OUTPATIENT DIALYSIS
HEALTH REIMBURSEMENT ARRANGEMENT PLAN
OF LAFAYETTE VENETIAN BLIND, INC.

Effective Date: April 1, 2022

OUTPATIENT DIALYSIS HEALTH REIMBURSEMENT ARRANGEMENT PLAN OF LAFAYETTE VENETIAN BLIND, INC.

Section 1. The Plan:

1.1 Establishment: Lafayette Venetian Blind, Inc. (the "Employer") does hereby adopt and establish effective as of April 1, 2022, this employee welfare benefit plan for the exclusive benefit of its Eligible Employees. The Plan shall be known as the Outpatient Dialysis Health Reimbursement Arrangement Plan of Lafayette Venetian Blind, Inc. (the "Plan").

1.2 Purpose: The Plan is intended to qualify as an employer-provided medical reimbursement plan under Sections 105 and 106 of the Code. The Plan is also intended to be an "integrated" health reimbursement arrangement within the meaning of Internal Revenue Service Notice 2013-54. The Eligible Expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants' gross income under Section 105(b) of the Code.

Section 2. Definitions:

Wherever appropriate, words used in the Plan in the singular may include the plural, or the plural may be read as the singular. References to one gender shall include the other. Whenever used in the Plan, including Section 1 and this Section 2, the following terms shall have the meaning set forth below (unless otherwise indicated by the context):

2.1 "Benefit Administrator" shall mean Specialty Care Management, LLC.

2.2 "Code" shall mean the Internal Revenue Code of 1986, as amended, and the rules and regulations issued thereunder.

2.3 "Covered Person" shall mean an Eligible Employee or Dependent who requires Outpatient Dialysis Services.

2.4 **"Dependent"** shall mean a Dependent as defined in the Qualifying Group Health Care Plan and who is covered under such Qualifying Group Health Care Plan.

2.5 **"Effective Date of the Plan"** shall mean April 1, 2022.

2.6 **"Eligible Employee"** shall mean each Employee who both is enrolled in the Qualifying Group Health Care Plan and requires Outpatient Dialysis Services.

2.7 **"Eligible Medical Expenses"** shall mean the cost of outpatient dialysis procedures (used for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis) as well as the cost of diagnostic testing, laboratory tests, equipment and supplies used in the treatment of acute renal failure and/or chronic renal insufficiency and other diagnoses related to renal failure ("Outpatient Dialysis Services"). This also includes injectable and intravenous medications including but not limited to Heparin, Epogen, Procrit and other medications administered directly before, during or after an outpatient dialysis procedure. Outpatient Dialysis Services must be medically necessary, and the cost of such Services will be calculated in accordance with the terms of this Plan.

2.8 **"Employee"** shall mean any individual in the employment of the Employer if the relationship between him and the Employer is the legal relationship of Employer and Employee. An individual who is classified on the books and records of the Employer as other than a common law Employee (e.g., an independent contractor) shall not be treated as an Employee for purposes of the Plan regardless of a later agency or judicial determination to the effect that such individual is a common law Employee of the Employer.

2.9 **"Employer"** shall mean Lafayette Venetian Blind, Inc.

2.10 "ERISA" shall mean the Employee Retirement Income Security Act of 1974 (including amendments of the Code affected thereby), as amended, and the rules and regulations issued thereunder.

2.11 "Medical Reimbursement Account" shall mean the account established and maintained for a Participant by the Employer pursuant to Section 3.1.

2.12 "Monthly Credit Amount" shall mean the monthly amount credited to a Participant's Medical Reimbursement Account by the Employer pursuant to Section 3.2. The Monthly Credit Amount will be in an amount sufficient to reimburse the cost of Eligible Medical Expenses for the month, as calculated in accordance with the terms of this Plan. The Monthly Credit Amount shall not exceed the amount calculated under Section 3.2 of this Plan. The Monthly Credit Amount shall be credited to the Participant's Medical Reimbursement Account as of the first day of each month.

2.13 "Participant" shall mean each Eligible Employee who both is covered under the Qualifying Group Health Care Plan and requires Outpatient Dialysis Services. An individual shall cease to be a Participant as of the date he is no longer eligible to participate in the Qualifying Group Health Care Plan.

2.14 "Plan" shall mean this Outpatient Dialysis Health Reimbursement Arrangement Plan of Lafayette Venetian Blind, Inc. or as duly amended.

