ADOPTION AGREEMENT
TO THE
BENEFIT MANAGEMENT, INC. CORE DOCUMENT

The undersigned, Allen County ("Plan Sponsor"), by executing this Adoption Agreement, elects to establish and maintain a self-insured group health plan, administered by Benefit Management, Inc. ("BMI"). Plan Sponsor, subject to the elections made in this Adoption Agreement, including any Appendices and Addendums that are attached hereto, adopts fully the attached Benefit Management, Inc. Core Document (the "Core Document") and Benefit Description. This Adoption Agreement, the Core Document, and the Benefit Description (including any Appendices and Addendums attached to any of the aforementioned documents) constitute the Plan Sponsor's entire Plan. ***All Article headings in this Adoption Agreement correspond with the Articles in the Core Document. Except where indicated, the numbers in parentheses which follow the numbered headings within each Article refer to sections in the Core Document.***

Plan Sponsor makes the following elections granted under the corresponding provisions of the Core Document.

ARTICLE I
INTRODUCTION

1. NAME OF PLAN **(1.01)**. The name of the Plan as adopted by Plan Sponsor is Allen County Employees Employee Health Care Plan (the "Plan") (e.g., ABC Company Group Medical and Dental Plan).

ARTICLE II
DEFINITIONS

2. BENEFIT DESCRIPTION **(2.04)**. The following benefits will be provided through the Plan as described in the Benefit Description *(Choose (a) and, if applicable, (b) and/or (c))*:

[X] (a) **Medical Benefits.**

[X] (b) **Prescription Drug Benefits.**

[X] (c) **Dental Benefits.**

3. BENEFIT YEAR **(2.05)**. Benefit Year means the 12-month period on which Claims will be paid under the Plan. The Benefit Period runs each year from (*fill in the blanks below)*:

April 1 through March 31**.**

4. DEFINITION OF DEPENDENT **(2.18)**. The term Dependent means the following *(Choose one or more of (a) through (h), as applicable)*:

[X] (a) **Spouse.** A person of the same or opposite sex to whom the Participant is legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which the couple currently resides. A person will not be considered a Spouse for purposes of this Plan if (i) his/her marriage to the Participant has been terminated by a court having jurisdiction over one or both parties to the marriage, (ii) he/she is legally separated from the Participant, or (iii) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

A common law marriage to a person of the opposite sex shall be considered to be a legal marriage if the common law marriage was entered into in a state that recognizes common law marriage and if the common law marriage is recognized as valid under the laws of that state. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of legal marriage (including, as may be applicable, the existence of a common law marriage).

A Spouse who is eligible to enroll and be covered under a group health plan that is sponsored by the Spouse's employer (other than a plan offering only HIPAA-excepted benefits) shall *(Choose (1) or (2))*:

[X] (1) **Be eligible to participate in the Dental Benefits Option of this Plan as a Dependent if he/she otherwise satisfies the Plan's eligibility conditions. The Spouse cannot participate**

in the Medical Benefits Option of the Plan.

[ ] (2) **Not be eligible to participate in this Plan as a Dependent.**

[ ] (b) **Domestic Partner.** A Domestic Partner means a person of the same sex as the Participant and for whom each of the following conditions is met:

(1) The person and the Participant have both attained the legal age of consent according to the laws of the state in which they reside;

(2) The person and the Participant are not related to each other by blood in a degree that is closer than what would be permitted in the state in which they reside if the person and the Participant desired to be married and the requirements for marriage were otherwise met;

(3) Neither the person nor the Participant is married to, or a Domestic Partner of, each other or any other person, any prior marriages involving the person and/or the Participant have been legally dissolved, the relationship between the person and the Participant is exclusive, and there is no other person who is a spousal equivalent of either the person or the Participant;

(4) The person and the Participant:

(i) Are legally registered as domestic partners in the state in which they reside; or

(ii) Have lived together in a spousal equivalent manner for the lesser of (a) the minimum period required by the state in which they reside or (b) one year, and plan to continue their relationship indefinitely; and

(5) The person and the Participant have made a mutual commitment to be jointly responsible for each other's welfare and to share financial obligations.

Please note: The coverage of Domestic Partners under this Plan *may result in imputed income* to the Participant for purposes of his/her personal federal income tax return. In addition, Plan Sponsor may be limited in its ability to deduct part of its contribution of the premiums for coverage for Domestic Partners.

