Baker Benefits Administrators, Inc.

This is a general description of the benefits and eligibility currently on file at our office.
THIS IS NOT A GUARANTEE OF COVERAGE AND/OR BENEFITS.

DISCLAIMER: PLEASE READ CAREFULLY

The following information is being provided to you as a courtesy. THIS IS NOT A GUARANTEE OF COVERAGE AND/OR BENEFITS. This is a general description of the information currently on file at our office. This Plan is a self-funded group health Plan subject to ERISA and the administration is provided through a Third Party Claims Administrator. Information about eligibility is provided by the Plan Administrator, also called the Plan Sponsor. The Claims Administrator can verify the participant named above is identified in our records as an eligible participant on the current roll of the Plan shown above. Claim processing and benefits will be subject to the patient's eligibility status and the Plan's benefit provisions in effect at the time services are actually rendered. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all.

All benefits described in this Schedule are subject to the exclusions and limitations described more fully in the Plan Document, including but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Appropriate; that services, supplies and care are not Experimental and/or Investigational. Certain Provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of medical necessity, lack of timely filing of claims or lack of coverage can reduce or deny reimbursement. Coverage and/or benefits will apply only for expenses incurred while coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for service or supply is incurred on the date the service or supply is rendered.

The Plan Administrator of this ERISA plan reserves the right to review/audit any claim for reasonable and appropriate charges as determined by the Plan before any discount will apply or payment made. No arrangement of any kind will override the provisions of the plan document.

Adverse Benefit Determination. When an adverse benefit determination is made in part or in whole, the participant and/or provider have 180 days following receipt of the notification in which to appeal the decision. Written comments, documents, records, and other information relating to the claim must be submitted for review.

CONFIDENTIALITY & PRIVACY NOTICE:

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The information you requested concerning a plan participant's eligibility, coverage or claims is outlined below. If this does not answer all your questions, please call our customer service department at. (210) 453-7333 or (800) 453-3330.

Audit No: 525643 Deliver To: (346) 230-7337 Tax Id: - Information On: 11/17/2025

Subscriber Information

Subscriber Id:	****9015
Subscriber Name:	JUAN PACHECO
Date of Birth:	09/19/1972
Gender:	M
Group Name:	LONE STAR HEAT TREATING
Group No:	750490
Has Medical Coverage:	YES Begin Date: 04/01/2018 End Date:

Deductibles, Out-of-Pocket Amounts Met

Dependent ID	Description	Amount Met
FAMILY	Family MEDICAL Deductible	510.07
FAMILY	Family MEDICAL Out-of-Pocket	985.98
SUB	Indiv. MEDICAL Out-of-Pocket	806.47
SUB	Indiv. MEDICAL Deductible	360.56

LONE STAR HEAT TREATING CORPORATION EMPLOYEE BENEFITS PLAN
GROUP #750490

SUBMIT CLAIMS TO:

Address: P O Box 211005
Eagan, MN 55121
EPID# PAS01

The Plan contains a Preferred Provider Organization (PPO Network) for PRACTITIONERS and ANCILLARY ONLY, as follows:

PPO Name: PHCS Practitioners and Ancillary Network
Telephone: 877-952-7427
Website: www.multiplan.com/phcspracanc

FOR FACILITIES PLEASE NOTE: This Plan utilizes the PHCS PPO Network for physician and ancillary claims only. This plan does not utilize a PPO Network for facility claims (inpatient or outpatient). Payment is based on Medicare Plus 40%, whenever possible. In instances where no Medicare fee schedule exists, the plan will utilize Reasonable and Appropriate standards based upon normative data such as cost to charge ratios and / or manufacturer's retail pricing (MRP) Please see the applicable benefit Plan Document for more details. The Provider agrees that Assignment of Benefits and the funds said Assignment of Benefits entitles Provider to receive (along with payment by the patient of their deductible, co-payment and / or co-insurance), is consideration in full of services, supplies and / or treatment rendered. PROVIDER THUS WAIVES THEIR RIGHT TO BALANCE BILL THE PATIENT. Benefit availability is in accordance with the Employer's Plan Document as amended. Please see the applicable benefit Plan Document for more details.