2.15 "Plan Administrator" shall mean the Employer.

2.16 "Plan Year" shall mean the twelve-month period ending on December 31 of each year, except for the initial short Plan Year beginning on April 1, 2022 and ending on December 31, 2022.

2.17 "Qualifying Group Health Care Plan" shall mean the Lafayette Venetian Blind, Inc. Group Health Benefit Plan; provided that, the Qualifying Group Health Care Plan must (i) provide minimum value pursuant to Section 36B(c)(2)(C)(ii) of the Code; (ii) not be limited to the provision of excepted benefits; and (iii) meet the requirements of Sections 2711 and 2713 of the Public Health Service Act.

2.18 "Usual and Customary" shall mean Eligible Medical Expenses, which are identified by the Plan Administrator, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates as such information is made publically available. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) for the specific service or supply furnished to a Participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary. Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, as such information is

made publically available, average wholesale price for prescriptions and/or manufacturer's retail pricing for supplies and devices.

Section 3. Medical Reimbursement Accounts:

3.1 Establishment of Accounts; Crediting of Accounts: The Employer will establish and maintain on its books a Medical Reimbursement Account with respect to each Participant. The Monthly Credit Amount shall be credited to the Participant's Medical Reimbursement Account as of the first day of each month. All amounts credited to each such Medical Reimbursement Account shall be the property of the Employer until paid out pursuant to Section 3.3.

3.2 Amount Credited to Accounts: The cost of Eligible Medical Expenses will be calculated at the Usual and Customary amount which, at the Plan Administrator's sole discretion and if applicable, will not exceed the Maximum Allowable Charge applicable to the treatment, supplies, and/or services, which typically is 125% of the current Medicare allowable fee for the appropriate area as such information is made publically available.

3.3 Debiting of Accounts: A Participant's Medical Reimbursement Account shall be debited from time to time in the amount of any payment to or for the benefit of the Participant or the Participant's Dependents for Eligible Medical Expenses incurred during a Plan Year.

3.4 Reimbursement of Eligible Medical Expenses: Subject to the provisions of Sections 3.5 and Section 4, the Plan shall reimburse each Participant for the cost of Eligible Medical Expenses incurred during the Plan Year by such Participant and such Participant's Dependents. An Eligible Medical Expense is incurred at the time the care or

service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the care or service. In no event shall benefits under the Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Eligible Medical Expenses.

3.5 Limitations on Reimbursements: Notwithstanding any other Plan provisions, the following limitations shall apply with respect to reimbursements under this Plan:

(a) In no event shall the Employer reimburse or pay to any Participant any Eligible Medical Expense to the extent the Participant or other individual incurring the expense is reimbursed for such expense by insurance, the Qualifying Group Health Care Plan or any other source outside of the Plan. If a Participant is reimbursed or paid under this Plan for any Eligible Medical Expense which has been or will be paid or reimbursed from any other source at any time, he shall remit to the Employer the amount of reimbursement received under the Plan to the extent of such reimbursement.

(b) A Participant shall be entitled to reimbursement under this Plan only with respect to Eligible Medical Expenses incurred on or after the date he became a Participant and during that part of the Plan Year in which he was a Participant. No reimbursements shall be made with respect to Eligible Medical Expenses incurred after the date an individual ceases to be a Participant. Requests for reimbursements may be made in accordance with Section 4.2.2 after the date of such termination of Participant status for expenses incurred prior to such date.

Section 4. Claims Procedure:

The following claims procedure shall apply with respect to the Plan:

4.1 Type of Claims and Definitions

4.1.1 Pre-Determination. A Pre-Determination is a determination of benefits by the Benefit Administrator, on behalf of the Plan, prior to Outpatient Dialysis Services being provided. This Plan requires Pre-Determination for visits to an outpatient dialysis facility. A Pre-Determination serves the purpose of providing prior notification to the Benefit Administrator of the visit for Outpatient Dialysis Services, and it informs a Covered Person of whether, and

under which circumstances, an Outpatient Dialysis Service is generally a covered benefit under the Plan. A Pre- Determination is not a claim and therefore cannot be appealed. A Pre-Determination that Outpatient Dialysis Services may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

4.1.2 Pre-Service Claim (needing prior authorization): This is a claim for a benefit where the Covered Person is required to get prior authorization from this Plan before obtaining the service. This Plan requires Pre-Determination for Outpatient Dialysis Services (see Section 4.1.1), but it does not require prior authorization. In the case that the Plan may grant prior authorization, it does not guarantee that the Plan will ultimately pay the claim.