[X] (c) **Children (Up to Age 26).** This option encompasses the default definition of Child or Children, as provided in the Core Document. The default definition provides that a Child or Children means the Participant's natural child, lawfully adopted child (including a child placed with the Participant for adoption but for whom the adoption is not yet final), stepchild, or other child for whom the Participant has obtained legal guardianship pursuant to a court order, until such Child attains age 26. This definition also includes a Spouse's lawfully adopted child or other child for whom the Spouse has obtained legal guardianship (up to the applicable age limitations).

Please note: The default definition provided in the Core Document falls within the Internal Revenue Code's definition of "dependent." This means that if the default definition of "Child" is elected here, the premiums paid to cover a child (if paid on a pre-tax basis), and any benefits received for accident or sickness through the Plan, are not included in the Participant's gross income. If a broader definition of "Child" is used in (e) below (e.g., allowing coverage up to age 28), then *this option may result in imputed income* to the Participant for purposes of his/her personal federal income tax return.

[ ] (d) **Children.** The Participant's Child or Children, as defined in (c) above, except that the Participant's Child or Children who are under _____ years of age (with coverage ending at the end of the month in which this age is attained) shall also be included in this definition. ***(This box should be checked only if Plan Sponsor intends to cover Children older than age 26.)***

Please note: By expanding the default definition of "Child" as found in (c) above and in the Core Document (i.e., increasing the age limits), the *Participant may have imputed income* for purposes of his or her personal federal income tax return.

[X] (e) **Children (Disabled).** This option encompasses the Participant's natural child, lawfully adopted child (including a child placed with the Participant for adoption but for whom the adoption is not yet final), stepchild, or other child for whom the Participant has obtained legal guardianship pursuant to a court order, who is unmarried and incapable of self sustaining employment by reason of mental retardation or physical disability and for whom the

Participant is the major source of financial support, from the end of the calendar month in which the Child attains age 26. ***(This box should be checked if Plan Sponsor intends to cover disabled Children older than age 26. Disabled Children under age 26 will be covered under one of the other options above.)***

The Plan Administrator may require proof of continuing incapacity from time to time, but not more than once a year. Failure to submit required proof or allow medical examination of the Child will be considered as proof that the Child is no longer incapacitated. Such child as covered by this paragraph is subject to all other provisions of this Plan.

[ ] (f) **No Dependents Covered Under the Plan.** Dependents are not eligible for coverage under the Plan.

[ ] (g) **Other Restrictions on Dependents' Coverage:** _____

_____.

5. EFFECTIVE DATE **(2.20)**. The Plan is a *(Choose either (a) or (b))*:

[ ] (a) **New Plan.** The Effective Date of the Plan is: _____.

[X] (b) **Restated Plan (aka, "Takeover Plan").** The *restated* Effective Date is: April 1, 2016.

6. (A) ELIGIBLE INDIVIDUAL - EXCLUSIONS **(2.21)**. The following individuals are not eligible to participate in the Plan *(Choose (1) or one or more of (2) through (6), as applicable)*:

[ ] (1) **No exclusions.**

[X] (2) **Part-time / Variable Hour workers, meaning those persons regularly scheduled to work less than thirty (30) hours per week (or, if measured monthly, no less than _____ hours per month).**

Note: If the figure elected is 30 hours/week or more (or, if measured monthly, 130 hours/month or more), then the Plan Sponsor may be subject to "shared responsibility" penalties under the Affordable Care Act in the event that it is deemed to be an "applicable large employer."

[X] (3) **Employees covered by a collective bargaining agreement.**

[X] (4) **Seasonal / Temporary Employees, meaning employees who are employed either (i) on a seasonal basis into a position for which the period of customary annual employment is six months or less, or (ii) for only a short period of time, typically only as long as is necessary to perform a particular piece of work or a discrete assignment.**

Note 1: A Temporary Employee is on the Employer's payroll and is not paid through a temporary agency.

Note 2: Beware that excluding Temporary Employees who are not properly classified as Seasonal Employees and who are regularly scheduled to work in excess of 30 hours/week (or, if measured monthly, 130 hours/month) may subject the Plan Sponsor to "shared responsibility" penalties under the Affordable Care Act.

[X] (5) **Leased workers, as that term is used in Code § 414(n).**

[ ] (6) **Other:** _____.

