

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500-SF.

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 01/31/2025

- A This return/report is for: [X] a single-employer plan [] a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEP. Other plans must attach a list of participating employer information in accordance with the form instructions.)
B This return/report is [] the first return/report [] the final return/report [X] an amended return/report [] a short plan year return/report (less than 12 months)
C Check box if filing under: [] Form 5558 [] automatic extension [] DFVC program [] special extension (enter description)
D If the plan is a collectively-bargained plan, check here []
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here []

Part II Basic Plan Information—enter all requested information

1a Name of plan: NORTH STATE ENVIRONMENTAL, INC.
1b Three-digit plan number (PN): 501
1c Effective date of plan: 02/01/2024
2a Plan sponsor's name (employer, if for a single-employer plan): NORTH STATE ENVIRONMENTAL, INC.
2b Employer Identification Number (EIN): 56-1890266
2c Sponsor's telephone number: 336-725-2010
2d Business code (see instructions): 562000
3a Plan administrator's name and address: [X] Same as Plan Sponsor.
3b Administrator's EIN
3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.
4b EIN
4d PN
5a Total number of participants at the beginning of the plan year: 56
5b Total number of participants at the end of the plan year: 62
5c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)
5c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)
5d(1) Total number of active participants at the beginning of the plan year: 56
5d(2) Total number of active participants at the end of the plan year: 62
5e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes entries for Stephanie Westmoreland dated 08/30/2025.

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Yes No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) Yes No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No Not determined
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____ (See instructions.)

Part III Financial Information			
7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	314475	511900
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	314475	511900
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	382320	
(2) Participants	8a(2)	64787	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b		
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		447107
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	206790	
e Certain deemed and/or corrective distributions (see instructions) .	8e		
f Administrative service providers (salaries, fees, commissions)	8f	42892	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		249682
i Net income (loss) (subtract line 8h from line 8c)	8i		197425
j Transfers to (from) the plan (see instructions)	8j		

- Part IV Plan Characteristics**
- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:
 4A 4B 4D 4E 4F 4H

Part V Compliance Questions				
10 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c		X	
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i		X	

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below. Yes No

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a**

b PBGC missed contribution reporting requirements. If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

Yes.

No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

No. Other. Provide explanation _____

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above. Yes No

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month _____ Day _____ Year _____

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year **12b**

c Enter the amount contributed by the employer to the plan for this plan year **12c**

d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) **12d**

e Will the minimum funding amount reported on line 12d be met by the funding deadline? Yes No N/A

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year? Yes No

a If "Yes," enter the amount of any plan assets that reverted to the employer this year. **13a**

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? Yes No

c If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

Part VIII IRS Compliance Questions

14a Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? Yes No

14b If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

Design-based safe harbor method

"Prior year" ADP test

"Current year" ADP test

N/A

15 If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter ___/___/___ (MM/DD/YYYY) and the Opinion Letter serial number _____.

Summary Annual Report and Wrap Plan 2024

Plan Name: North State Environmental, Inc.

Plan Number: 4015

Employer Identification Number (EIN): 56-1890266

Plan Year: 2/1/2024 to 1/31/2025

Introduction:

This is a summary of the annual report for the North State Environmental, Inc., EIN 56-1890266, for the period 02/1/2024 to 1/31/2025. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Wrap Plan Information:

The wrap plan includes the following benefits:

1. **Medical Insurance:**
 - **Plan Name:** North State Environmental, Inc.
 - **Plan Number:** 501
 - **Provider:** Planned Administrators, Inc
 - **Coverage Details:**

MEDICAL BENEFITS PLAN		
COVERED SERVICES	NETWORK	NON-NETWORK
Skilled Nursing Facility Inpatient Services	Covered at 100% after Deductible	Covered at 80% after Deductible
Hospital Confinement for Rehabilitation	Covered at 100% after Deductible	Covered at 80% after Deductible
Surgery - Inpatient Hospital - Outpatient Hospital - Ambulatory Surgical Facility - Office / Urgent Care Facility <i>Includes surgeon, assistant surgeon, and anesthesiologist services.</i>	Covered at 100% after Deductible	Covered at 80% after Deductible
Home Health Care	Covered at 100% after Deductible	Covered at 80% after Deductible
Hospice Care	Covered at 100% after Deductible	Covered at 80% after Deductible
Durable Medical Equipment and Supplies	Covered at 100% after Deductible	Covered at 80% after Deductible
Prosthetics/Orthotics	Covered at 100% after Deductible	Covered at 80% after Deductible
Outpatient Physical Therapy	Covered at 100% after Deductible	Covered at 80% after Deductible
Outpatient Occupational Therapy	Covered at 100% after Deductible	Covered at 80% after Deductible
Outpatient Speech Therapy	Covered at 100% after Deductible	Covered at 80% after Deductible
Outpatient Chemotherapy/Radiation/IV Therapy Hospital, Freestanding Facility or Physician's Office	Covered at 100% after Deductible	Covered at 80% after Deductible
Mental Health/Substance Abuse	Benefits will be the same as those stated under each covered services category.	
Chiropractic/Spinal Manipulation Services	\$40 Copay, then Covered at 100%	Covered at 80% after Deductible
Dialysis Services	Covered at 100% after Deductible	Covered at 80% after Deductible
Organ/Marrow/Tissue Transplants	Covered at 100% after Deductible	Covered at 80% after Deductible
All Other Covered Services	Covered at 100% after Deductible	Covered at 80% after Deductible

PRESCRIPTION DRUGS - BENEFIT MANAGER OPTUMRX		
COVERED SERVICES	30-DAY SUPPLY	90-DAY SUPPLY / MAIL
Generic Drugs	\$10 Copay	\$25 Copay
Brand Name Drugs	\$30 Copay	\$75 Copay
Non-Preferred Brand Name Drugs	\$60 Copay	\$150 Copay
ACA Required Preventive Medications	\$0 Copay	
Specialty Drugs (Specialty Network) Limited to a 30-day supply per script	\$140 per script	Not Applicable

MEDICAL BENEFITS PLAN		
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Durable Medical Equipment and Supplies	Covered at 100% after Deductible	Covered at 80% after Deductible
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Outpatient Occupational Therapy	Covered at 100% after Deductible	Covered at 80% after Deductible
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IMPORTANT STEPS FOR YOUR ENROLLMENT PROCESS

Newly hired employees are eligible for benefits on the 31st day of hire (except Long Term Disability - eligibility begins on the 90th day). You must accept or waive coverage prior to your eligibility date. You will not be able to enroll in the North State Environmental Employee Benefit Plan until the next annual open enrollment unless you have a qualifying life event.

ELIGIBLE DEPENDENTS

- Legal spouse
- Any child of an eligible employee up to age 26
- Any child under legal guardianship of the eligible employee up to age 26
- Step-children of eligible employee up to age 26
- Dependent child(ren) required to be covered through a Qualified Medical Support Order
- Any child meeting the criteria above who is over the age 26 and legally incapacitated

LIFE EVENTS

- Birth or adoption of a child
- Marriage or divorce
- Death of spouse and/or dependents
- Dependent's loss of eligibility
- Gain/loss of health care coverage of spouse due to employment changes
- Taking an unpaid leave of absence
- You or your spouse become eligible or ineligible for Medicare benefits
- Other such event Plan Administrator determines to be permitted under I.R.S. Section 125 or other applicable guidelines issued by the I.R.S.
- Gain/loss of eligibility for Medicaid/CHIP (60 days to enroll/cancel coverage rather than 31 for all other life events)

The change to your benefit election must be consistent with the change in family status (i.e. birth of child allows the plan to add a newborn but does not allow you to drop your current coverage). Newborn children of an eligible employee will not be covered from the moment of birth unless enrollment for the child as a dependent is completed within 31 days from the child's date of birth.

WEEKLY COST	MEDICAL	DENTAL	VISION
Employee Only	\$0.00	\$7.92	\$1.42
Employee & Spouse	\$91.48	\$15.44	\$2.95
Employee & Children	\$70.81	\$20.19	\$3.11
Employee & Family	\$181.76	\$28.12	\$4.87

ABOUT YOUR NETWORK

The MedCost Network is one of the largest, most effective networks in the Carolinas, which is comprised of more than 13,000 primary care physicians, over 35,000 specialists, and more than 1,300 hospitals/facilities/ ancillary providers. Our travel network, First Health, is available if the employee or dependent is outside of NC.

Do I have access to an online website so I can view my claim activity and have access to my plan document?

Yes, you have a claim dashboard available 24/7 to access your claim activity. ID Cards and Plan Documents can also be found by visiting www.paisc.com.

CONTACT INFORMATION

Mutual of Omaha - Dental, Vision, Life & Disability

Service Team | 800-769-7159

Claims | 800-775-8805

Planned Administrators, Inc. (PAI) Group Number 4015

Customer Service (Medical) | 800-768-4375

Pharmacy Benefits | 855-260-0974

Benefits Online Member Portal | paisc.com

MedCost (Medical Network) | paisc.com

North State Environmental- North Carolina Human Resources

Stephanie Westmoreland

stephanie@nsenv.com

336-245-1246 direct

336-725-8218 fax

PAI Connect (Optional Mobile Messaging)

Text "PAI Connect" to 735-29 to enroll

or call 888-596-0719

IMPORTANT NUMBERS

Pre-Authorization: 1-800-652-3076

Pre-Authorization for MRI, MRA, PET, CT & CAT scans: 1-800-652-3076

Pre-Authorization for Mental Health and Substance Abuse: 1-800-868-1032

MedCost

paisc.com

MEDICAL NETWORK

The MedCost Network is one of the largest networks in the Carolinas, offering access to quality, affordable healthcare. This is your primary Medical Network.



Care you will love. | (888)691-7867 | fshealth.com

US board certified doctors by phone or video anytime and anywhere.

Use First Stop Health instead of the ER or urgent care center for a non-emergency issue, such as:

- Cold & flu symptoms
- Allergies
- Sinus problems
- Short term Rx refills & more!



Helpful Hints & Information

- **Set up OptumRx account** - Call OptumRx at 855-811-2218.
 - A debit/credit card is NOT required to be kept on file.
 - Once your account is established you can download and use the OptumRx app for easy use.
- **Get new Rx from doctor** - Current prescriptions CANNOT be transferred.
 - 90 day supply for 2 1/2 times the retail co-pay
 - Once your prescriptions are received from your doctor it takes 24 to 48 hours for them to be scanned into the OptumRx system.
- **Plan ahead** - It can take up to 10 days for the medications to be processed and sent to the warehouse for shipping.
- **Track it** - Once the medications are filled, a tracking number will be assigned. Medication ships standard US mail.

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Preventative Care is covered at 100%

Be sure to stay up to date with all of your annual wellness exams. Regardless of which medical plan you select, in-network preventative care is covered at no cost to you! Preventative Services include, but are not limited to:

- ▶ Routine Annual Physicals
- ▶ Well-Child Visits
- ▶ Well-Women Visits
- ▶ Adult and Child Immunizations
- ▶ Flu Shots
- ▶ Covid-19 Vaccines
- ▶ Prostate Screenings
- ▶ Routine Mammograms (one between 35-40, and annually 40 and over)
- ▶ Routine Colorectal Screenings (45 and older, per ACA Guidelines)

Visit www.Healthcare.gov to see the complete list of covered preventive services.

Stay Informed: MyPAI Member Portal

MyPAI Member Portal gives you quick and easy access to view your plan documents, print, view, and request an ID card, or download a PDF, find a network provider, access claims and EOBs, view deductible and out-of-pocket balances, pharmacy benefits and member discounts and value-add programs.