4.1.3 Post-Service Claim. This is a claim that involves payment for the cost of health care that has already been provided.

4.1.4 Concurrent Care Claim. This is a claim that means an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

4.1.5 Personal Representative. Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or legal guardian in order to appoint a third party as a Personal Representative. If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant his Personal Representative access to his Protected Health Information. The Covered

Person should contact the Benefit Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

4.2 Claims Procedures

4.2.1 Submission of Claims for Eligible Medical Expenses. Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the Outpatient Dialysis Services claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting Outpatient Dialysis Services claims is on the back of the Outpatient Dialysis identification card.

A Covered Person who receives Outpatient Dialysis Services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the Outpatient Dialysis Services claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of the Outpatient Dialysis Services if the paid date is not known.

A complete Outpatient Dialysis Services claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, Social Security number, address, and relationship to the Covered Person
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service

- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

4.2.2 Timely Filing. Covered Persons are responsible for ensuring that complete Outpatient Dialysis Services claims are submitted to the Benefit Administrator as soon as possible after Outpatient Dialysis Services are received, but no later than 12 months from the date of the Outpatient Dialysis Services. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to 3 years from the date of the Outpatient Dialysis Services. A Veteran's Administration Hospital has 6 years from the date of the Outpatient Dialysis Services to submit the Outpatient Dialysis Services claim. A complete claim means that the Plan has all of the information that is necessary in order to process the Outpatient Dialysis Services claim. Outpatient Dialysis Services claims received after the timely filing period will not be allowed.

4.2.3 Incorrectly Filed Claims (Applies to Pre-Service Claims only). If a Covered Person or Personal Representative attempts to, but does not properly follow this Plan's procedures for requesting prior authorization, the Benefit Administrator will notify the person and explain the proper procedures within 5 calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

4.2.4 How Health Benefits Are Calculated. When the Benefit Administrator receives a claim for an Outpatient Dialysis Service that has been provided to a Covered Person, it will determine if the Outpatient Dialysis Service is an Eligible Medical Expense under this Plan. If the Outpatient Dialysis Service is not an Eligible Medical Expense, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the Outpatient Dialysis Service is as Eligible Medical Expense, the Benefit Administrator will establish the allowable payment amount for that Outpatient Dialysis Service, in accordance with Section 3.2 of this Plan.

4.2.5 Notification of Benefit Determination. If an Outpatient Dialysis Services claim is submitted by a Covered Person or a provider on behalf of a Covered Person, and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility. The provider will receive a similar form for each Outpatient Dialysis Services claim that is submitted.

4.2.6 Timelines for Initial Benefit Determination. The Benefit Administrator will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan

will notify the Covered Person prior to the coverage for the treatment ending or being reduced.

A claim is considered to be filed when the claim for benefits has been submitted to the Benefit Administrator for formal consideration under the terms of this Plan.

4.2.7 Circumstances Causing Loss or Denial of Benefits. Outpatient Dialysis Services claims may be denied for any of the following reasons:

- Termination of employment.
- A Covered Person's loss of eligibility for coverage under this Plan.
- Charges are incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Termination of the Qualifying Group Health Care Plan.
- The Covered Person or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered medically necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums, if required.
- The Covered Person is responsible for charges due to deductible, Plan participation obligations or penalties, where applicable.
- Application of the Usual and Customary fee limits, the fee schedule or negotiated rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered experimental, investigational or unproven.
- Other reasons as stated elsewhere in this Plan.

4.2.8 Adverse Benefit Determination (Denied Claims). Adverse Benefit Determination means a denial, reduction or termination of the benefits under this Plan, or a failure to provide or make payment, in whole or in part, for Eligible Medical Expenses. It also includes any such denial, reduction, termination, rescission of coverage with respect to the benefits under this Plan (whether or not, in connection with the rescission, there is an adverse

effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on medical necessity or experimental, investigational, or unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

4.2.9 Appeals Procedure for Adverse Benefit Determinations. If a Covered Person disagrees with the denial of an Outpatient Dialysis Services claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he received the EOB form from the Plan showing that the Outpatient Dialysis

Services claim was denied. The Plan will assume the Covered Person received the EOB form 7 days after the Plan mailed the EOB form.

