate recipient.

5. Determine if the document is a qualified medical child support order under applicable law.

6. Notify the plan participant and the alternate recipient whether the document is a qualified medical support order within a reasonable time after date of the order (not to exceed 40 business days in the case of a National Medical Support Notice).

A person who is an alternate recipient under a QMCSO will considered a "participant" under the group health plan for purposes of the reporting and disclosure requirements of ERISA, and will be considered a "beneficiary" under the group health plan for all other purposes of ERISA.

Any payment for benefits made by the group health plan pursuant to a QMCSO as reimbursement for expenses paid by an alternate recipient or the alternate recipient's custodial parent or legal guardian will be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

These procedures are applicable only to group health plan benefits subject to Section 609(a) of ERISA.

HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC.
FORMAL RECORD OF ACTION

The following is a formal record of action taken by the governing body of Hocking Athens Perry Community Action Agency, Inc. (the "Company").

With respect to the amendment and restatement of the Hocking Athens Perry Community Action Agency, Inc. Welfare Benefit Plan (the "Plan"), the following resolutions are hereby adopted:

RESOLVED: That the Plan be amended and restated in the form attached hereto, which Plan is hereby adopted and approved;

RESOLVED FURTHER: That the appropriate officers of the Company be, and they hereby are, authorized and directed to execute the Plan on behalf of the Company;

RESOLVED FURTHER: That the officers of the Company be, and they hereby are, authorized and directed to take any and all actions and execute and deliver such documents as they may deem necessary, appropriate or convenient to effect the foregoing resolutions including, without limitation, causing to be prepared and filed such reports, documents or other information as may be required under applicable law.

Dated this _____ day of _____, 2018.

_____

_____

_____

COBRA CONTINUATION COVERAGE ELECTION NOTICE

HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC. WELFARE BENEFIT PLAN

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

Date: _____
Participant name: _____

This notice has important information about your right to continue your health care coverage in the Hocking Athens Perry Community Action Agency, Inc. Welfare Benefit Plan (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided at the end of this notice.

Why am I getting this notice?

You're getting this notice because your coverage under the Plan will end on _____ due to:

- ☐ End of employment
- ☐ Reduction in hours of employment
- ☐ Death of employee
- ☐ Divorce or legal separation
- ☐ Entitlement to Medicare
- ☐ Loss of dependent child status

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

- ☐ Employee or former employee
- ☐ Spouse or former spouse
- ☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- ☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?
If elected, COBRA continuation coverage will begin on _____ and can last until _____. Continuation coverage may end before the date noted in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?
If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify your employer of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

If you elect continuation coverage, the coverage ends at the end of the current plan year.

For more information about extending the length of COBRA continuation coverage visit http://www.dol.gov/ebsa/publications/cobraemployee.html

How much does COBRA continuation coverage cost?
COBRA continuation coverage will cost: _____.

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?
The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at

www.HealthCare.gov. Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?
You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?
If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." However, if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.
If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?
You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.
If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?
When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

MORE INFORMATION

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact Hocking Athens Perry Community Action Agency, Inc. 3 Cardaras Drive Glouster, OH 45732. The Company's telephone number is 740-767-4500.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

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

COBRA CONTINUATION COVERAGE ELECTION FORM

HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC. WELFARE BENEFIT PLAN

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: Hocking Athens Perry Community Action Agency, Inc. 3 Cardaras Drive Glouster, OH 45732. The Company's telephone number is 740-767-4500.

This Election Form must be completed and postmarked by _____.
If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the Hocking Athens Perry Community Action Agency, Inc. Welfare Benefit Plan (the Plan) listed below:

_____

_____

_____

_____

Name Date of Birth Relationship to Employee SSN (or other identifier)

Dated this _____ day of _____, 2018.

_____

Participant Signature

_____

Print Participant Name

_____

Relationship to Individual(s) listed above

_____

Address

_____

Telephone number

Important Information About Payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. You may contact Hocking Athens Perry Community Action Agency, Inc. 3 Cardaras Drive Glouster, OH 45732 (telephone number 740-767-4500) to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due _____ for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you'll be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to: Hocking Athens Perry Community Action Agency, Inc. 3 Cardaras Drive Glouster, OH 45732. The Company's telephone number is 740-767-4500.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC. WELFARE BENEFIT PLAN

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Contact your plan administrator for more information.

PLAN ADMINISTRATOR INFORMATION

The Plan Administrator is Hocking Athens Perry Community Action Agency, Inc..
Address: 3 Cardaras Drive, Glouster, OH 45732
Phone number: 740-767-4500
Fax number: 740-767-2738

NOTICE OF ADVERSE BENEFIT DETERMINATION

Date: _____
Hocking Athens Perry Community Action Agency, Inc. [Telephone/Fax]
Welfare Benefit Plan
[Address] [Website/Email Address]

This document contains important information that you should retain for your records.

This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights).

Case Details

Participant Name:							ID Number:
Address (street, county, state, zip):							
Claim #:		Date of Service:					
Provider:							
Reason for Upholding Denial (in whole or in part):							
Amt Charged	Allowed Amt.	Other Insurance	Deductible	Co-pay	Coinsurance	Other Amts. Not Covered	Amt. Paid
YTD Credit toward Deductible:				YTD Credit toward Out-of-Pocket Maximum:			
Description of Service:				Denial Codes:			

If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.