How to Register

1. Visit MyPAI Customer Login at paisc.com.
2. Click on *Select your portal* and choose *Member Portal*.
3. Click on *Create account*, accept the license agreement, click *Next*, and follow the prompts. **Enter your name exactly as shown on your member ID card.**
For security, a new account is required and a two-step authentication process has been added. Your Member ID Number is on your ID Card.
4. Once completed, an email is sent confirming success of the sign up process.

Logging In

Once you have registered for the Member Portal, you may use your username and password to sign in. The Sign In button is on the Member Portal home screen.

Once logged in to the Home page, you can see dashboards containing your coverage summary, claim information and Quick Links.

MyPAI Mobile App

Download the MyPAI app today from the App Store or Play Store.

Note: When searching for this app, be sure to include a space between the words "My" and "PAL"

To ensure successful mobile app usage, your device must be capable of accommodating software updates. Some older models may no longer be capable of running this more current mobile application.

Discount Programs

PAI has partnered with a variety of organizations to provide discount programs and services to help members on the road to better health. These discounts and services are offered as a courtesy to members carrying a PAI member ID card and are not an extension of, or connected to, members' medical benefits. Programs may be terminated and pricing, discount rates and other program features may be modified at any time. Suppliers that participate in these programs are solely responsible for the quality of the goods and services they provide. Discounts cannot be combined with benefits. Programs are subject to change.

Hearing Aids

Beltone offers an extra value-added discount to our members. Beltone has been helping the world hear better for over 78 years. Beltone has led the industry in hearing aid innovation and boasts amazing sound quality and features focused on ease of use. You can wirelessly stream music and other audio from your smartphone and you can even test drive models right in the office.

TruHearing is an exclusive hearing aid savings program for PAI members. PAI members save on average \$980 per hearing aid compared to national average prices. Members can visit any of the over 5,000 TruHearing locations nationwide.

Vision

QualSight LASIK Members receive preferred pricing on LASIK through QualSight providers across the nation with more than 900 locations to choose from. You can save 40 to 50 percent on the national average LASIK cost. LASIK prices have increased slightly due to advancements in laser technologies. Prices also can vary by the LASIK procedure type and the region of the country.

QualSight LASIK features a national network of credentialed surgeons that have collectively performed more than 6.5 million procedures. LASIK surgery is an FDA-approved procedure, and it is performed to correct nearsightedness, farsightedness and astigmatism.

Vision Discount Program Present your PAI ID card at participating vision locations and save on eye exams, frames and lenses. You do not need to have vision coverage with PAI to enjoy these savings. Doctors of optometry and ophthalmology have practices at most participating vision locations to provide exams and prescriptions.

Allergy

Allergy Control Products works hard to find effective products to offer allergy, asthma and sinus sufferers relief from the effects of indoor allergies. Their goal is to help make allergy sufferers' homes and lifestyles healthier and more manageable. PAI members can enjoy discounts on select doctor-recommended products.

National Allergy* For more than 40 years, doctors have trusted National Allergy as their patient resource for non-drug allergy, asthma and sinus relief products. Products are satisfaction guaranteed and sold at competitive prices to relieve you even more!

Alternative Medicine

ChooseHealthy* PAI members have access to a credentialed network of acupuncturists, massage therapists, chiropractors, dietitians, fitness clubs and exercise centers throughout the country. Discounts offered for occupational therapy, physical therapy, and podiatry visits. Medical insurance benefits for these services must be exhausted before using the value-added discount. You also have access to the ChooseHealthy online store discount program where you can take advantage of substantial savings on vitamins and supplements, diet and sports nutrition information, home fitness equipment, books, videos, DVDs, and much more.

Use Your Benefit Dollars Wisely

Use generic medications when possible

A generic drug is a medication created to be the same as an already marketed brand-name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. These similarities help to demonstrate bioequivalence, which means that a generic medicine works in the same way and provides the same clinical benefit as the brand-name medicine. In other words, you can take a generic medicine as an equal substitute for its brand-name counterpart.

Any generic medicine must perform the same in the body as the brand-name medicine. It must be the same as a brand-name medicine in dosage, form and route of administration, safety, effectiveness, strength, and labeling (with certain limited exceptions). It must also meet the same high standards of quality and manufacturing as the brand-name product, and it must be and quality, taken and used in the same way as well. This standard applies to all generic medicines.

Generic medicines use the same active ingredients as brand-name medicines and work the same way, so they have the same risks and benefits as the brand-name medicines.

The FDA Generic Drugs Program conducts a rigorous review to ensure generic medicines meet these standards, in addition to conducting inspections of manufacturing plants and monitoring drug safety after the generic medicine has been approved and brought to market.

A generic drug may have certain minor differences from the brand-name product, such as different inactive ingredients. By using available generics, you can pay the lowest co-pays, while keeping health care costs and ultimately employee premiums down.

Avoid the Emergency Room (ER)

The Emergency Room is a high cost option that should only be used in true emergencies. It is important to have a relationship with a primary care physician for the best quality care. You should always use your primary care physician when possible. If after hours, try an urgent care facility, leaving the ER as a last resort.



Use an Ambulatory Surgical Center (ASC)

Increasingly, outpatient surgeries are performed at ASCs because they are more specialized and efficient, resulting in lower costs. Consider this option for your next outpatient surgery, in an effort to reduce the cost to the plan and lower your out-of-pocket expenses.

Use a Free-Standing Imaging Center

Free-Standing Imaging Centers are much more cost effective than the hospital setting. The median average hospital charges for imaging services is three times more than those charges at free standing facilities/providers. Even though your provider might refer you to the hospital, as many offices are now owned by hospital systems, you can always request a script that you can use at a free-standing imaging center. Consider this option for all x-rays, ultrasounds, MRI, CT and PET Scans.

Read Your Explanation of Benefits (EOB)

An Explanation of Benefits (EOB) Statement is a notification form provided to members when a health care benefits claim is processed by PAI. The EOB displays the expenses submitted by the provider and shows how the claim was processed.

Make sure you have your EOB from PAI before paying any medical bills. You are using the Preferred Blue Network that offers significant discounts from provider charges. You should always check your medical bills against the EOB, to confirm that you are not paying more than you actually owe the provider. It can be a challenge to get refunds, once you have paid more than you owe.

- 1. Customer Service:** PAI's website and customer service telephone number, as well as general information identifying the enrolled member and the employer group. Refer to the Messages section (#21) for additional details on customer service assistance information.
- 2. Dates of Service:** The date(s) the patient received services with the provider.
- 3. Service Code:** The type of service(s) billed on the claim. Refer to the Service Code Description section (#19) for additional details.
- 4. Total Charges:** The amount(s) the provider charged for the service.
- 5. Ineligible:** The portion of charges ineligible under your health plan.
- 6. Reason Code:** The reason for the ineligible amount(s). Refer to the Reason Code Description section (#18) for additional details.
- 7. Provider Discount:** If a preferred provider is used, this amount represents the negotiated discount for the service. (Preferred providers must write off this amount.)
- 8. Covered Amount:** Amount covered by your plan after subtracting any ineligible amounts or provider discounts.
- 9. Deductible Amount:** The amount, if any, you are responsible for paying to the health care provider before we start paying contract benefits. You do not send this amount to us. We subtract this amount from the covered charges on the claim(s) you and health care professionals send to us.
- 10. Co-Pay Amount:** The set fee you pay each time you receive a certain service.
- 11. Co-Insurance:** The percentage of the Allowed Amount you pay as your share of charges. If your plan pays 80 percent of eligible charges, then 20 percent of eligible charges would be your Co-Insurance amount.
- 12. Balance:** Remainder of the charges after the Deductible, Co-Pay and/or Co-Insurance have been subtracted from the Allowed Amount.
- 13. Paid At:** The percentage of the balance paid by your plan for each service.
- 14. Payment Amount:** The amount to be paid by your plan for each service, based on your coverage.
- 15. Amount You May Owe or Have Paid Provider:** The amount you owe the provider for this claim.
- 16. Other Insurance Credits or Adjustments:** Amounts on this line represent any other insurance or adjustments to be applied.
- 17. Total Net Payment:** The actual amount paid by your plan after taking into consideration Other Insurance Credits or Adjustments.
- 18. Reason Code Description:** This section describes the Reason Code(s) referenced in section #6.
- 19. Service Code:** This section describes the Service Code(s) referenced in section #3.
- 20. Accumulators:** This section shows the total amount you have accumulated toward your deductible(s) and/or out-of-pocket maximum(s) during this benefit period.
- 21. Messages:** This section provides additional detail for customer service assistance.

Note: Additional pages following the EOB include definitions to help you better understand your benefits, provide important information about your appeal rights, and the process for filing an appeal if you disagree with how your claim was paid.

On-the-go Health Information: Mobile Messaging

PAI now offers communications with our members via their mobile devices. Our goal is to give members and their dependents (over the age of 18) information and access to resources through their smartphones. Members who opt into the Relay text messaging program will receive text messages that link to secure and personalized information regarding health benefits and tips. This information is targeted to help our members maximize their health care benefits, take advantage of cost savings, and provide tips on how to improve their health. We will use this service to reach out to policyholders on a regular basis.

Messaging topics will include:

- ▶ Health and wellness reminders
- ▶ Cost saving tips
- ▶ And more

Mobile messaging is recommended but completely optional. It's a simple and secure way to get information you can use.

It's Easy to Sign up

Call 888-596-0719 or text "*PAI Connect*" to 735-29 from your mobile phone today. Please have your member ID card ready.

Customer Service

Your dedicated PAI Customer Service Advocates are ready to assist you with any questions you have!

PAI Customer Service Advocates

800-768-4375

Monday – Friday

8:30 a.m. to 5 p.m. (EST)

Online Provider Locator

Getting Started

Go to www.paisc.com.

- Towards the top of the page, click on **Find a Doctor**.

OR

- On the upper right or left side of the page under **MyPAI Customer Login**, select **Member Portal** from the dropdown box. Click "Log In."
- Once redirected to the Member portal, sign in to your account. (If you don't have an account, you will need to create one.)
- Click on "Find a Provider."

THEN

- On the Provider Directory Links page, click on the preferred provider network logo that corresponds with the logo on your member ID card to be redirected to the network provider locator page.

Search Tool

Enter data in the required fields to complete your search. Required fields may include:

- **Zip Code**
- **Provider Type**
- **Specialty**

There may be optional/advanced fields that can be used to refine your search criteria:

- **County**
- **City**
- **Distance**
- **Gender**

To get the best results from your search:

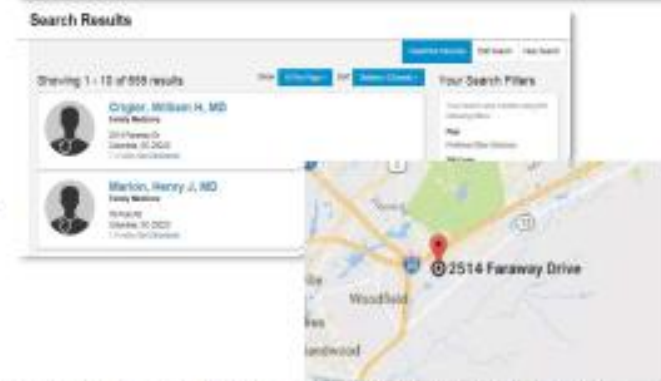
- Consider your search radius
- Ensure you are using correct spelling in the provider or hospital name field
- If your initial provider search doesn't produce results, try again with a similar specialty

The more fields that have entries, the narrower the search results will be.