- The Covered Person or his Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records and other information relating to the claim to explain why he believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his Outpatient Dialysis Services claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the Outpatient Dialysis Services claim. This will include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the Outpatient Dialysis Services claim.
- If the Outpatient Dialysis Services claim denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the Outpatient Dialysis Services claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any Outpatient Dialysis Services claim determinations.
- After the Outpatient Dialysis Services claim has been reviewed, the Covered Person will receive written notification letting him know if the Outpatient Dialysis Services claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his right to file suit under ERISA after he has completed all mandatory appeal levels described in this Plan.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his Personal Representative must submit a written request for a second review within 60 calendar days following the date he received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal 7 days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records and other pertinent information to explain why he believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his Outpatient Dialysis Services claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the Outpatient Dialysis Services claim that either were not submitted previously or were not considered in the initial Outpatient Dialysis Services claim decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.
- If the Outpatient Dialysis Services claim denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the Outpatient Dialysis Services claim, the experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any Outpatient Dialysis Services claim determinations.
- After the Outpatient Dialysis Services claim has been reviewed, the Covered Person will receive written notification letting him know if the Outpatient Dialysis Services claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with an Outpatient Dialysis Services claim that is being appealed, the Plan will automatically provide the relevant information. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his right to file suit under ERISA after he has completed all mandatory appeal levels described in this Plan.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his rights to any other benefits under the Plan.

A Covered Person should send his appeal within the prescribed time period as stated above to the following addresses:

Pre-Service Claim Medical appeals should be sent to:
Specialty Care Management
P.O. Box 732
Lahaska, PA 18931
(267) 544 0566

Post-Service Claim Medical appeals should be sent to:
Specialty Care Management
P.O. Box 732
Lahaska, PA 18931
(267) 544 0566

4.2.10 Time Periods for Making Decision on Appeals. After reviewing an Outpatient Dialysis Services claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although participants may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to the Covered Person free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is

unable to provide the Covered Person with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow the Covered Person a reasonable opportunity to respond to the new or additional evidence.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

4.2.11 Right to External Review. If, after exhausting the internal appeals, the Covered Person is not satisfied with the final determination, the Covered Person may choose to participate in the external review program. This program applies only if the adverse benefit determination involves:

- Clinical reasons;
- The exclusions for experimental, investigational, or unproven services;
- Determinations related to entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits); or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of requested Outpatient Dialysis Services (other than a pre-determination of benefits) or the denial of payment for Outpatient Dialysis Services. The process is available at no charge to a Covered Person after the Covered Person has exhausted the appeals process identified above and received a decision that is unfavorable, or if the Benefit Administrator or the Plan Administrator fail to respond to the appeal within the timelines stated above.

A Covered Person may request an independent review of the Adverse Benefit Determination. Neither the Covered Person, the Benefit Administrator nor the Plan Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If the Covered Person wishes to pursue an external review, he should send a written request to the following address:

Specialty Care Management
P.O. Box 732
Lahaska, PA 18931
(267) 544 0566

The written request should include: (1) a specific request for an external review; (2) the Covered Person's name, address, and member ID number; (3) the designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. The Covered Person will be provided more information about the external review process at the time the request is received.

Any requests for an independent review must be made within 4 months of the date the Adverse Benefit Determination is received. The Covered Person or an authorized designated representative may request an independent review by contacting the toll-free number on the Outpatient Dialysis identification card or by sending a written request to the address on the Outpatient Dialysis identification card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested Outpatient Dialysis Services are a qualified medical care expense under the Plan. The Independent Review Organization ("IRO") has been contracted by the Benefit Administrator and has no material affiliation or interest with the Benefit Administrator or the Plan Sponsor. The Benefit Administrator will choose the IRO

based on a rotating list of approved IROs. In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of the Benefit Administrator's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by the Benefit Administrator and/or the Plan Sponsor in making a decision on the case; and
- All other information or evidence that the Covered Person or the Covered Person's Physician has already submitted to the Benefit Administrator or the Plan Sponsor.

If there is any information or evidence that was not previously provided and that the Covered Person or the Covered Person's physician wishes to submit in support of the request, this information may be included with the request for an independent review, and the Benefit Administrator will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if the criteria is met for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide the Covered Person and the Benefit Administrator and/or the Plan Sponsor with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide coverage for such Outpatient Dialysis Services in accordance with the terms and conditions of the Plan. If the final independent review decision is that

payment or referral will not be made, the Plan will not be obligated to provide coverage for such Outpatient Dialysis Services.