(B) ELIGIBLE INDIVIDUAL – ADDITIONS **(2.21)**. In addition to Employees of Plan Sponsor, the following classes of individuals are eligible to participate in the Plan, provided that they otherwise satisfy the Plan's eligibility conditions, as set forth in Article III of the Core Document and the corresponding portions of this Adoption Agreement. *(Choose (1) or one or more of (2) through (6) as applicable)*:

[ ] (1) **None (that is, no additional individuals are eligible).**

[X] (2) **Retired employees who satisfy the conditions set forth in Election 10 below:**.

[ ] (3) **Former employees who satisfy the following conditions:** _____

_____.

[ ] (4) **A member of the Board of Directors.** *(Note: If the Board member is not an employee, coverage will be taxed and the Board member may be issued a 1099 from the Employer.)*

[ ] (5) **Unpaid elected officials.** *If necessary, describe:* _____.

[ ] (6) **Other (specify):** _____

7. NEW ENROLLMENT DEADLINE. An Eligible Individual who is not a Special Enrollee must apply for coverage within the number of days specified below after becoming eligible for coverage.

[X] (a) **sixty-three days.**

[ ] (b) **thirty days.**

[ ] (c) **thirty-one days.**

[ ] (d) **Other:** _____.

8. OPEN ENROLLMENT PERIOD **(2.33).** *(Choose (a), (b), or (c).* The Open Enrollment Period for the Plan is:

[ ] (a) **The one month period immediately preceding the new Plan Year.**

[X] (b) **The month of March.**

[ ] (c) **Other:** _____.

9. PLAN YEAR **(2.39)**. Plan Year means the 12-month period (except for a short Plan Year) ending every *(Choose one of (a) or (b). Choose (c) as well if applicable)*:

[ ] (a) **December 31.**

[X] (b) **Other: March 31.**

[ ] (c) **Short Plan Year:** commencing on: _____ and ending on: _____.

10. RETIREE **(2.41)**. To the extent Plan Sponsor has elected to provide coverage to Retirees under the Plan, a Retiree shall be an individual who satisfies each of the following conditions:

(a) *Term of Service.* The Participant has at least ten (10) years of service with the Employer at the time of his/her "retirement" from the Employer.

(b) *Waiver of COBRA.* The Participant waives his/her right to elect COBRA continuation coverage pursuant to Section 8.02 of the Core Document.

(c) *Timely Election to Continue Coverage*. The Participant affirmatively elects, using the procedures prescribed by the Plan Administrator, to continue coverage under the Plan no later than thirty (30) days after his/her retirement from employment with the Employer.

Retirement. For purposes of this section, the term "retirement" means that the Participant has terminated employment and is receiving a retirement or disability benefit for service with the Employer.

(d) *Payment of Premium.* The Participant must pay the entire cost of coverage for this retiree continuation coverage. Although exact premiums will be determined by the Employer, the Employer may also require that the Participant pay an administrative fee of up to 25% of the cost of the coverage.

Termination of Continuation Coverage. The continuation coverage under this Section shall terminate upon the earliest occurrence of the following events:

(1) The Participant attains age sixty-five (65);

(2) The Participant becomes covered, or becomes eligible to be covered, under another employer's group health plan;

Note: The reference to "another employer's group health plan" only refers to an employer of the Participant himself/herself.

(3) The Participant fails to make a required premium payment on a timely basis; or

(4) The Employer terminates the Plan.

Coverage of Retiree's Spouse and/or Dependents. A Participant who elects to continue coverage under this section may also elect to cover any Spouse and/or dependent(s) who were covered (through the Participant) under the Plan as of the day of the Participant's retirement from employment with the Employer and who did not elect COBRA continuation coverage pursuant to Section 8.02 of the Core Document. The coverage of the Spouse and/or dependent(s) shall terminate upon the earliest occurrence of the following events:

(1) The Participant's coverage under the Plan terminates;

(2) The Spouse/dependent attains age sixty-five (65);

(3) The Participant fails to make a required premium payment on a timely basis;

(4) The Spouse/dependent becomes covered, or becomes eligible to be covered, under another employer's group health plan; or

(5) The Employer terminates the Plan.

Construction and Application. This section shall be construed and applied in a manner consistent with the requirements of Kansas Statutes Annotated 12-5040.

11. SPECIAL ENROLLEES **(2.43)**. Special Enrollees must generally enroll within sixty-three (63) days of a HIPAA special enrollment event unless otherwise elected below. Subject to the exceptions set forth below, the number of days a Special Enrollee has to enroll in the Plan following a HIPAA special enrollment event is:

[X] (a) **sixty-three days.**

[ ] (b) **thirty days.**

[ ] (c) **thirty-one days.**

[ ] (d) **Other:** _____. [Note: Must be at least thirty-days.]