Search Results

Your search results will be displayed when you click the applicable **Search** button. The provider's office address and phone number are listed. You may have the option to view a map of the provider's location.

If you cannot find a provider in your city or county, please contact PAI's Customer Service Department (800-768-4375).



Information is subject to change without prior notice. PAI cannot guarantee that the provider's directory information is always current. Check with your provider before making an appointment to verify that they are still part of the network.

ABOUT YOUR PLAN

Because of the dramatic increase in the cost of medical care, group health Plans encourage and reward those covered individuals who are selective in their purchase of medical services.

Please review this booklet, which describes your health Plan. Be a selective medical consumer and assume the major role in keeping the cost of medical services at a minimum.

Your Plan Sponsor has established a comprehensive Group Health Plan (Plan) for its Employees. In connection with the Plan, your Plan Sponsor has retained the services of *Planned Administrators, Inc.* (PAI) (a third-party administrator) to process and pay health claims and to provide administrative services in connection with the operation of this Plan of Benefits. PAI has contracted with **Medcost** as the Preferred Provider Organization (PPO) and **First Health** will be used only for travel. Drug coverage is handled by a Pharmacy Benefit Manager (PBM), Optum Rx, is an independent company. The PBM provides administrative prescription drug claims processing and other general PBM support services.

You will receive maximum Benefits that can be paid when you use Providers who participate in the PPO Program (the term "PPO Providers" is explained further below) and when you obtain preauthorization (when required) for services. You will pay more if you do not use PPO Providers or if you do not obtain preauthorization (unless it is an emergency) before you receive medical care or services. This information explains how to obtain authorization for services or supplies covered under this Plan.

It is your responsibility to ensure that your Provider is a PPO Provider. You should verify your Provider's status before services are rendered. To verify whether your Provider is a PPO Provider, you may:

- Ask the Provider if they participate in the PPO program referenced above.
- See the appropriate website for Provider information. Link available on www.paisc.com.
- Call PAI.*

* The methods of verifying PPO participation may have timing differences between when a Provider is participating in the PPO or terminating from the PPO. The preferable method of obtaining the most correct information is to ask your Provider.

For all Employees, First Health is the PPO for this Group Health Plan.

PPO Providers include Hospitals, Skilled Nursing Facilities, Home Health Agencies, hospices, doctors and other Providers of medical services and supplies (as listed in the Definitions section) that have a written agreement with the PPO. Under their agreement with the PPO, PPO Providers will:

- File all claims for Benefits or supplies with PAI;
- Ask you to pay only the Deductible, per occurrence Copays and Coinsurance amounts, if any, for Benefits;
- Accept the preferred allowance as payment in full for Covered Expenses;
- Make sure that all necessary approvals are acquired from the Medical Services Department.

Non-PPO Providers include Hospitals, Skilled Nursing Facilities, Home Health Agencies, hospices, doctors and other Providers of medical services and supplies that are not under contract with the PPO. Non-PPO Providers can bill you their total charge. They may ask you to pay the total amount of their charges at the time you receive services or supplies, or to file your own claims, and you will need to obtain any necessary approvals for benefits to be paid. In addition to Deductibles and Coinsurance, you are responsible for the difference between the Non-PPO Provider's charge and the Allowed Amount for Covered Expenses.

Although Benefits typically are reduced when you use a Non-PPO Provider, Benefits provided by a Non-PPO Provider will be covered at the PPO Provider level under these circumstances:

- In the event treatment is for an Emergency Medical Condition as defined in this Plan of Benefits and PPO Provider care is not available;
- For Dependents living out of state;
- For treatment by a Specialist when a PPO Provider Specialist is not available;
- For Non-PPO Provider ancillary services rendered in a PPO Provider Hospital.

Out-of-area Emergency Provision—If a Participant receives care for an Emergency Medical Condition from a Non-Participating Provider, the Plan will pay for Benefits at a PPO Provider level of Benefits if all of these conditions are met:

- You were traveling for reasons other than seeking medical care when the Emergency Medical Condition occurred.
- You were treated for an accidental injury or new Emergency Medical Condition.

Benefits under this provision are subject to the Deductibles or Copays, Coinsurance and all Plan of Benefits maximums, limits and exclusions.

If you have claims that meet all of these conditions, write or call PAI. PAI will review your claims to determine if additional Benefits can be provided.

Customer Service

PAI is committed to helping you understand your coverage and obtain maximum Benefits on your claims. If you have questions about your coverage, you may access www.paisc.com, call or write PAI at:

Planned Administrators, Inc.
Attn: Claims
P.O. Box 6927
Columbia, SC 29260
800-768-4375

Once a claim has been processed, you will have access to an Explanation of Benefits (EOB) via PAI's website or by contacting customer service. An EOB also will be mailed to you. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowed Amount, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim.

Website

A variety of information is available through PAI's website www.paisc.com, including the Provider Locator, Benefits Portal and a useful guide, "How to Read Your EOB", and a complete list of prescription drugs and specialty drugs that require Preauthorization.

Time Limits to File a Claim

Claims must be filed no later than 12 months from the incurred dates of service in which you or your Dependents receive the medical services or supplies. Exceptions may be made where you show that you were not legally competent to file the claim.

Prescription Drug Claims Processed by PBM

A prescription Drug Claim must be submitted for payment by a participating pharmacy no later than one hundred and eighty (180) days after the service, or a longer period of time if required by law.

Authorized Representatives and Representatives designated under Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Unless expressly permitted by law, you and your Dependent's PHI generally cannot be released to any other person without your or your Dependent's consent. Nevertheless, there are instances when you may want someone to discuss your PHI with PAI or receive Explanation of Benefits etc. to manage your care. In order to comply with applicable laws and also to comply with your request, you must sign a written authorization form. To obtain a copy of the form, please log in to your Member page at www.paisc.com and click on the Forms tab where you will find the PAI HIPAA Forms option. You can print this form and mail to the PAI address, or you can call 800-768-4375 for a copy of the form.

A Provider may be considered a Participant's authorized representative without a specific designation by the Participant when the claim request is for an Urgent Care Claim. A Provider may be a Participant's authorized representative with regard to non-Urgent Care Claims for Benefits or an appeal of an Adverse Benefit Determination only when the Participant gives the Plan supervisor a specific written designation in a format that is reasonably acceptable to PAI to act as an authorized representative. All information and notifications will continue to be directed to the Participant unless the Participant gives contrary directions.

PREAUTHORIZATION

To receive the maximum Benefits, certain types of services and equipment and all Admissions require Preauthorization in order to be covered under the Plan. Depending on the type of service, either the BlueCross BlueShield of South Carolina Medical Review Department or Companion Benefit Alternatives, Inc. (CBA) or Optum Specialty Pharmacy must give advance authorization for Specialty Drugs services and equipment that require Preauthorization and for all Admissions.

All Admissions and some Benefits (as indicated herein or on the Schedule of Benefits) require Preauthorization to determine the Medical Necessity of such Admission or Benefit. The Group Health Plan reserves the right to add or remove Benefits that are subject to Preauthorization. Each Participant is responsible for obtaining Preauthorization and the appropriate review. If Preauthorization is not acquired for an Admission or outpatient services and the Participant is still admitted, Benefits may be reduced (up to and including denial of all or a portion of the room and board charges associated with the Admission) as listed on the Schedule of Benefits. If a PPO fails to obtain Preauthorization, they are required to write off this reduced amount and cannot bill the Participant for this amount. The Participant is responsible for obtaining Preauthorization for Admission to a Non-PPO Provider facility, and the Participant will be responsible for any penalty or reduction in payable charges as stated in the Schedule of Benefits if approval is not obtained. Preauthorization is obtained through these procedures:

1. For all Admissions that are not the result of an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Preadmission Review.
2. For all Admissions that result from an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Emergency Admission Review.
3. For Admissions that are anticipated to require more days than approved through the initial review process, Preauthorization is granted or denied for additional days in the course of the Continued Stay Review.
4. For specific Benefits that require Preauthorization, Preauthorization is granted or denied in the course of the Preauthorization process.
5. For items requiring Preauthorization, the Medical Review Department or CBA must be called at the numbers listed below or on the Identification Card.

Items requiring Preauthorization are listed on the Schedule of Benefits.

Who to Call for Preauthorization

For Preauthorization for medical care, call the BlueCross Medical Review Department at 800-652-3076.

For Preauthorization for Inpatient and Outpatient Mental Health Services, Mental Health Conditions or Substance Use Services, call CBA at 800-868-1032. CBA is a Mental Health and Substance Use subsidiary of BlueCross.

Preauthorization for Specialty Drugs, call Optum Specialty Pharmacy at 877-259-9428.

If you are unsure if Preauthorization is required, call PAI customer service. Nevertheless, customer service representatives cannot give approval for services.

These numbers also are on your Identification Card. Be sure to keep your Identification Card with you at all times, since you never know when you may need to reach us.

When you call for Preauthorization, you will be asked for this information:

- Your name and ID number
- Participant's Employer
- The patient's name and relationship to you
- The Provider's name, address and phone number
- If applicable, the Hospital or Skilled Nursing Facility's name, address and phone number
- The reason the requested service, supply or Admission is necessary

After careful review, your Physician and Hospital will be notified whether the service, supply or Admission is approved as Medically Necessary and how long the approval is valid.

If you are or a Dependent is undergoing a human organ and/or tissue Transplant, written approval must be obtained in advance and the procedure must be done at a facility that PAI designates. **If PAI does not pre-approve these services in writing** or they are not done by a Provider PAI designates, then this Plan will not pay any Benefits.

If your Physician recommends services and supplies for you or your Dependent for any reason, make sure you tell your Physician that your health insurance Plan requires Preauthorization. Participating Providers will be familiar with this requirement and will obtain the necessary approvals.

Please note that if your claim for services or Benefits is denied, you may request further review under the guidelines set out in the Claims Filing and Appeal Procedures section of this booklet. Remember that a denial of a Preauthorization is a denied claim for purposes of an appeal.

CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. Where a Participating Provider renders medical services or supplies, generally the Participating Provider should either file the claim on a Participant's behalf or provide an electronic means for the Participant to file a claim while the Participant is in the Participating Provider's office. Nevertheless, the Participant is responsible for ensuring that the claim is filed.

Where a Participating PBM Provider fills prescription drugs, claims for covered prescription services are submitted to the PBM through the PBM's point-of-service system in accordance with NCPDP guidelines.

2. Written notice of receipt of services on which a claim is based must be furnished to PAI, at its address listed in this booklet, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Participant can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, PAI will furnish or cause a claim form to be furnished to the Participant. If the claim form is not furnished within fifteen (15) days after PAI receives the notice, the Participant will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Participant must submit written proof covering the character and extent of the services within this Plan of Benefits' time fixed for filing proof of loss.
3. For Benefits not provided by a Participating Provider, the Participant is responsible for filing claims with PAI. When filing the claims, the Participant will need:
 - a. A claim form for each Participant. Participants can obtain claim forms from PAI at the telephone number indicated on the Identification Card or via the website, www.paisc.com.
 - b. Itemized bills from the Provider(s). These bills should contain the:
 - i. Provider's name and address;
 - ii. Participant's name and date of birth;
 - iii. Participant's Identification Card number;
 - iv. Description and cost of each service;
 - v. Date that each service took place; and
 - vi. Description of the illness or injury and diagnosis.
 - c. Participants must complete each claim form and attach the itemized bill(s) to it. If a Participant has other insurance that already paid on the claim(s), the Participant also should attach a copy of the other Plan's Explanation of Benefits notice.
 - d. Participants should make copies of all claim forms and itemized bills for the Participant's records, since they will not be returned. Claims should be mailed to PAI's address listed on the claim form.
4. PAI must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Participant shows it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months for medical services or supplies following the date services were received. For prescription drug claims submitted to the PBM by participating pharmacies, claims must be filed within one hundred and eighty (180) days or longer if required by a specific law following the date services were received.
5. Receipt of a claim by PAI will be deemed written proof of loss and will serve as written authorization from the Participant to PAI to obtain any medical or financial records and documents useful to the Plan of Benefits. The Plan of Benefits, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to PAI in support of a Participant's claim will be deemed to be acting as the agent of the Participant. If the Participant desires to

appoint an Authorized Representative in connection with such Participant's claims, the Participant should contact PAI for an Authorized Representative form.