4.2.12 Legal Actions Following Appeals. After completing all mandatory appeal levels in this Plan, a Covered Person has the right to further appeal an Adverse Benefit Determination by bringing a civil action under ERISA.

4.2.13 Physical Examination and Autopsy. The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

4.2.14 Right to Request Overpayments. The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against participants if the Plan has paid them or any other party on their behalf.

4.3 Coordination of Benefits: If any Covered Person is eligible for Medicare benefits because of End Stage Renal Disease, the coverage of Outpatient Dialysis Services under this Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the coverage under this Plan will be determined in accordance with such law.

Section 5. General Provisions

5.1 Plan Administration:

(a) The Plan Administrator shall be responsible for the general administration, operation and interpretation of the Plan and for compliance by the Plan with all requirements of ERISA and the Code, except to the extent all or any of such obligations are specifically imposed on another person or persons. The Plan Administrator shall be the agent for service of legal process on the Plan.

(b) Subject to the claims procedures set forth in Section 4, the Plan Administrator shall have the duty, authority and discretion to interpret and construe the provisions of the Plan and to decide any dispute which may arise regarding the rights of participants thereunder, including the authority to make determinations as to eligibility for participation and reimbursement under the Plan.

(c) The Plan Administrator shall exercise any discretionary authority granted to them under the Plan in a nondiscriminatory manner. Determinations by the Plan Administrator shall apply uniformly to all persons similarly situated and shall be binding and conclusive upon all interested persons.

(d) Subject to the limitations of the Plan and applicable law, including ERISA and the Age Discrimination in Employment Act of 1967 ("ADEA"), as amended, the Plan Administrator may from time to time establish rules, regulations, guidelines or by-laws for the administration of the Plan and the transaction of its business.

(e) The Plan Administrator may correct errors and, so far as practicable, may adjust any reimbursement accordingly.

(f) The Plan Administrator shall maintain full and complete records of their deliberations and decisions with respect to the Plan. Such records shall contain all relevant data pertaining to individual participants and their rights under the Plan.

(g) The Plan Administrator may waive any notice requirements in the Plan. A waiver of notice in one or more cases shall not be deemed to constitute a waiver of notice in any other case.

(h) The Plan Administrator shall not have any right to vote or decide upon any matter relating solely to themselves or to any of their rights under the Plan.

(i) No fee or compensation shall be paid to the Plan Administrator for their services with respect to the Plan, but they shall be entitled to reimbursement by the Employer for the reasonable expenses properly and actually incurred in the performance of their duties in the administration of the Plan.

(j) The Plan Administrator may engage an attorney, accountant, insurance company or similar entity, consultant, benefit Administrator, or any other technical advisor to advise on matters regarding the operation of the Plan, to assist in the administration of the Plan, and to perform such other duties as shall be required in connection therewith, and may employ such clerical and related personnel as the Plan Administrator shall deem requisite or desirable in carrying out the provisions of the Plan.

(k) To the maximum extent permitted by ERISA, the Plan Administrator shall not be personally liable by reason of any contract or other instrument executed by him or on his behalf as Plan Administrator, nor for any mistake of judgment made in good faith, and the Employer shall indemnify and hold harmless, directly from its own assets (including the proceeds of any insurance policy the premiums for which are paid from the Employer's own assets), the Plan Administrator and each other officer, Employee, or director of the Employer to whom any duty or power relating to the administration or interpretation of the Plan may be delegated or allocated, against any unreimbursed or uninsured cost or expense (including any

sum paid in settlement of a claim with the prior written approval of an authorized representative) arising out of any act or omission to act in connection with the Plan unless arising out of such person's own fraud, bad faith, willful misconduct or gross negligence.

5.2 Delegation of Fiduciary Duties: All fiduciaries (as defined in ERISA) with respect to the Plan shall discharge their duties as such solely in the interest of the participants and their successors in interest, and (i) for the exclusive purpose of providing reimbursements to participants and defraying reasonable expenses of administering the Plan, (ii) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims, and (iii) in accordance with the Plan, except to the extent such documents may be inconsistent with applicable law.