WHEN CLAIMS MUST BE FILED

Post-service health claims (which must be Clean Claims) must be filed with the Third Party Administrator within 365 days of the date charges for the service(s) and/or supplies were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Claims filed later than that date shall be denied.

SUMMARY OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures, if applicable, are after the out of pocket Deductible has been satisfied. Benefits for Pregnancy expenses, which are covered for Employee and spouse only, are paid the same as any other Sickness. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Utilization Management

Services that Require Pre-Certification or Notification

The following services will require Pre-Certification or Notification (or reimbursement from the Plan may be reduced). Call Spectrum Review at **(800) 258-5055.**

1. Inpatient hospitalization.
2. Transplant candidacy evaluation and transplant (organ and/or tissue)
3. Residential Treatment Facility programs.
4. Skilled Nursing Facility stays.
5. MRI/PET/CT scans
6. Outpatient surgery and procedures
7. Non-emergency Ambulance (air and ground)

Failure to comply with Utilization Management will result in a higher cost to Participants. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan.

Remember that although the Plan will automatically pre-authorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has his or her Physician call to obtain pre-certification in case there is a need to have a longer stay.

Pre-certification does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.
The analysis will be employed to identify charges billed in error and/or charges that are not Reasonable and Appropriate and/or Medically Necessary and Reasonable and Appropriate, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Reasonable and Appropriate amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Reasonable and Appropriate charge, in accord with the terms of this Plan Document.

Calendar Year Maximum Benefit

The following Calendar Year maximums apply to each Participant.

Summary of Benefits - Medical

The following benefits are per Participant per Calendar Year:

MEDICAL BENEFITS

Calendar Year Maximum Benefits	
All Essential Health Benefits	**Unlimited**

	Facilities and Network Physicians	Non-Network Physicians	Limits
Deductible			
Individual	$500	$3,000	
Family Unit	$1500	$9,000	

4th Quarter Deductible Carryover: Covered Expenses Incurred in and applied toward the Deductible in October, November and December will be applied toward the Deductible in the next Calendar Year. This Deductible amount will apply towards the Plan's total out-of-pocket maximum in the new Calendar Year.

	Facilities and Network Physicians	Non-Network Physicians	Limits
Payment Level (unless otherwise stated)	80%	50%	
Maximum Out-of-Pocket			
Individual	$2,500	$9,000	
Family Unit	$7,500	$27,000	

The following table identifies what does and does not apply toward the In-Network and Out-of-Network Out-of-Pocket Maximums.

Plan Features	Applies to the In-Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes	Yes
Coinsurance payments, including those for covered services available in the Prescription Drug Benefits section, except for those covered health services identified in the Summary of Benefits that do not apply to the Out-of-Pocket Maximum (e.g., non-essential health benefits).	Yes	Yes
Copayments	Yes	Yes
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Allowable Expenses	No	No

Hospital and Other Facility Services		
Covered Medical Expenses	**Benefits**	**Limits**
Ambulatory Surgical Center	80% after CYD	
Birthing Center	80% after CYD	
Chemotherapy	80% after CYD	
Cochlear Implants	Not Covered	
Hospice Care		
Inpatient	80% after CYD	
Hospital		
Inpatient	80% after CYD	
Outpatient	80% after CYD	
Mental Health and Substance Abuse Expenses		
Residential Treatment Facility	80% after CYD	
Partial Hospitalization		
Intensive Outpatient Services		
Outpatient Diagnostic X-ray and Lab	80% after CYD	
Outpatient Emergency Services	$250 Co-pay then plan pays 80%	
Radiation Therapy	80% after CYD	
Sex Assignment/Sex	Not Covered	