6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The Group Health Plan will make a determination for each type of claim within these time periods:
 - a. Pre-Service Claim
 - i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.
 - ii. If a Pre-Service Claim is improperly filed, or otherwise does not follow applicable procedures, the Participant will be sent notification within five (5) days of receipt of the claim.
 - iii. An extension of fifteen (15) days is permitted if PAI (on behalf of the Group Health Plan) determines, for reasons beyond the control of PAI, an extension is necessary. If an extension is necessary, PAI will notify the Participant within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date PAI expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If PAI does not receive the required information within the forty-five (45) day time period, the claim will be denied. PAI will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If PAI receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first-level appeal. Reference the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, for details regarding the appeals process.
 - b. Urgent Care Claim
 - i. A determination will be sent to the Participant in writing or in electronic form as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.
 - ii. If the Participant's Urgent Care Claim is determined to be incomplete, the Participant will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Participant then will have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.
 - iii. If the Participant requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Participant will be notified within twenty-four (24) hours of receipt of the request for an extension.
 - c. Post-Service Claim
 - i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.
 - ii. An extension of fifteen (15) days may be necessary if PAI (on behalf of the Group Health Plan) determines, for reasons beyond the control of PAI, an extension is necessary. If an extension is necessary, PAI will notify the Participant within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date PAI expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If PAI does not receive the required information within the forty-five (45) day time period, the claim will be denied. PAI will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If PAI receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first-level appeal. Reference the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, for details regarding the appeals process.

d. Concurrent Care Claim

The Participant will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Participant time to appeal the decision before the Benefits are reduced or terminated.

7. Notice of Determination

- a. If the Participant's claim is filed properly, and the claim is in part or wholly denied, the Participant will receive notice of an Adverse Benefit Determination. This notice will:
- i. State the specific reason(s) for the Adverse Benefit Determination;
 - ii. Reference the specific Plan of Benefits provisions on which the determination is based;
 - iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
 - iv. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;
 - v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);
 - vi. If the reason for denial is based on a lack of Medical Necessity, or Experimental or Investigational services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).
- b. The Participant will also receive a notice if the claim is approved.

B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. The Participant has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet these requirements:
 - a. An appeal must be in writing;
 - b. An appeal must be sent (via U.S. mail or FAX) at the address or FAX number below:
Planned Administrators, Inc.
Attention: Appeals
P.O. Box 6927
Columbia, SC 29260
FAX 803-870-8012
 - c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question;
 - d. An appeal must include the Participant's name, address, identification number and any other information, documentation or materials that support the Participant's appeal.
2. The Participant may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.
3. If the appealed claim involves an exercise of medical judgment, the Plan Sponsor will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4. The final decision on the appeal will be made within the time periods specified below:
 - a. Pre-Service Claim

PAI (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.
 - b. Urgent Care Claim

The Participant may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Plan Sponsor will communicate with the Participant by telephone or facsimile. The Plan Sponsor will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.
 - c. Post-Service Claim

PAI (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.
 - d. Concurrent Care Claim

The Plan Sponsor will decide the appeal of Concurrent Care Claims within the time frames set forth in the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, item 4 a.-c., depending on whether such claim also is a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.
5. Notice of Final Internal Appeals Determination
 - a. If a Participant's appeal is denied in whole or in part, the Participant will receive notice of an Adverse Benefit Determination.
 - i. State specific reason(s) for the Adverse Benefit Determination;
 - ii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;
 - iii. State 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 claim for Benefits;
 - iv. Disclose and provide any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination;
 - v. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, or Experimental or Investigational services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
 - vi. Include a statement regarding the Participant's right to request an external review;
 - vii. Include a statement regarding the Participant's right to bring an action under section 502(a) of ERISA.
 - b. The Participant will also receive a notice if the claim on appeal is approved.
6. The Plan Sponsor may retain PAI to assist the Plan Sponsor in making the determination on appeal. Regardless of its assistance, PAI is acting only in an advisory capacity and is not acting in a fiduciary capacity. The Plan Sponsor at all times retains the right to make the final determination.

C. EXTERNAL REVIEW PROCEDURES

1. After a Participant has completed the appeal process, a Participant may be entitled to an additional, external review of the Participant's claim at no cost to the Participant. An external review may be used to reconsider the Participant's claim if PAI has denied, either in whole or in part, the Participant's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated.
2. After a Participant has completed the appeal process (and an Adverse Benefit Determination has been made), such Participant will be notified in writing of such Participant's right to request an external review. The Participant should file a request for external review within four (4) months of receiving the notice of PAI's decision on the Participant's appeal. In order to receive an external review, the Participant will be required to authorize the release of such Participant's medical records (if needed in the review for the purpose of reaching a decision on Participant's claim).
3. Within six (6) business days of the date of receipt of a Participant's request for an external review, PAI will respond by either:
 - a. Assigning the Participant's request for an external review to an Independent Review Organization and forwarding the Participant's records to such organization;
 - b. Notifying the Participant in writing that the Participant's request does not meet the requirements for an external review and the reasons for PAI's decision.
4. The external review organization will take action on the Participant's request for an external review within forty-five (45) days after it receives the request for external review from PAI.
5. Expedited external reviews are available if the Participant's Physician certifies that the Participant has a serious medical condition. A serious medical condition, as used in the Claims Filing and Appeal Procedures section, C. External Review Procedures, item 5, means one requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or would place the Participant's health in serious jeopardy. If the Participant may be held financially responsible for the treatment, a Participant may request an expedited review of PAI's decision if PAI's denial of Benefits involves Emergency Medical Care and the Participant has not been discharged from the treating Hospital.

CASE MANAGEMENT

Case management is provided through a contract between PAI and BlueCross.

CASE MANAGEMENT

In the event of a serious or catastrophic illness or injury, this Plan of Benefits provides for a comprehensive case management program. The comprehensive case management program is a patient-centered approach to developing a comprehensive plan of cost-effective health care. The services provided under the case management program include:

- A. Evaluation and assistance for the Participant to help develop a plan of services to meet specific needs;
- B. Assistance with obtaining unusual equipment or supply needs;
- C. Assistance in home care planning and implementation;
- D. Arrangements for needed nursing/caregiver services;
- E. Providing help with assessment of rehabilitation needs and Provider arrangements;
- F. Offering appropriate and effective alternative care/therapy suggestions for Mental Health Services and/or Substance Use Services as determined by medical care review;
- G. Monitoring and assuring treatment programs and interventions for Mental Health Services and/or Substance Use Services;
- H. Functioning as an effective resource for information on treatment facilities and available care for Mental Health Services and/or Substance Use Services.

The case management program is voluntary and will not provide Benefits in excess of those ordinarily available under the Plan.

ALTERNATIVE TREATMENT PLAN UNDER CASE MANAGEMENT

In the course of the case management program, the Plan Administrator shall have the right to alter or waive the normal provisions of this Plan of Benefits when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care.

Benefits provided under this section are subject to all other Plan of Benefits provisions. Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Participant or any other Participant. Nothing contained in this Plan of Benefits shall obligate the Plan Administrator to approve an alternative treatment plan.

Be Well Health Management Engagement Suite—Coaching Support for Life's Lasting/Chronic Conditions:

<ul style="list-style-type: none">• Asthma (pediatric and adult)• Chronic Obstructive Pulmonary Disease (COPD)• Diabetes (pediatric and adult)• Heart Disease<ul style="list-style-type: none">○ Congestive Heart Failure (CHF)○ Coronary Artery Disease (CAD)○ Hyperlipidemia (High Cholesterol)○ Hypertension (High Blood Pressure)• Metabolic Health	<ul style="list-style-type: none">• Migraine• Maternity Care (includes post-partum support)• Behavioral Health Conditions:<ul style="list-style-type: none">○ Recovery Support○ Anxiety○ Attention Deficit Hyperactivity Disorder for Adults○ Bipolar Disorder○ Depression
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As a Participant in Be Well Health Management, you will receive personalized information and tools to help you learn more about your condition and ways to improve your health. You will also have access to a personal health coach—a healthcare professional who can help you reach your health goals. If you are identified as someone with one of the conditions listed above who could benefit from the program, you will be automatically enrolled. If you do not wish to participate, you can disenroll by calling 855-838-5897.

Telemedicine is an innovative program that allows Participants to access quality medical care for individuals of all ages through a national network of Physicians. Medical consultations can be conducted with a board certified, credentialed and licensed Physician who can diagnose illnesses, recommend treatment and, when necessary, prescribe medication AND do it all by phone or video. 24 hour a day EVERY day availability saves valuable time and money by avoiding unnecessary visits to the emergency room, urgent care clinics and your Primary Care Physician (PCP).

Call 800-835-2362 for fast, convenient medical help with conditions such as:

Sore throat	Urinary Tract Infection
Bronchitis	Respiratory Infection
Allergies	Ear Infections
Stuffy nose	Sinus problems
Poison Ivy	Cold and flu symptoms
Pink Eye	And many more.

PRESCRIPTION DRUG UTILIZATION MANAGEMENT PROGRAMS

Prescription Drug Utilization Management Programs are designed to promote cost-effective drug utilization management and to discourage Prescription Drug over and under-utilization. PAI or the PBM may communicate with Participants to describe health-related products or services provided by the Benefit Plan. They may also conduct population-based activities relating to improving health of Participants and reducing healthcare costs. They may also contact Members with health education information about Prescription Drugs, treatment alternatives or other related functions. Please refer to www.paisc.com for a complete list of Prescription Drugs and Specialty Drugs that are subject to Prescription Drug Utilization Management Programs such as Pharmacy Benefit Prior Authorization, Step Therapy, and Quantity Limits.

MEDICAL SCHEDULE OF BENEFITS

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits. Percentages stated are those paid by the Group Health Plan. Covered Expenses will be paid only for Benefits that are Medically Necessary.

Benefit Year is from February 1st – January 31st.

Deductibles:

Benefit Year Deductible: Benefits with an "*" indicate that the Benefit Year Deductible is waived.	<p>\$1,750 per Participant per Benefit Year at a Participating Provider, limited to \$3,500 per family (includes Non-Participating Providers of ambulance services, Emergency Services, and Non-Emergency Services furnished at certain Participating Provider facilities).</p> <p>\$3,500 per Participant per Benefit Year at a Non-Participating Provider, limited to \$7,000 per family.</p>
Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductible.	