NOTE: Where an individual's special enrollment right is triggered by eligibility, or a loss of eligibility, for Medicaid or a state children's health insurance program subsidy, the special enrollment deadline shall be sixty (60) days unless a longer period of time has been elected above.

12. (A) WAITING PERIOD **(2.48)**. Each Eligible Individual is eligible to participate in the Plan upon completion of the Waiting Period. During the Waiting Period, the individual must be in continuous, active employment with Plan Sponsor. The Waiting Period for entry into this Plan is *(Choose one of (1), (2), (3), or (4))*:

[ ] (1) **There is no Waiting Period.**

[ ] (2) **30 days.**

[X] (3) **60 days.**

[ ] (4) **Other:** *(Special Waivers of the Waiting Period Should Also Be Referenced Here)*: _____

_____.

Note: For plans subject to the Affordable Care Act's maximum 90-day waiting period requirement, the total Waiting Period may not exceed 90 calendar days. An Eligible Individual thus must be permitted to commence participation in the Plan no later than the 91st day following his/her satisfaction of all other eligibility criteria (including, for example, the completion of a bona fide orientation period referenced in Subparagraph (B) below).

(B) ORIENTATION PERIOD **(2.34)**. Before the Waiting Period (if any) elected in Subparagraph (A) above may begin, an Eligible Individual must complete a bona fide Orientation Period. The Orientation Period utilized by Plan Sponsor is *(Choose one of (1), (2),or (3)*:

[X] (1) **There is no Orientation Period that is separate from the Waiting Period.**

[ ] (2) **30 days.**

[ ] (3) **Other:** _____

_____.

Note: Absent unusual circumstances, the Orientation Period may not exceed 30 days. The Orientation Period generally refers to the period of time at the outset of an Eligible Individual's employment during which the Eligible Individual and the Plan Sponsor evaluate whether the employment situation is satisfactory for each party, and standard orientation and training processes begin.

ARTICLE III
ELIGIBILITY

13. EFFECTIVE DATE OF COVERAGE UPON COMPLETION OF THE WAITING PERIOD **(3.02)**. Upon completion of the Waiting Period (if any), each Eligible Individual is eligible to participate in this Plan *(Choose (a), (b) or (c))*:

[ ] (a) **Immediately.**

[X] (b) **On the first day of the first month coincident with or next following the completion of the Waiting Period.**

[ ] (c) **Other:** _____.

Note: The federal Affordable Care Act prohibits the Plan Sponsor from utilizing a Waiting Period that would delay an Eligible Individual's commencement of participation in the Plan more than 90 days after he/she commences employment. Accordingly, to the extent the Plan Sponsor's Waiting Period election causes an Eligible Employee's commencement of participation in the Plan to extend beyond 90 days from his/her commencement of employment, the election shall be construed to allow the Eligible Individual to begin participation on the 91st day following his/her commencement of employment.

14. EFFECTIVE DATE OF COVERAGE FOR ELIGIBLE INDIVIDUALS WHO BECOME ELIGIBLE TO PARTICIPATE BASED ON ELIGIBILITY, OR LOSS OF ELIGIBILITY, FOR A STATE PREMIUM ASSISTANCE SUBSIDY **(4.14)**. An individual who becomes eligible to participate in this Plan by virtue of his/her eligibility (or loss of eligibility) for a state premium assistance subsidy shall enter the Plan *(Choose (a) or (b))*:

[X] (a) The first day following the individual's eligibility for the premium subsidy or loss of eligibility for the premium subsidy, as applicable, provided the Plan Administrator receives the enrollment application within the time period required by the Plan.

[ ] (b) On the first day of the first month coincident with or next following the date the individual becomes eligible for the premium subsidy or loses eligibility for the premium subsidy, as applicable, provided the Plan Administrator receives the enrollment application within the time period required by the Plan.