Explanation of Basis for Determination

If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the definition of a plan or policy term, include that information here.

[Insert language assistance disclosure here, if applicable.

Important Information about Your Appeal Rights

What if I need help understanding this denial?
Contact us at *[insert contact information]* if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision?
You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part).

How do I file an appeal?
[Complete the bottom of this page, make a copy, and send this document to *insert address*.] [or] *[insert alternative instructions]* See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

What if my situation is urgent?
If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also *[insert instructions for filing request for simultaneous external review)]*.

Who may file an appeal?
You or someone you name to act for you (your authorized representative) may file an appeal. *[Insert information on how to designate an authorized representative.]*

Can I provide additional information about my claim?
Yes, you may supply additional information. *[Insert any applicable procedures for submission of additional information.]*

Can I request copies of information relevant to my claim?
Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at [insert contact information] .

What happens next?
If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you:
For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program may be able to assist if available in your state - *[insert information as applicable from list available at www.dol.gov/ebsa/capupdatelist.doc or attach the list]*.

APPEAL FILING FORM

HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC. WELFARE BENEFIT PLAN

Name of Person Filing Appeal: _____

☐ Covered person ☐ Patient ☐ Authorized Representative

Contact information of person filing appeal (if different from patient)

Last Name	First Name	MI

Address - Number and Street	City	State	Zip

( )	
Daytime Phone	Email Address

If person filing appeal is other than patient, patient must indicate authorization by signing here:

_____

Are you requesting an urgent appeal? ☐ Yes ☐ No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

_____

_____

_____

_____

Send this form and your denial notice to: *[Insert name and contact information]*

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.

FINAL NOTICE OF ADVERSE BENEFIT DETERMINATION

Date: _____
Hocking Athens Perry Community Action Agency, Inc. [Telephone/Fax]
Welfare Benefit Plan
[Address] [Website/Email Address]

This document contains important information that you should retain for your records.

This document serves as notice of a final internal adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you may have the right to appeal (see the back of this page for information about your appeal rights).

Internal Appeal Case Details

Participant Name:							ID Number:
Address (street, county, state, zip):							
Claim #:		Date of Service:					
Provider:							
Reason for Upholding Denial (in whole or in part):							
Amt Charged	Allowed Amt.	Other Insurance	Deductible	Co-pay	Coinsurance	Other Amts. Not Covered	Amt. Paid
YTD Credit toward Deductible:				YTD Credit toward Out-of-Pocket Maximum:			
Description of Service:				Denial Codes:			

If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.

Background Information: *Describe facts of the case including type of appeal and date appeal filed.*

Final Internal Adverse Benefit Determination: *List all documents and statements that were reviewed to make this final internal adverse benefit determination.*

Adverse benefit determination has been upheld.

Findings: *Discuss the reason or reasons for the final internal adverse benefit determination.*

[Insert language assistance disclosure here, if applicable.

Important Information about Your Rights to External Review

What if I need help understanding this denial?
Contact us *[insert contact information]* if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision?
For certain types of claims, you are entitled to request an independent, external review of our decision. Contact *[insert external review contact information]*with any questions on your rights to external review.*[For insured coverage, insert: If your claim is not eligible for independent external review but you still disagree with the denial, your state insurance regulator may be able to help to resolve the dispute.]*
See the "Other resources section" of this form for help filing a request for external review.

How do I file a request for external review?
Complete the bottom of this page, make a copy, and send this document to *insert address*.] *[or] [insert alternative instructions.]* See also the "Other resources to help you" section of this form for assistance filing a request for external review.

What if my situation is urgent?
If your situation meets the definition of urgent under the law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by *[insert instructions to begin the process (such as by phone, fax, electronic submission, etc.)]*.

Who may file a request for external review?
You or someone you name to act for you (your authorized representative) may file a request for external review. *[Insert information on how to designate an authorized representative.]*

Can I provide additional information about my claim?
Yes, once your external review is initiated, you will receive instructions on how to supply additional information.

Can I request copies of information relevant to my claim?
Yes, you may request copies (free of charge) by contacting us at *[insert contact information]*.

What happens next?
If you request an external review, an independent organization will review our decision and provide you with a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your health care item or service.

Other resources to help you:
For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).*[and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, a consumer assistance program can help you file your appeal. Contact: [insert information as applicable from list available at www.dol.gov/ebsa/capupdatelist.doc or attach the list.]]*

EXTERNAL APPEAL FILING FORM

HOCKING ATHENS PERRY COMMUNITY ACTION AGENCY, INC. WELFARE BENEFIT PLAN

Name of Person Filing Appeal: _____

☐ Covered person ☐ Patient ☐ Authorized Representative

Contact information of person filing appeal (if different from patient)

Last Name	First Name	MI

Address - Number and Street	City	State	Zip

( )	
Daytime Phone	Email Address

If person filing appeal is other than patient, patient must indicate authorization by signing here:

_____

Are you requesting an urgent appeal? ☐ Yes ☐ No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

_____

_____

_____

_____

Send this form and your denial notice to: [*Insert name and contact information]*

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.