Maximums:

Annual Out-of-Pocket Maximum:	<p>\$2,750 per Participant and \$5,500 per family at a Participating Provider (includes Non-Participating Providers of ambulance services, Emergency Services, and Non-Emergency Services furnished at certain Participating Provider facilities).</p>
Includes Benefit Year Deductible, Medical Copays and Prescription Drug Copays.	<p>\$5,500 per Participant and \$11,000 per family at a Non-Participating Provider</p> <p>Allowed Amounts are paid at 100% after the Out-of-Pocket Maximum is met.</p> <p>Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums.</p> <p>Penalties do not contribute to the Out-of-Pocket Maximum determination, nor does the percentage of reimbursement change from the amount indicated on the Schedule of Benefits.</p>

MEDICAL SCHEDULE OF BENEFITS

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits. Percentages stated are those paid by the Group Health Plan. Covered Expenses will be paid only for Benefits that are Medically Necessary.

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Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductible.	

Maximums:

Annual Out-of-Pocket Maximum:	\$2,750 per Participant and \$5,500 per family at a Participating Provider (includes Non-Participating Providers of ambulance services, Emergency Services, and Non-Emergency Services furnished at certain Participating Provider facilities).
Includes Benefit Year Deductible, Medical Copays and Prescription Drug Copays.	\$5,500 per Participant and \$11,000 per family at a Non-Participating Provider Allowed Amounts are paid at 100% after the Out-of-Pocket Maximum is met. Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums. Penalties do not contribute to the Out-of-Pocket Maximum determination, nor does the percentage of reimbursement change from the amount indicated on the Schedule of Benefits.

⁴When services are received from a Non-PPO provider, and the Non-PPO Provider satisfies advance patient notice and consent requirements, the Participant may be required to pay the balance of the Provider's charge if the Allowable charge is less.

²Non-PPO provider at a PPO Provider Facility: When services are received from a Non-PPO provider in a PPO Provider Facility, such services will be processed at the PPO benefit level. This means an application of the appropriate PPO deductible and coinsurance. Otherwise, the Participant must pay the balance of the Provider's Charge, if greater than the Allowable Charge.

OUTPATIENT SERVICES:	PPO:	Non-PPO:
Hospital and Ambulatory Surgical Center Charges: Includes services provided on an outpatient basis, such as: Lab, X-ray and other diagnostic services	100%	80% ^{1 2}
Hospital and Physician Charges (Non-Emergency Services):	100%	80% ^{1 2}
Emergency Room Facilities Charges:	\$150 Copay, then 100%	\$150 Copay, then 100%
Emergency Room Physician Charges:	100%	100%
Preadmission Testing:	100%	80% ^{1 2}
Anesthesia:	100%	80% ^{1 2}
Cardiac Rehabilitation:	100%	80% ^{1 2}
Mental Health or Substance Use (Non-Emergency Services): Preauthorization required	100%	80% ^{1 2}
Mental Health or Substance Use (Emergency Room) charges:	\$150 Copay, then 100%	\$150 Copay, then 100% ^{1 2}
Diagnostic X-ray, Laboratory, Pathology, and Radiology:	100%	80% ^{1 2}
MRI/MRA/CT/PET Scans at free standing facility: Preauthorization is required	\$50 Copay, then 100%	80%

⁴When services are received from a Non-PPO provider, and the Non-PPO Provider satisfies advance patient notice and consent requirements, the Participant may be required to pay the balance of the Provider's charge if the Allowable charge is less.

²Non-PPO provider at a PPO Provider Facility: When services are received from a Non-PPO provider in a PPO Provider Facility, such services will be processed at the PPO benefit level. This means an application of the appropriate PPO deductible and coinsurance. Otherwise, the Participant must pay the balance of the Provider's Charge, if greater than the Allowable Charge.

PHYSICIAN OFFICE SERVICES:	PPO:	Non-PPO:
Physician Office Visit for Accident or Illness: Including Surgery, Lab, X-ray, Pathology, Radiology, Supplies, Allergy Services and Injections, Mental Health, Substance Use and Injections billed in office Generalist: Specialist:	\$20 Copay, then 100% \$40 Copay, then 100%	80%
Urgent Care:	\$40 Copay, then 100%	80%
Lab, X-ray, Pathology, Radiology, Supplies, Mental Health, Substance Use and Injections billed separate from office	100%	80%
Convenience Care Clinic: Located in retail store/supermarket/pharmacy	\$10 Copay, then 100%	100%
Birth Control Device Surgery: Includes IUD, Implanon, Norplant and Others	*100%	Not Covered

Primary Care Physicians (PCP) - Family Practice, General Practice, Internal Medicine, Pediatrician, OB/Gyn, Nurse Practitioner.

OTHER SERVICES:	PPO:	Non-PPO:
Chiropractic Care:	\$40 Copay, then 100%	80%
Hospice Care: Preauthorization is required	100%	80%
Home Health Care: Preauthorization is required	100%	80%
Durable Medical Equipment: Preauthorization is required if \$250 or more	100%	80%
Second Surgical Opinion :	\$40 Copay, then 100%	80%
Human Organ/Tissue Transplants: Preauthorization required—Covered only at a facility approved by PAI in writing.	100%	80%
Air Ambulance:	100%	100% ^{1 2}
Ground Ambulance:	100%	100% ^{1 2}
Physical Therapy:	100%	80%
Self Injectibles:	100%	80%
Occupational Therapy:	100%	80%
Colonoscopies-Diagnostic:	100%	80%
Speech Therapy:	100%	80%
Radiation Therapy and Chemotherapy:	100%	80%
Pre-Admission Testing:	100%	80%
Bereavement Counseling:	100%	80%
Diabetic Supplies:	100%	80%
Orthotics:	100%	80%
Sleep Apnea Testing:	100%	80%
Wigs:	100%	80%
Private Duty Nursing: Must be performed by an RN, LPN or LVP	100%	80%
Pain Management:	100%	80%
Hearing Aids: Limited to 1 hearing aid per hearing –impaired ear every 36 months	100%	80%
All Other Covered Benefits:	100%	80%

¹When services are received from a Non-PPO provider, and the Non-PPO Provider satisfies advance patient notice and consent requirements, the Participant may be required to pay the balance of the Provider's charge if the Allowable charge is less.

²Non-PPO provider at a PPO Provider Facility: When services are received from a Non-PPO provider in a PPO Provider Facility, such services will be processed at the PPO benefit level. This means an application of the appropriate PPO deductible and coinsurance. Otherwise, the Participant must pay the balance of the Provider's Charge, if greater than the Allowable Charge.

WELLNESS SERVICES :	PPO:	Non-PPO:
Annual Physical Exam: Includes X-Rays/Labs/Pathology/Facility Charges/Immunizations/Radiology	*100%	Not Covered
Annual Gynecological Exam and Prostate Exam: Includes X-Rays/Labs/Pathology/Office Visits	*100%	Not Covered
Routine Colonoscopies as per ACA age guidelines: Includes Lab/Pathology/Facility Charges/Office Visits/Anesthesia/Radiology	*100%	Not Covered
Well-Child Care: Includes X-Rays/Labs/Pathology/Facility Charges/Immunizations/Radiology	*100%	Not Covered
Routine Mammograms: Subject to these age guidelines: one mammogram is covered between ages 35 and 39 and each year for women 40 and over.	*100%	Not Covered

Note: Benefits covered per ACA guidelines with no cost sharing for services at a Participating Provider.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Prescription Drug Benefits are subject to all of the Prescription Drug Exclusions listed in this Document.

Participating Pharmacy: Copay per prescription (up to 90-day supply Maximum per prescription)

Mail Service/Home Delivery Pharmacy: (90-day supply maximum per prescription)

Prescription Drug	Participating Pharmacy	Mail Service Pharmacy	Home Delivery
Generic Drugs			
30-Day Supply	\$10 Copay, then 100%	\$25 Copay, then 100%	
31-90 Day Supply	\$25 Copay, then 100%		
Preferred Brand Drugs			
30-Day Supply	\$30 Copay, then 100%	\$75 Copay, then 100%	
31-90 Day Supply	\$75 Copay, then 100%		
Non- Preferred Brand Drugs			
30- Day Supply	\$60 Copay, then 100%	\$150 Copay, then 100%	
31-90 Day Supply	\$150 Copay, then 100%		
Specialty	\$140 copay, then 100%	Not Applicable	

Prescription Drug Benefits are paid for Prescription Drugs that are listed as covered within this plan document as well as listed on the Prescription Drug List (PDL).

If a patient or a doctor requests a brand when a generic is available the patient will pay the difference in the cost of the brand to generic and the brand copay.

Group covers Seasonal /Non-Seasonal Vaccines outlined by ACA at zero cost to the member.

Prescription Drug Copays track to the Medical Out of Pocket Maximum.

Prior Authorization Program

A quality and safety program that promotes the proper use of certain medications by requiring prior approval before the Plan will cover them.

Quantity Management Program:

The Quantity Management Program is a quality and safety program that promotes the safe use of medications. The program limits the amount of some medications that are covered.

Step Therapy Program:

Through the Step Therapy Program Participants are required to try cost-effective "First Choice" medications before trying (or "stepping up to") more expensive "Second Choice" medications.

If Prior Authorization is not obtained, benefits may be denied. Please refer to www.paisc.com for a complete list of Prescription Drugs and Specialty Drugs that require Prior Authorization.

Specialty Drugs may be obtained through Optum Specialty Pharmacy. For questions regarding Specialty Drug cost, please contact Optum Specialty Pharmacy at 877-259-9428.

For a list of Preferred/Non-Preferred Brand Name Drugs, please reference

<https://www.paisc.com/members.aspx>.

MEDICAL BENEFITS

A. Payment

The payment of Covered Expenses for Benefits is subject to all terms and conditions of the Plan of Benefits and the Schedule of Benefits. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Covered Expenses will be paid only for Benefits:

1. Performed or provided on or after the Participant Effective Date;
2. Performed or provided prior to termination of coverage;
3. Provided by a Provider, within the scope of his or her license;
4. For which the required Preadmission Review, Emergency Admission Review, Preauthorization and/or Continued Stay Review has been requested and Preauthorization was received from PAI (the Participant should refer to the Schedule of Benefits for services that require Preauthorization);
5. That are Medically Necessary;
6. That are not subject to an exclusion of this Plan of Benefits;
7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copays.

B. Specific Covered Benefits

If all of these requirements are met, the Group Health Plan will provide the Benefits described in this section:

1. All of the requirements of this Benefits Section must be met;
2. The Benefit must be listed in this section;
3. The Benefit (separately or collectively) must not exceed the dollar amount or other limitations contained on the Schedule of Benefits;
4. The Benefit must not be subject to one or more of the exclusions set forth in the Exclusions and Limitations Section.

The Group Health Plan will provide these Benefits:

1. **Ambulance Services-** Benefits will be paid for professional ground and air ambulance services to the nearest network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance services and transports:
 - a. The transport is Medically Necessary and reasonable under the circumstances;
 - b. A Participant is transported;
 - c. The destination is local within the United States; and,
 - d. The facility is medically appropriate to treat the Participant's condition.

Benefits will be paid for ground ambulance transport between two Hospitals only when such ground ambulance transport has been Preauthorized and PAI confirms that the receiving Hospital is the closest facility that can provide medically appropriate care to treat the Participant's condition. Transport from one facility to a new facility for the purpose of the Participant obtaining a lower level of care at the new receiving facility must be Preauthorized. Repatriation for Participant convenience is excluded and is not a Benefit for which Covered Expenses are payable.