5.3 Amendment or Termination of Plan: The Plan has been established by the Employer with the intention of being maintained for an indefinite period of time. However, the Employer hereby reserves the right to amend or terminate the Plan or any part thereof or coverages provided thereunder at any time. Except as otherwise provided in the Plan, the right to amend or terminate the Plan shall not in any way affect a Covered Person's right to claim a reimbursement, or diminish or eliminate any claim for reimbursement, to which the Covered Person shall have become entitled under the provisions of the Plan prior to such termination or amendment.

5.4 Rights Against the Employer; Continuation of Employment: The Employer intends that the Plan terms shall be legally enforceable. However, neither the establishment of the Plan nor any modification thereof shall be construed as giving to any Participant or any other person any legal or equitable right against the Employer, any officer or

Employee of the Employer, the Plan Administrator, or the Plan, except as herein provided. Under no circumstances shall the terms of the Plan constitute a contract of continuing employment or in any manner obligate the Employer to continue or discontinue the employment of an Employee by the Employer.

5.5 Assignment: Assignment by a claimant to the provider of the claimant's right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an Assignment of Benefits, if and only if the provider accepts said Assignment of Benefits as consideration in full for services rendered. A provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document. If benefits are paid, however, directly to the claimant – despite there being an Assignment of Benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the claimant's responsibility to compensate the applicable Provider(s). The Plan will not be responsible for determining whether an Assignment of Benefits is valid; and the claimant shall retain final authority to revoke such Assignment of Benefits if a provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the claimant, has been received.

No claimant shall at any time, either during which he is a claimant in the Plan, or following his termination as a claimant, in any manner, have any right to assign his right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he may have against the Plan or its fiduciaries. This prohibition applies to providers as well. Any attempt to assign such rights shall be void.

5.6 Funding: Reimbursements pursuant to the Plan shall be made by the Employer from its general assets. The Employer also shall be responsible for all of the administration costs incurred by the Plan. Nothing herein shall be construed as requiring the Employer to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any reimbursement under the Plan may be made.

5.7 Facility of Payment: If any Participant entitled to reimbursement under the Plan shall be physically, mentally or legally incapable of receiving or acknowledging receipt of any reimbursement under the Plan to which he is entitled, the Plan Administrator, upon the receipt of satisfactory evidence of such Participant and satisfactory evidence that another person or institution is maintaining him and that no guardian has been appointed for him, may cause any reimbursement otherwise payable to him to be made to such person or institution so maintaining him. If, in the judgment of the Plan Administrator, any Participant is unable because of physical or mental incapacity to file a claim for reimbursement as provided in Section 4, the Plan Administrator may pay directly from the Plan all or any portion of the eligible expenses incurred by such Participant (subject to the limitations of Section 3). Any reimbursement made pursuant to this Section 5.7 shall fully discharge the Employer, the Plan Administrator and the Plan to the extent of such reimbursement.

5.8 Communication to Participants: In accordance with the requirements of ERISA and the Code, the Plan Administrator shall communicate the material terms of the Plan to the participants and shall provide reasonable notification of reimbursements available under the Plan. The Plan Administrator shall make available for inspection by the participants during regular office hours of the Employer, at the principal office of the Plan Administrator and at such

other places as may be required by ERISA and the Code, a copy of the Plan and of such other documents as may be required by ERISA and the Code.

5.9 COBRA Compliance: Notwithstanding any other provision of the Plan to the contrary, the Plan Administrator shall at all times administer the Plan in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as provided in Section 4980B of the Code and Part 6 of Title 1 of ERISA, as the same may be amended from time to time. To the extent required by COBRA and other applicable law, upon the occurrence of a "qualifying event" (as defined in COBRA), a Participant and any other "qualified beneficiary" (as defined in COBRA) shall be entitled to commence or continue participation in the Plan.

5.10 Family Leave Act Compliance: Notwithstanding any other provision of the Plan to the contrary, the Plan Administrator shall at all times administer the provisions of the Plan in accordance with the provisions of the Family and Medical Leave Act of 1993, as the same may be amended from time to time.

5.11 Uniformed Services Act Compliance: Notwithstanding any other provision of the Plan to the contrary, the Plan Administrator shall at all times administer the provisions of this Plan in accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994, as the same may be amended from time to time.

5.12 Compliance with Other Acts: Notwithstanding any other provisions of the Plan to the contrary, the Plan Administrator shall at all times administer the provisions of this Plan in accordance with the applicable provisions (including the applicable effective dates of such provisions) of the Mental Health Parity and Addiction Equity Act, the Genetic Information Nondiscrimination Act, the Women's Health and Cancer Rights Act of 1998, the Newborns and

Mothers' Health Protection Act, the Patient Protection and Affordable Care Act, and the Health Care and Education Reconciliation Act of 2010, as such laws may be amended from time to time.