Hospital and Other Facility Services		
Covered Medical Expenses	**Benefits**	**Limits**
Reassignment Inpatient Services		
Skilled Nursing Facility	80% after CYD	Limited to within 14 days of a minimum 3 day stay and a 60 day Calendar Year maximum
Surgery **Transplants** Recipient Expenses Donor Expenses	80% after CYD 80% after CYD	
Urgent Care	$70 Copay; then plan pays 100%	
All Other Covered Services	80% after CYD	

Physician-Only Services			
Covered Medical Expenses	**In-Network Benefits**	**Out-of-Network Benefits**	**Limits**
Allergy Services Office Visit Injections & Serum	$30 Co-pay; then plan pays 100%	50% after CYD	100% Coinsurance
Ambulance (Ground/Water)	80% after CYD	50% after CYD	
Ambulance (Air)	80% after CYD	50% after CYD	Limits may apply
Anesthesia	80% after CYD	50% after CYD	
Blood & Plasma	80% after CYD	50% after CYD	
Chiropractic Care	80% after CYD	50% after CYD	
Clinical Trials (Patient Costs)	80% after CYD	50% after CYD	
Durable Medical Equipment	80% after CYD	50% after CYD	
Glaucoma, Cataract Surgery and Lenses (one set)	80% after CYD	50% after CYD	
Habilitative Services Applied Behavior Analysis (ABA) Occupational Therapy Physical Therapy Speech-Language Pathology	80% after CYD	50% after CYD	
Hearing Aids	Not Covered	Not Covered	
Home Health Care	80% after CYD	50% after CYD	50 visits per Calendar Year
Hospice Care Inpatient Outpatient Family Bereavement Counseling	80% after CYD 80% after CYD Not Covered	50% after CYD 50% after CYD Not Covered	$20,000 Lifetime Max

Physician-Only Services			
Covered Medical Expenses	**In-Network Benefits**	**Out-of-Network Benefits**	**Limits**
Infertility Treatment	Not Covered	Not Covered	
Mental Health and Substance Abuse Expenses Outpatient Physician	$30 Co-pay; then plan pays 100%	50% after CYD	
Newborn Care	80% after CYD	50% after CYD	
Outpatient Diagnostic X-ray and Lab	80% after CYD	50% after CYD	
Physician Services Office Visit Lab and X-rays	$30 Co-pay; then plan pays 100%	50% after CYD	
Pregnancy Expenses Routine Prenatal Services	100%	50% after CYD	
Non-Routine Prenatal Services, Delivery and Postnatal Care	80% after CYD		
Pre-natal screening as defined under Women's Preventive Services of the Patient Protection and Affordable Care Act of 2010	100%	50% after CYD	
Preventive Care Well Adult Care Routine Physical Exam Mammograms – over age 40, unless Medically Necessary Pap Smears Routine Immunizations Well Child Care Exam Immunizations	100%	50% after CYD	
Private Duty Nursing	80% after CYD	50% after CYD	
Prostate Exam	100%	50% after CYD	
Prosthetics, Orthotics, Supplies and Surgical Dressings	80% after CYD	50% after CYD	
Second Surgical Opinions	80% after CYD	50% after CYD	
Sex Assignment/Sex Reassignment Outpatient Physician	Not Covered	Not Covered	
Surgery	80% after CYD	50% after CYD	

Physician-Only Services			
Covered Medical Expenses	**In-Network Benefits**	**Out-of-Network Benefits**	**Limits**
Therapy Services Autism Spectrum Disorder Treatment Cardiac Therapy Cognitive Therapy Occupational Therapy Physical Therapy Respiration Therapy Speech Therapy Vision Therapy	80% after CYD	50% after CYD	
Temporomandibular Joint Disorder (TMJ)	Not Covered	Not Covered	
All Other Covered Services	80% after CYD	50% after CYD	