Preauthorization is required for transportation as an inpatient from one Hospital to a second Hospital using an air ambulance. The following requirements must be met:

- a. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Participant's illness or injury (such as burn care, cardiac care, trauma care, and critical care);
 - b. The second Hospital is the nearest medically appropriate facility to treat the Participant's illness or injury;
 - c. A ground ambulance transport would endanger the Participant's medical condition; and,
 - d. The transport is not related to a hospitalization outside the United States.
2. Covered Expenses made by an **Ambulatory Surgical Center** or minor emergency medical clinic.
3. Covered Expenses for the cost and administration of an **anesthetic**; however, anesthesia rendered by the attending surgeon or his/her assistant is excluded.
4. Covered Expenses for **artificial limbs or breast prosthesis**, to replace body parts when the replacement is necessary because of physiological changes.
5. When an **assistant surgeon** is required to render technical assistance at an operation, the eligible expense for such services shall be limited to 20% of the Allowed Amount of the surgical procedure.
6. Covered Expenses incurred for the treatment of **autism**.
7. **Blood transfusions**, including cost of blood, blood plasma, blood plasma expanders and other blood products not donated or replaced by a blood bank.
8. Phase II **cardiac rehabilitation** (to improve a patient's tolerance for physical activity or exercise) will be covered under a medically supervised and controlled reconditioning program.
9. Covered Expenses for **Chiropractic Care**.
10. Charges incurred for Routine Participant Costs for items and services related to **clinical trials** are covered when:
- A. The Participant has cancer or other life-threatening disease or condition;
 - B. The referring Provider is a Participating Provider that has concluded the Participant's involvement in such a trial would be appropriate;
 - C. The Participant provides medical and scientific information establishing the Participant's involvement in such a trial would be appropriate;
 - D. The services are furnished in connection with an Approved Clinical Trial.

Group Health Plans may not:

- A. Deny a Qualified Individual participation in an Approved Clinical Trial with respect to the treatment of cancer or another life-threatening disease or condition;
- B. Deny (or limit or impose additional conditions on) a Qualified Individual the coverage of Routine Participant Costs for items and services furnished in connection with participation in the trial;
- C. Discriminate against an individual on the basis of the individual's participation in the trial.

USE OF IN-NETWORK PROVIDERS: If one or more Participating Providers participate in an Approved Clinical Trial, then the Plan requires the Qualified Individual participate in the trial through a Participating Provider accepting patients for the trial.

USE OF OUT-OF-NETWORK PROVIDERS: Qualified Individuals participating in Approved Clinical Trials conducted outside the State in which the Qualified Individual resides will receive out-of-network Benefits for Routine Participant Costs.

11. Covered Expenses for **cosmetic surgery**, only for these situations:

-
- A. When the malappearance or deformity is due to a congenital anomaly;
 - B. When due solely to surgical removal of all or part of the breast tissue because of an injury or illness to the breast;
 - C. When required for the medical care and treatment of a cleft lip and palate.
- Coverage for the proposed cosmetic surgery or treatment must be preauthorized by the Medical Review Department prior to the date of that surgery or treatment.
12. Charge for **dental services** rendered by a Physician for treatment of an accidental injury to Natural Teeth if all treatment is rendered within twelve (12) months of the accidental injury.
 13. Covered Expenses for Prescription **Drugs** requiring a written prescription of a licensed Physician; such drugs must be necessary for the treatment of an illness or injury.
 14. Covered Expenses for **Durable Medical Equipment** (such as renal dialysis machines, resuscitators or Hospital-type beds), required for temporary therapeutic use in the Participant's home by an individual patient for a specific condition when such equipment ordinarily is not used without the direction of a Physician. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved by the Plan supervisor. Benefits will be reduced to standard equipment allowances when deluxe equipment is used. The rental or purchase Benefits cannot exceed the purchase price of the equipment. **Preauthorization required for expenses \$250 or more.**
 15. Covered Expenses for **electrocardiograms**, electroencephalograms, pneumoencephalograms, basal metabolism tests or similar well-established diagnostic tests generally approved by Physicians throughout the United States.
 16. Benefits will be paid for the treatment of **Emergency Medical Conditions**. Benefits are only available to treat an Emergency Medical Condition provided on an outpatient basis at a Hospital emergency room or department and only for as long as the condition continues to be considered an Emergency Medical Condition, unless otherwise required by applicable law.
 17. Covered Expenses for Preauthorized **Home Health Care** when rendered to a homebound Participant in the Participant's current place of residence.
 18. Covered Expenses for Preauthorized **Hospice Care** provided in an inpatient or outpatient setting.
 19. **Hospital** Covered Expenses for:
 - A. Daily room and board charges in a Hospital, not to exceed the daily semiprivate room rate (charges when a Hospital private room has been used will be reimbursed at the average semiprivate room rate in the facility). Hospitals with all private rooms will be allowed at the prevailing private room rate;
 - B. The day on which a Participant leaves a Hospital or Skilled Nursing Facility, with or without permission, is treated as the discharge day and will not be counted as an inpatient care day, unless he returns to the Hospital by midnight of the same day. The day the Participant returns to the Hospital or Skilled Nursing Facility is treated as the Admission day and is counted as an inpatient care day. The days during which the Participant is not physically present for inpatient care are not counted as inpatient days;
 - C. Confinement in an intensive care unit, cardiac care unit or burn unit;
 - D. Miscellaneous Hospital services and supplies during Hospital confinement if such charges should not have been included in the underlying Hospital charge (as determined by the Plan);
 - E. Inpatient charges for well newborn care for nursery room and board and for professional service. Eligible expenses will be subject to the fee schedule rates for pediatric services and circumcision;
 - F. Outpatient Hospital services and supplies and emergency room treatment.
 20. Covered Expenses for **License Marriage and Family Therapist (LMFT)**.
 21. Routine **mammograms**. Non-routine mammograms are covered when Medically Necessary.
 22. Covered Expenses for **maternity care**.
 23. Any expenses incurred in obtaining **medical records** in order to substantiate Medical Necessity.

24. Covered Expenses for dressings, sutures, casts, splints, trusses, crutches, pacemakers, braces (not dental braces) or other **Medical Supplies** determined by the Plan to be appropriate for treatment of an illness or injury.
25. Covered Expenses for **Mental Health Services** if rendered by a licensed medical Physician (M.D.), licensed psychologist (Ph.D.), clinical psychologist, licensed masters social worker or licensed professional counselor. Expenses for psychological testing are also covered.
26. Covered Expenses for **newborn care**. The Plan of Benefits will comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan of Benefits will not restrict Benefits for any length of Hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, PAI may not require that a Provider obtain authorization from PAI for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. Nevertheless, Preauthorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.
27. Covered Expenses for the treatment and services rendered by an **occupational therapist** in a home setting, at a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free-standing outpatient facility.
28. Covered Expenses for **Orthotics**.
29. Covered Expenses for these **oral surgical procedures**:
 - A. Excision of wholly or partly unerupted impacted teeth;
 - B. Open or closed reduction of a fracture or dislocation of the jaw;
 - C. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when a lab exam is required; excision of benign bony growths of the jaw and hard palate; external incision and drainage of cellulitis and incision of sensory sinuses, salivary glands or ducts.
30. Covered Expenses for **oxygen** and other gases and their administration.
31. Covered Expenses for **Pain Management Services** if deemed medically necessary.
32. Covered Expenses for **Private Duty Nursing**. Must be performed by an RN, LPN or LVN, OP only covered if medically necessary.
33. Covered Expenses incurred for Admission in a **physical rehabilitation facility or Skilled Nursing Facility**, for participation in a multidisciplinary team-structured rehabilitation program following severe neurologic or physical impairment. The Participant must be under the continuous care of a Physician, and the attending Physician must certify that the individual requires nursing care 24 hours a day. Nursing care must be rendered by a registered nurse or a licensed vocational or practical nurse. The confinement cannot be primarily for domiciliary, custodial, personal-type care, care due to senility, alcoholism, drug abuse, blindness, deafness, mental deficiency, tuberculosis or mental disorders.
34. Covered Expenses for the treatment or services rendered by a **physical therapist** in a home setting, a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free-standing duly licensed outpatient therapy facility.
35. Covered Expenses for the services of a **Physician** for medical care and/or surgical treatments including office, home visits, Hospital inpatient care, Hospital outpatient visits/exams, clinic care, and surgical opinion consultations, subject to:

In-Hospital medical service consists of a Physician's visit or visits to a Participant who is a registered bed-patient in a Hospital or Skilled Nursing Facility for treatment of a condition other than that for which surgical service or obstetrical service is required, as:

- A. In-Hospital medical Benefits will be provided, limited to one visit per specialty per day;

- B. In-Hospital medical Benefits in a Skilled Nursing Facility;
 - C. When two or more Physicians, within the same study, render in-Hospital medical services at the same time, payment for such service will be made only to one Physician;
 - D. Concurrent medical/surgical care Benefits for in-Hospital medical service in addition to Benefits for surgical service will be provided only:
 - i. When the condition for which in-Hospital medical service requires medical care not related to Surgical or obstetrical service and does not constitute a part of the usual, necessary and related pre-operative and postoperative care but requires supplemental skills not possessed by the attending surgeon or his assistant;
 - ii. When a Physician other than a surgeon admits a Participant to the Hospital for medical treatment and it later develops that surgery becomes necessary, such Benefits cease on the date of surgery for the admitting Physician and become payable under the surgeon only;
 - iii. When the surgical procedure performed is designated by the Plan supervisor as a "warranted diagnostic procedure" or as a "minor surgical procedure."
36. **Preadmission testing** for a scheduled Admission when performed on an outpatient basis prior to such Admission. The tests must be in connection with the scheduled Admission and:
- A. Must be made within seven (7) days prior to Admission;
 - B. Must be ordered by the same Physician who ordered the Admission and must be Medically Necessary for the illness or injury for which the Participant is subsequently admitted to the Hospital.
37. **Preventive services** are covered according to:
- A. United States Preventive Services Task Force (USPSTF recommendations Grade A or B);
 - B. Centers for Disease Control and Prevention (CDC) recommendations for immunizations;
 - C. Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screening;
 - D. Women's preventive services as provided under the ACA.
- These Benefits are provided without any cost-sharing by the Participant when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as shown in the Schedule of Benefits.
38. Covered Expenses for **radiation therapy** or treatment, and **chemotherapy**.
39. Covered Expenses at a **Residential Treatment Center**.
40. Expenses for a **Second Opinion** (Not Mandatory). The Second Opinion must be rendered by a board-certified surgeon who is not professionally or financially associated with the Physician or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery. If the Second Opinion is different from the first, a third opinion also will be payable, provided the opinion is obtained before the procedure is performed. The conditions that apply to a Second Opinion also apply to any third surgical opinion.
41. Covered Expenses for **Sleep Apnea Testing**.
42. Fees of a licensed **speech therapist** for restorative speech therapy for speech loss or impairment due to:
- A. Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenulectomy);
 - B. An injury or illness.
43. Covered Expenses for Substance Use treatment will be payable if rendered by a licensed medical Physician (M.D.), licensed psychologist (Ph.D.), clinical psychologist, licensed masters social worker or licensed professional counselor. Services or charges for Detoxification are also covered.
44. Covered Expenses for **surgical procedures**, subject to:

- A. If two or more operations or procedures are performed at the same surgical approach, the total amount covered for the operations or procedures will be payable for the major procedure only, or Benefits will be payable according to the recommendations of the Medical Review Department;
 - B. If two or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be paid according to the Allowed Amount for the operation or procedure bearing the highest allowance, plus one half of the Allowed Amount for all other operations or procedures performed;
 - C. If an operation consists of the excision of multiple skin lesions, the total amount covered will be paid according to the Allowed Amount for the procedure bearing the highest allowance, 50 percent (50%) for procedures bearing the second- and third-highest allowance, 25 percent (25%) for procedures bearing the fourth- through the eighth-highest allowance, and 10 percent (10%) for all other procedures;
 - D. If an operation or procedure is performed in two or more steps or stages, coverage for the entire operation or procedure will be limited to the allowance for such operation or procedure;
 - E. If two or more Physicians perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the allowance, subject to the above paragraphs, will be prorated between them by the Plan supervisor when so required by the Physician in charge of the case;
 - F. Certain surgical procedures, which are normally exploratory in nature, are designated as "independent procedures" by the Plan supervisor, and the Allowed Amount is covered when such a procedure is performed as a separate and single entity. Nevertheless, when an independent procedure is performed as an integral part of another surgical service, the total amount covered will be paid according to the Fee Schedule for the major procedure only.
45. Covered Expenses for services for **voluntary sterilization** for Participants.
46. Covered Expenses for **Wigs**. Only covered to treat hair loss resulting from alopecia, chemotherapy or radiation therapy.
47. Covered Expenses for **x-rays**, microscopic tests, and **laboratory tests**.