5.13 Qualified Medical Child Support Order: Upon receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order, as defined in Section 609 of ERISA, in accordance with written procedures adopted by the Plan Administrator. If a medical child support order is determined to be qualified, the Plan Administrator shall administer the benefits provided by this Plan in accordance with the terms of such qualified medical child support order.

5.14 Nondiscrimination Requirements: The Plan Administrator shall be responsible for determining whether the Plan complies with the nondiscrimination requirements of Section 105(h) of the Code.

5.15 Construction: The provisions of the Plan shall be construed and enforced according to the laws that govern the Qualifying Group Health Care Plan, except to the extent such laws shall be superseded by the provisions of ERISA or other applicable federal laws.

Section 6. Use and Disclosure of Protected Health Information:

6.1 Use and Disclosure of Protected Health Information: The Plan may use Protected Health Information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Plan may use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

(a) Payment includes activities undertaken to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual

to whom health care is provided. These activities may include, but are not limited to, the following:

(1) Determination of eligibility, coverage and cost sharing amounts for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);

(2) Coordination of benefits;

(3) Adjudication of health benefit claims (including appeals and other payment disputes);

(4) Establishing Employee contributions;

(5) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(6) Billing, collection activities and related health care data processing;

(7) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;

(8) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(9) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(10) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(11) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health Plan; and

(12) Reimbursement to the Plan.

(b) Health Care Operations may include, but are not limited to, the following activities:

(1) Quality assessment;

(2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) Business management and general administrative activities of the Plan, including, but not limited to:

(i) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or

(ii) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

(iii) Resolution of internal grievances; and

(iv) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

6.2 Disclosure of PHI to the Employer: The Plan will disclose PHI to the Employer only upon receipt of a certification from the Employer that the Plan has been amended to incorporate the provisions of Section 6.3.

6.3 With respect to PHI, the Employer agrees to Certain Conditions: The

Employer agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(e) Report to the Plan any PHI use or disclosure that is inconsistent with the use or disclosures provided for of which it become aware;

(f) Make PHI available to an individual in accordance with HIPAA's access requirements;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

(j) If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed

for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

6.4 Adequate Separation Between the Plan and the Employer Must Be Maintained: In accordance with HIPAA, only the Employer's Benefits Administrator and staff designated by the Benefits Administrator may be given access to PHI. These persons may only have access to use and disclose PHI for Plan administration functions that the Employer performs for the Plan. If these persons do not comply with the Plan, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

6.5 HIPAA Security Requirements Applicable to Electronic PHI: The Employer also agrees to:

(a) The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information ("Electronic PHI"), as defined in the HIPPA Security Standards, 45 CFR Parts 160, 162 and 164, that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPPA Security Standards.

(b) The Employer will ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate safeguards to protect such information.

(c) The Employer will report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

(d) The Employer will establish reasonable and appropriate security measures to ensure adequate separation between the Plan and the Employer, in support of the requirements described in Section 6.4.

6.6 Restrictions on Certain Disclosures and Sales of PHI: Effective February 17, 2010, in the case that an individual requests under 45 C.F.R. §164.522(a)(1)(i)(A) that the Employer restrict the disclosure of the PHI of the individual, notwithstanding paragraph (a)(1)(ii) of such section, the Employer must comply with the requested restriction if: (i) except as otherwise required by law, the disclosure is to a health Plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (ii) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

In general, effective February 17, 2010,

(a) Subject to paragraph (b) below, the Employer shall be treated as being in compliance with 45 C.F.R. §164.502(b)(1) with respect to the use, disclosure, or request of PHI described in such section, only if the Employer limits such PHI, to the extent practicable, to the limited data set (as defined in section §164.514(e)(2) of such title) or, if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request, respectively.

(b) Paragraph (a) above shall not apply on and after the effective date on which the Secretary issues the guidance on what constitutes "minimum necessary" for purposes of subpart E of Title 45, Code of Federal Regulations.

(c) For purposes of paragraph (a), in the case of the disclosure of PHI, the Employer or business associate disclosing such information shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure.

(d) The exceptions described in 45 C.F.R. §164.502(b)(2), shall apply to the requirement under paragraph (a) as of February 17, 2010 in the same manner that such exceptions apply to §164.502(b)(1) of such title before such date.