2. Dental Insurance:

- **Plan Name:** North State Environmental, Inc.
- **Plan Number:** 502
- **Provider:** Mutual of Omaha
- **Coverage Details:**

MUTUAL DENTAL



Voluntary Dental Insurance

FOR EMPLOYEES OF NORTH STATE ENVIRONMENTAL, INC.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES		
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.	
Dependent Eligibility Requirement	A child must meet the eligibility requirements of the Policy and be under age 26 if eligible as defined by Policy. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.	
Premium Payment	The premiums for this insurance are paid in full by you.	
LATE ENTRANT		
Type A	None	
Type B	12 Months	
Type C	12 Months	
PLAN YEAR DEDUCTIBLES AND MAXIMUMS		
	IN-NETWORK	OUT-NETWORK
Type A	Waived	
Type B & C Deductible		
Individual	\$50	\$50
Family	3 times Individual	3 times Individual
Annual Maximum	\$2,000	\$2,000
The same expenses may be used to satisfy both the In-Network and Out-Network deductible.		
COVERED SERVICES		
	IN-NETWORK	OUT-NETWORK
Type A Services	100%	100%
<ul style="list-style-type: none"> • Examinations/Evaluations • Bitewing X-rays • Fluoride Treatments • Cleaning/Prophylaxis • Sealants • Space Maintainers • Brush Biopsy/Cancer Screening 		
Type B Services	80%	80%
<ul style="list-style-type: none"> • Full Mouth X-rays, Panoramic Film • Palliative Treatment • Periodontal Maintenance • Harmful Habit Appliances • Fillings • Stainless Steel Crowns • Simple Extractions • Oral Surgery • Surgical Extractions • General Anesthesia or I.V. Sedation 		

MUTUAL DENTAL

COVERED SERVICES (CONTINUED)	PARTICIPATING	NON-PARTICIPATING*
Type C Services	50%	50%
<ul style="list-style-type: none"> • Endodontics • Periodontics • Full or Partial Removable Dentures • Repair of Full or Partial Removable Dentures • Adjustments, Tissue Conditioning, Rebasement or Relining of Full or Partial Removable Dentures • Bridges • Repair/Recementation of Bridges • Cast Crowns, Inlays, Onlays, Labial Veneers • Repair/Recementation of Cast Crowns/Inlays/Onlays/Labial Veneers • Implants • Surgical Periodontics • Non-Surgical Periodontics 		
<p>1) The plan pays the percentage shown after the deductible is satisfied up to the maximum. Additional information about the benefits and covered services of this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or benefits administrator if you have questions prior to enrolling.</p> <p>2) The plan pays the same coverage levels for both In-Network and Out-Network services. However, because In-Network providers offer their services at predetermined fees, out-of-pocket expenses may be lower for plan members when receiving covered services from an In-Network provider.</p> <p>3) The Maximum Allowance for Out-Network Services is based on the 90th Percentile as determined by Mutual of Omaha. Charges that exceed the Maximum Allowance (as defined in the certificate booklet) for any covered dental service are not considered.</p>		
LIMITATIONS		
<p>Information about the limitations and exclusions for this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or Benefits Administrator if you have any questions prior to enrolling.</p> <ul style="list-style-type: none"> • Exams – 2 services in a 12 month period. • Bitewing X-rays – 4 films in a 12 month period. • Full Mouth X-rays or Panoramic Film – 1 in any 36 month period. • Fluoride – For dependent children up to age 14, 2 services in a 12 month period. • Harmful Habit Appliance – For dependent children up to age 14. • Cleaning/Prophylaxis – 2 services in a 12 month period. • Sealants – For dependent children up to age 14, one per permanent bicuspid or molar tooth in any 36 month period. • Brush Biopsy/Cancer Screen – 2 services in a 12 month period. • Space Maintainers – For dependent children up to age 14, includes recementations and removal. • Fillings – Composite fillings on molars are limited to the amount otherwise payable for an amalgam filling. Replacement once in a 12 month period. • Stainless Steel Crowns – For dependent children up to age 16, one per tooth per lifetime. Not for temporary restoration. • Periodontal Maintenance – 2 services in a 12 month period in addition to routine cleaning. Following active periodontal treatment only. • Cast Crowns, Inlays, Onlays, Labial Veneers – Replacement allowed once in 10 years. • Bridges – Replacement allowed once in 10 years. • Dentures – Replacement allowed once in 10 years. • Implants – 1 per tooth per lifetime. 		
SERVICES		
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit	

WEEKLY COST	MEDICAL	DENTAL	VISION
Employee Only	\$0.00	\$7.92	\$1.42
Employee & Spouse	\$91.48	\$15.44	\$2.95
Employee & Children	\$70.81	\$20.19	\$3.11
Employee & Family	\$181.76	\$28.12	\$4.87

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
1-800-927-9197

GROUP VOLUNTARY DENTAL INSURANCE OUTLINE OF COVERAGE



READ YOUR CERTIFICATE CAREFULLY

This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company.

It is therefore important that you **READ YOUR CERTIFICATE CAREFULLY**.

POLICY INFORMATION

Policyholder (Administrator): North State Environmental, Inc.
Policy Effective Date: August 1, 2016
Group Number: G000AQ8Q
Class: All Eligible Employees

DEPENDENT CHILD AGE LIMIT

Unmarried Dependent children under the age of 26, as stated in the Certificate.

BENEFITS

The following is a brief description of the benefits provided under the Policy.

Late Entrant Waiting Period

If you do not elect insurance during your First Enrollment Period with us, you will be considered a Late Entrant to the plan. If you are a Late Entrant, you must complete the following waiting periods before benefits for Covered Services are payable for you or your Dependents:

Type A Covered Services	None
Type B Covered Services	12 Months
Type C Covered Services	12 Months

Deductible

The following Deductibles must be satisfied by you and each of your Dependents each Policy Year before any benefits are payable.

Individual:	In-Network	Out-Network
Type A Covered Services	None	None
Type B and C Covered Services	\$50	\$50

Percentage Payable

If you or your Dependents receive a Covered Service described in the Certificate after the completion of any applicable waiting periods and the satisfaction of the Deductible, we will pay benefits according to the percentage of the Maximum Allowance described in the Certificate, not to exceed the amount of the charge.

In-Network	Out-Network
-------------------	--------------------

Type A Covered Services	100%	100%
Type B Covered Services	80%	80%
Type C Covered Services	50%	50%

Policy Year Maximum Benefit

The Policy Year Maximum Benefit will apply each Policy Year. This maximum benefit is the total amount of benefits payable for Type A, B and C Covered Services received by you or your Dependents during a Policy Year.

	In-Network	Out-Network
Policy Year Maximum Benefit	\$2,000	\$2,000

Work in Progress

Benefits will be provided for dentures, bridgework, and cast restorations for which the final impression is taken prior to the date an Insured Person’s insurance ends if final placement of the denture, bridgework, or cast restoration occurs within 31 days after the Insured Person’s insurance ends.

General Anesthesia Benefit

We will pay benefits for general anesthesia or I.V. (intravenous) sedation if the anesthesia is performed in the dental office, it is medically necessary for the treatment being performed, or the individual is incapacitated, or if it is used for a child age 6 and under.

Predetermination of Benefits

A predetermination of your benefits is available upon request. This will provide you and your dentist with information regarding a future course of treatment, allowing you to discuss treatment options with your dentist, including less expensive alternative treatment plans, or terms of payment to the dentist. Your dentist can submit a predetermination request on your behalf by completing a standard dental claim form and submitting it to:

Mutual of Omaha Insurance Company
P.O. Box 211472
Eagan, MN 55121

3. Vision Insurance:

- **Plan Name:** North State Environmental, Inc.
- **Plan Number:** 503
- **Provider:** Mutual of Omaha

○ Coverage Details

MUTUAL VISION

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES		
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.	
Dependent Eligibility Requirement	To be eligible for coverage, any dependent child(ren) must be under 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.	
Premium Payment	The premiums for this insurance are paid in full by you.	
BENEFITS		
	MEMBER COST IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT*
Exam with Dilation as Necessary	\$10 copay	Up to \$37
Exam Options:		
•Retinal Imaging	•Up to \$39	
•Standard Contact Lens Fit & Follow-up	•Up to \$40	•Not Applicable
•Premium Contact Lens Fit & Follow-up	•10% off retail price	
Frames		
•Any available frame at provider location	•\$0 copay, \$150 allowance plus 20% off balance over allowance	•Up to \$66
Standard Plastic Lenses:		
•Single Vision	•\$25 copay	•Up to \$20
•Bifocal	•\$25 copay	•Up to \$36
•Trifocal	•\$25 copay	•Up to \$64
•Lenticular	•\$25 copay	•Up to \$64
•Standard Progressive Lenses (add on to bifocal copay)	•\$65 copay	•Up to \$36
•Premium Progressive Lenses (add on to bifocal copay)		
•Tier 1	•\$85 copay	•Up to \$36
•Tier 2	•\$95 copay	•Up to \$36
•Tier 3	•\$110 copay	•Up to \$36
•Tier 4	•\$65 copay plus 80% of charge less \$120 allowance	•Up to \$36
Lens Options:		
•UV Coating	•\$0 copay	•Up to \$12
•Tint (Solid and Gradient)	•\$0 copay	•Up to \$12
•Standard Scratch Coating	•\$0 copay	•Up to \$12
•Standard Polycarbonate (Adults)	•\$40	•Not Applicable
•Standard Polycarbonate (Children under 19)	•\$40	•Up to \$32
•Standard Anti-Reflective	•\$0 copay	•Not Applicable
•Photochromic – Transitions	•\$45	•Not Applicable

MUTUAL VISION

•Other Add-ons	•\$75 •20% off retail price	•Not Applicable
Contact Lenses: (Contact lens allowance includes materials only)		
•Conventional	•\$0 copay, \$150 allowance plus 15% off balance over allowance	•Up to \$102
•Disposable	•\$0 copay, \$150 allowance	•Up to \$120
•Medically Necessary	•\$0 copay, paid in full	•Up to \$210
Laser Vision Correction:	•15% off retail price or 5% off promotional price	
•LASIK or PRK from U.S. Laser Network		
Additional Pair of Glasses or Contacts	40% discount off of complete pair of eyeglasses and 15% off conventional contact lenses once the funded benefit has been used	
FREQUENCY		
Exams	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	
Out-of-Network Reimbursement will be the lesser of the listed amount of the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see the online provider locator to determine which participating providers have agreed to the discounted rate.		
EXCLUSIONS		
We will not pay benefits for any services or materials connected with or changes arising from:		
• orthoptic or vision training, subnormal vision aides and any associated supplemental testing;		
• Aniseikonic lenses;		
• medical or surgical treatment of the eye, eyes or supporting structures;		
• any eye or vision examination, or any corrective eyewear required by the policyholder as a condition of employment;		
• safety eyewear;		
• services or materials provided or paid for in whole or in part by a state or federal government or its agencies;		
• services or materials provided or paid for in whole or in part as a result of any workers' compensation or occupational disease law or as required by any federal or state governmental agency or program;		
• Plano (non-prescription) lenses or contact lenses;		
• non-prescription sunglasses;		
• two pair of glasses in lieu of bifocals;		
• services or materials provided or paid for in whole or in part by any other group benefit plan providing vision benefits;		
• certain name brand vision materials for which the manufacturer maintains a no-discount practice;		
• services rendered after the date an insured person ceases to be covered under the policy; or		
• lost, stolen, or broken lenses, frames, glasses, or contact lenses until the next benefit frequency when vision materials would next become available.		
SERVICES		
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.	

WEEKLY COST	MEDICAL	DENTAL	VISION
Employee Only	\$0.00	\$7.92	\$1.42
Employee & Spouse	\$91.48	\$15.44	\$2.95
Employee & Children	\$70.81	\$20.19	\$3.11
Employee & Family	\$181.76	\$28.12	\$4.87

4. Life Insurance:

- **Plan Name:** North State Environmental, Inc.
- **Plan Number:** 504
- **Provider:** Mutual of Omaha
- **Coverage Details:**

MUTUAL TERM LIFE



Term Life Insurance

FOR EMPLOYEES OF NORTH STATE ENVIRONMENTAL, INC.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Life Insurance Benefit Amount	For You: \$20,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: \$20,000
FEATURES	
Living Care/ Accelerated Death Benefit	75% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed \$15,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Seat Belt - Airbag - Coma - Common Carrier
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com .
AGE REDUCTIONS AND EXCLUSIONS	
Insurance benefits and guarantee issue amounts are subject to age reductions. - At age 65, amounts reduce to 85% - At age 70, amounts reduce to 50%	

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



> Term Life Insurance



Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of North State Environmental, Inc., you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?



5. **Disability Insurance:**

- **Plan Name:** North State Environmental, Inc.
- **Plan Number:** 505
- **Provider:** Mutual of Omaha
- **Coverage Details:**

MUTUAL SHORT TERM DISABILITY



Short-Term Disability Insurance

FOR EMPLOYEES OF NORTH STATE ENVIRONMENTAL, INC.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: <ul style="list-style-type: none"> • On the 8th day of your disabling injury. • On the 8th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources.
Maximum Benefit Period	Up to 12 weeks
Maximum Weekly Benefit	\$500
Minimum Weekly Benefit	None
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
Definition of Weekly Earnings	Weekly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 52. Weekly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per week during the 12 month period immediately prior to the date disability begins. If employed for part of the prior 12 month period, weekly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL of OMAHA COMPANY

GROUP SHORT-TERM DISABILITY CERTIFICATE SUMMARY



This summary describes some of the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on January 12, 2022.

POLICY INFORMATION

Policyholder:	North State Environmental, Inc.
Policy Effective Date:	August 1, 2013
Policy Anniversary:	February 1
Policy Number:	GUG-AQ8Q
Group Number:	G000AQ8Q
Classification:	All Eligible Employees
Minimum Work Hours Required:	30 hours per week
Eligibility Present Waiting Period:	30 days
Eligibility Future Waiting Period:	30 days
When Insurance Begins:	the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.
Elimination Period:	
Injury:	7 calendar days
Sickness:	7 calendar days

BENEFITS

Weekly Benefit Percentage:	60%
Maximum Weekly Benefit:	\$1,000
Maximum Benefit Period:	12 weeks
Vocational Rehabilitation Benefit:	5%



CONTACT INFORMATION

Mutual of Omaha - Dental, Vision, Life & Disability
Service Team | 800-769-7159
Claims | 800-775-8805

Planned Administrators, Inc. (PAI) Group Number 4015
Customer Service (Medical) | 800-768-4375
Pharmacy Benefits | 855-260-0974
Benefits Online Member Portal | paisc.com
MedCost (Medical Network) | paisc.com

PAI Connect (Optional Mobile Messaging)
Text "PAI Connect" to 735-29 to enroll
or call 888-596-0719

**North State Environmental- North Carolina
Human Resources**

Stephanie Westmoreland
stephanie@nsenv.com
336-245-1246 direct
336-725-8218 fax

IMPORTANT NUMBERS

Pre-Authorization: 1-800-652-3076
Pre-Authorization for MRI, MRA, PET, CT & CAT scans: 1-800-652-3076
Pre-Authorization for Mental Health and Substance Abuse: 1-800-868-1032

Financial Information:

- **Total Plan Assets:** \$299,237.38
- **Total Plan Liabilities:** \$0
- **Net Plan Assets:** \$299,237.38

Income and Expenses:

- **Total Contributions Received:** \$447,107.10
- **Total Benefits Paid:** \$206,789.85
- **Administrative Expenses:** \$42,892.21

Insurance Information:

The plan has insurance contracts with Planned Administrators Inc and Mutual of Omaha to pay certain claims incurred under the terms of the plan. The total premiums paid for the plan year ending January 31, 2025 were \$206,789.85.

Rights to Additional Information:

You have the right to receive a copy of the full annual report, or any part thereof, on request. To obtain a copy, contact Melissa Austin at maustin@nsenv.com, 2889 Lowery St, Winston-Salem, NC 27101, (336) 725-2010. The fee to print a copy is \$20.00 per copy.



ATTN: Melissa Austin, North State Environmental
 ATTN: MyLeah Stroud, Parrish & Gwinn Insurance Group, LLC
 EMAIL: m.austin@nsenv.com
 EMAIL: mstroud@pginsgroup.com
 # PAGES: 1 (including this page)
 FROM: Theresa Dent, Accountant
 DATE: February 10, 2025

IMPORTANT
 This information is being provided to assist you in complying with FORM 5500 filing requirements.

Plan Sponsor/Administrator:
 Plan Group Number:
 ERISA Plan Number:

North State Environmental	
4015	
N/A	
From:	To:
2/1/2024	1/31/2025

Reporting Period:

This information is being furnished to assist you in preparing Schedules A and C of Form 5500. It is your responsibility, as the Plan Sponsor/Administrator, to complete and submit any required filings of Form 5500 to the appropriate governmental authorities. As in all technical matters, PAI recommends that you seek professional advice or assistance in completing your annual filing.

INSURANCE INFORMATION FOR SCHEDULE A:

Net Insurance Premiums Paid:	Fed Tax ID#	NAIC Code	Description	Insurance Amounts
Berkley Life & Health Insurance Company	91-6034263	64890	Stop Loss-Premiums	163,897.64
Total Net Insurance Premiums Paid				163,897.64

Insurance Commissions Paid To:

SERVICE PROVIDER INFORMATION FOR SCHEDULE C:

Total "DIRECT COMPENSATION" Payments to PAI as a Service Provider			42,892.21
Of the Total Direct Payments made to PAI, the following "INDIRECT COMPENSATION" was remitted by PAI:			
	Grp#	Description	Service Fees
Planned Administrators, Inc.	57-0718839	TPA Administrative Fees	26,841.45
Blue Cross Blue Shield of South Carolina	57-0287419	PPO & Utilization Review/Mgd Care	1,777.50
Blue Cross Blue Shield of South Carolina	57-0287419	Health Management	1,777.50
First Stop Health, LLC	45-1542958	Managed Care Programs	2,180.00
Multiplan/Private Health Care Systems	13-3068979	PPO Network Fees	78.00
MedCost	56-1999192	PPO Network Fees	5,584.00
FirstHealth	20-1736437	PPO Network Fees	4,653.76
Total Service Provider Payments			42,892.21
TOTAL PAYMENTS MADE BY PLAN SPONSOR/ADMINISTRATOR TO PLANNED ADMINISTRATORS, INC.			206,789.85

HEADCOUNTS:

	Grp#	End of Previous Reporting Period	End of Current Reporting Period
Number of Covered Employees	4015	56	62
Number of Covered Members (Employees + Dependents)	4015	85	94

Planned Administrators, Inc. (as Plan Supervisor and Third Party Administrator) hereby certifies that, to the best of its knowledge, the foregoing information is complete and accurate.

Theresa Dent

 Signature



ATTN: Melissa Austin, North State Environmental
 ATTN: MyLeah Stroud, Parrish & Gwinn Insurance Group, LLC
 EMAIL: m.austin@nsenv.com
 EMAIL: mstroud@pginsgroup.com
 # PAGES: 1 (including this page)
 FROM: Theresa Dent, Accountant
 DATE: February 10, 2025

IMPORTANT
 This information is being provided to assist you in complying with FORM 5500 filing requirements.

Plan Sponsor/Administrator:
 Plan Group Number:
 ERISA Plan Number:

North State Environmental	
4015	
N/A	
From:	To:
2/1/2024	1/31/2025

Reporting Period:

This information is being furnished to assist you in preparing Schedules A and C of Form 5500. It is your responsibility, as the Plan Sponsor/Administrator, to complete and submit any required filings of Form 5500 to the appropriate governmental authorities. As in all technical matters, PAI recommends that you seek professional advice or assistance in completing your annual filing.

INSURANCE INFORMATION FOR SCHEDULE A:

Net Insurance Premiums Paid:	Fed Tax ID#	NAIC Code	Description	Insurance Amounts
Berkley Life & Health Insurance Company	91-6034263	64890	Stop Loss-Premiums	163,897.64
Total Net Insurance Premiums Paid				163,897.64

Insurance Commissions Paid To:

SERVICE PROVIDER INFORMATION FOR SCHEDULE C:

Total "DIRECT COMPENSATION" Payments to PAI as a Service Provider			42,892.21
Of the Total Direct Payments made to PAI, the following "INDIRECT COMPENSATION" was remitted by PAI:			
			Service Fees
Planned Administrators, Inc.	57-0718839	TPA Administrative Fees	26,841.45
Blue Cross Blue Shield of South Carolina	57-0287419	PPO & Utilization Review/Mgd Care	1,777.50
Blue Cross Blue Shield of South Carolina	57-0287419	Health Management	1,777.50
First Stop Health, LLC	45-1542958	Managed Care Programs	2,180.00
Multiplan/Private Health Care Systems	13-3068979	PPO Network Fees	78.00
MedCost	56-1999192	PPO Network Fees	5,584.00
FirstHealth	20-1736437	PPO Network Fees	4,653.76
Total Service Provider Payments			42,892.21
TOTAL PAYMENTS MADE BY PLAN SPONSOR/ADMINISTRATOR TO PLANNED ADMINISTRATORS, INC.			206,789.85

HEADCOUNTS:

	Grp#	End of Previous Reporting Period	End of Current Reporting Period
Number of Covered Employees	4015	56	62
Number of Covered Members (Employees + Dependents)	4015	85	94

Planned Administrators, Inc. (as Plan Supervisor and Third Party Administrator) hereby certifies that, to the best of its knowledge, the foregoing information is complete and accurate.

Theresa Dent

 Signature