(e) Rule of Construction - Nothing in this subsection shall be construed as affecting the use, disclosure, or request of PHI that has been de identified.

6.7 Accounting of Certain PHI Disclosures: When an Employer makes available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528 in the case that the Employer uses or maintains an electronic health record with respect to PHI: (1) an individual shall have a right to receive an accounting of disclosures made by the Employer during the three years prior to the date on which the accounting is requested; and (2) the exception under 45 C.F.R. §164.528(a)(1)(i) shall not apply. In response to the request of an individual for an accounting, the Employer shall elect to provide either (i) an accounting, as specified above, for disclosures of PHI that are made by the Employer and by a business associate acting on behalf of the Employer; or (ii) an accounting, as specified above, for disclosures that are made by the Employer and provide a list of all business associates acting on behalf of the Employer, including contact information for such associates (such as mailing address, phone, and email address). A business associate included on a list under subparagraph (ii) of the immediately preceding sentence shall provide an accounting of disclosures (as required above for the Employer) made by the business associate upon a request made by an individual directly to the business associate for such an accounting.

In the case of an electronic health record acquired as of January 1, 2009, this section shall apply to disclosures, with respect to PHI, made by the Employer from such a record on and after January 1, 2014. In the case of an electronic health record acquired after January 1,

2009, this section shall apply to disclosures, with respect to PHI, made by the Employer from such record on and after the later of the following:

(a) January 1, 2011; or

(b) the date that it acquires an electronic health record.

The Secretary may set an effective date that is later than the dates specified above if the Secretary determines that such later date is necessary, but in no case will the date specified for current users of electronic records be later than 2016; or for others, be later than 2013.

6.8 Access to Certain Information Electronic Format:

(a) Except as provided in paragraph (b), the Employer shall not directly or indirectly receive remuneration in exchange for any PHI of an individual unless the Employer obtained from the individual, in accordance with 45 C.F.R. §164.508 a valid authorization that includes, in accordance with such section, a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that individual.

(b) Paragraph (a) shall not apply in the following cases:

(1) The purpose of the exchange is for public health activities (as described in 45 C.F.R. §164.513(b)).

(2) The purpose of the exchange is for research (as described in 45 C.F.R. §§164.501 and 164.513(i)) and the price charged reflects the costs of preparation and transmittal of the data for such purpose.

(3) The purpose of the exchange is for the treatment of the individual, subject to any regulation that the Secretary may promulgate to prevent PHI from inappropriate access, use, or disclosure.

(4) The purpose of the exchange is the health care operation specifically described in subparagraph (iv) of paragraph (6) of the definition of healthcare operations in 45 C.F.R. §164.501.

(5) The purpose of the exchange is for remuneration that is provided by the Employer to a business associate for activities involving the exchange of PHI that the business associate undertakes on behalf of and at the specific request of the Employer pursuant to a business associate agreement.

(6) The purpose of the exchange is to provide an individual with a copy of the individual's PHI pursuant to section 45 C.F.R. §164.524.

(7) The purpose of the exchange is otherwise determined by the Secretary in regulations to be similarly necessary and appropriate as the exceptions provided in subparagraphs (1) through (6).

Paragraph (a) shall apply to exchanges occurring on or after the date that is 6 months after the date of the promulgation of final regulations implementing this subsection.

(c) Effective February 17, 2010, when an Employer makes available PHI to comply with HIPAA's right to access in accordance with 45 C.F.R. §154.524, in the case that the Employer uses or maintains an electronic health record with respect to PHI of an individual:

(1) the individual shall have a right to obtain from the Employer a copy of such information in an electronic format and, if the individual chooses, to direct the Employer to transmit such copy directly to an entity or person designated by the individual, provided that any such choice is clear, conspicuous, and specific; and

(2) notwithstanding paragraph (c)(4) of such section, any fee that the Employer may impose for providing such individual with a copy of such information (or a summary or explanation of such information) if such copy (or summary or explanation) is in an electronic form shall not be greater than the entity's labor costs in responding to the request for the copy (or summary or explanation).

IN WITNESS WHEREOF, the Outpatient Dialysis Health Reimbursement Arrangement Plan of Lafayette Venetian Blind, Inc. is, by the authority of an authorized representative of the Employer, effective as of April 1, 2022.

Lafayette Venetian Blind, Inc.

By_____