15. ENROLLMENT OF DEPENDENTS INTO THE PLAN **(3.01)**. If a Dependent is otherwise eligible to participate in the Plan, such Dependent may enroll in the Plan for the following reasons *(Options (a), (b), and (c) must always be checked.*

Plan Sponsor, however, should choose (d) or one or more of (e) and (f):

[X] (a) **Open Enrollment Period under the Plan.**

[X] (b) **HIPAA Special Enrollment Rights apply.**

[X] (c) **Dependent is the subject of a Qualified Medical Child Support Order.**

[X] (d) **Dependent may not enter the Plan for any reason other than those described in (a), (b), and (c) above.**

[ ] (e) **A reason that is permitted under Plan Sponsor's cafeteria plan.** The Plan Sponsor maintains a cafeteria plan within the meaning of Code § 125, and a Dependent is enrolling for a reason permitted by such cafeteria plan's election change rules (e.g., change in family status, gain of student status, significant reduction in the cost of coverage, court judgment, decree, or order, etc.).

[ ] (f) **Other reasons for permitting Dependents to enter the Plan.** *(Please specify)*: _____

_____.

16. ENTRY DATE FOR ELIGIBLE DEPENDENTS **(3.02, 4.06-4.08, 4.12, 4.13)**. Unless required otherwise by the Core Document (e.g., Dependents acquired by birth, adoption, or appointment of legal guardianship), a Dependent who becomes eligible to enroll in the Plan at a time other than an Open Enrollment Period will enter the Plan as follows *(Choose (a) or (b), and, if applicable, (c) and/or (d))*:

[ ] (a) **Immediately, provided the Plan Administrator receives the enrollment application within the time period required by the Plan.**

[X] (b) **On the first day of the month coincident with or next following the date he/she becomes eligible under the Plan, provided the Plan Administrator receives the enrollment application within the time period required by the Plan.**

[X] (c) **Notwithstanding the election in (a) or (b), in the case of eligibility through marriage (4.12):**

[X] On the date of the marriage, but only if the enrollment application is received by the Plan Administrator within the enrollment deadline applicable to Special Enrollees, as elected by Plan Sponsor.

[ ] On the first day of the first month coincident with or next following the date of the marriage.

[ ] On the first day of the first month coincident with or next following the date on which a timely enrollment application is received by the Plan Administrator.

[X] (d) **Notwithstanding the election in (a) or (b), in the case of a loss of other coverage (4.13):**

[X] The first day following the loss of other coverage, provided the Plan Administrator has received the enrollment application within the time period required by the Plan.

[ ] The first day of the calendar month following the loss of other coverage, provided the Plan Administrator has received the enrollment application.

[ ] The first day of the calendar month beginning after the Plan Administrator has received the enrollment application.

17. SPECIAL RULE FOR PERSONS WHO ARE ELIGIBLE INDIVIDUALS AS OF THE PLAN'S EFFECTIVE DATE **(3.06)**. If coverage has not been provided to Eligible Individuals prior to adoption of this Plan, individuals who meet the definition of an Eligible Individual on the Effective Date may be eligible to participate in this Plan on the Effective Date, without regard to whether they have completed the Waiting Period, based on Plan Sponsor's election below. *(Choose (a) or (b))*:

[ ] (a) **Eligible Individuals <u>will</u> be eligible to participate in this Plan on the Effective Date, without regard to whether they have completed the required Waiting Period.**

[X] (b) **Eligible Individuals will not be eligible to participate in this Plan on the Effective Date unless and until they have completed the required Waiting Period.**

18. SPECIAL RULE FOR CHANGING FROM PART-TIME TO FULL-TIME EMPLOYMENT **(3.07)**. If Plan Sponsor has elected to exclude part-time workers from the definition of Eligible Individual in Article II, #6(A) above, will a part-time worker who becomes a full-time worker, and who was *not* an Eligible Individual due only to his/her status as a part-time worker, be permitted to enter the Plan as if the Waiting Period has been satisfied?

[ ] (a) **Yes.**

[X] (b) **No.**

[ ] **N/A.** Part-time workers are included in the definition of Eligible Individual.

ARTICLE IV
COVERAGE UNDER THE PLAN

19. BENEFITS. The group number assigned to the Benefit Description is BMI238.

20. FMLA LEAVE **(4.17)**. In addition to the other payment options provided in the Core Document, a Participant who goes on a qualifying unpaid leave pursuant to the FMLA has the following options for paying his/her premiums under the Plan *(Choose all that apply)*:

[ ] (a) **Pay all or a Portion of his/her share of the premium upon the termination of his/her leave (i.e., a "catch up" option).**

[ ] (b) **Pay all or a Portion of his/her share of the premium prior to his/her expected leave (i.e., a "prepay" option).**

[ ] (c) **Other: _____.**

21. LEAVES OF ABSENCE **(4.19)**. A Participant on an approved leave of absence (other than FMLA or USERRA) shall become ineligible under the Plan, as indicated below *(Choose (a), (b), (c), or (d)*:

[ ] (a) **At the end of the day on which the person last satisfied the criteria for an Eligible Individual.**

[X] (b) **The last day of the calendar month following the first day in which the person last satisfied the criteria for an Eligible Individual.**

[ ] (c) **As provided in Plan Sponsor's employee handbook or similar policy manual.**

[ ] (d) **Other: _____.**

22. STATUS AS ELIGIBLE EMPLOYEE DURING APPROVED (NON-FMLA/USERRA) LEAVE OF ABSENCE (**4.19**). During the period of time in which a Participant is on an approved leave of absence (other than FMLA or USERRA), he/she shall continue to be an Eligible Individual during all of the following time periods *(Choose one or more of (a) through (f))*:

[ ] (a) **Any period of unpaid approved leave not to exceed _____.**

[ ] (b) **Any period of paid and/or unpaid approved leave, the combination of which does not exceed _____.**

[X] (c) **While the individual is receiving regular pay for personal paid time off.**

[X] (d) **While the individual is receiving regular pay for vacation time.**

[X] (e) **While the individual is receiving regular pay for sick leave.**

[ ] (f) **While the individual is receiving benefits pursuant to a short-term disability plan/policy.**

23. TERMINATION OF COVERAGE – PARTICIPANTS **(4.20(a), (c))**. As a general rule, but subject to any special rule for leaves of absence in this Adoption Agreement, the coverage for a Participant who loses eligibility under the Plan shall end *(Choose one)*:

[ ] (a) **At 12:01 a.m. on the date following the loss of eligibility or termination of employment.**

[X] (b) **At the end of the last day of the month coincident with or following the loss of eligibility or termination of employment.**

24. TERMINATION OF COVERAGE – DEPENDENTS **(4.20(a), (c))**. Unless provided otherwise in the Core Document, the coverage for a Dependent under the Plan shall end *(Choose (a) or (b)*:

[ ] (a) **On the date on which the Dependent ceases to satisfy the eligibility conditions of the Plan.**

[X] (b) **At the end of the month coincident with or next following the date on which the Dependent ceases to satisfy the eligibility conditions of the Plan.**

25. REINSTATEMENT OF FORMER PARTICIPANT **(4.21)**. A former Participant whose employment is terminated with Plan Sponsor and who is later rehired by Plan Sponsor shall enter the Plan *(Choose (a), (b) or (c))*:

[ ] (a) **Upon completing the eligibility conditions of Article III, including the applicable Waiting Period.**

[X] (b) **On the first day of the month coincident with or next following the rehire date, if and only if the former Participant is reemployed by Plan Sponsor within one-hundred twenty (120) days of having terminated employment with Plan Sponsor. Otherwise, the former Participant shall enter the Plan only after completing the eligibility conditions of Article III, including the applicable Waiting Period.**

[ ] (c) **Other:** _____.

ARTICLE V
RESERVED

ARTICLE VI
CLAIMS PROCEDURES

26. GRANDFATHERED VS. NON-GRANDFATHERED PLAN **(6.01)**. Indicate below whether the Plan is a grandfathered plan or non-grandfathered plan for purposes of compliance with federal regulations governing claims procedures:

[ ] (a) **Grandfathered plan.**

[X] (b) **Non-grandfathered plan.**

[ ] (c) **Not Applicable (Grandfathered Status is Irrelevant to the Plan).**

ARTICLE VII
HIPAA MEDICAL PRIVACY

27. AUTHORIZED EMPLOYEES **(7.10)**. Schedule 1 to this Adoption Agreement lists the "authorized employees" (as defined in the HIPAA medical privacy regulations) who are permitted to use and have access to "protected health information" to the extent necessary to perform "plan administration functions," as set forth in Article VII of the Core Document. In the event there is a change in the Authorized Employees, Schedule 1 may be updated by the Plan Administrator, as provided in Sections 7.10 of the Core Document.

ARTICLE VIII
COBRA COVERAGE

28. COBRA COVERAGE FOR COVERED DOMESTIC PARTNERS **(8.02)**. If the Plan covers Domestic Partners, then such individuals have the same COBRA continuation coverage rights as any other qualified beneficiary, unless Plan Sponsor elects otherwise below *(Choose (a), (b) or (c))*:

[ ] (a) **Covered Domestic Partners shall have the same COBRA continuation coverage rights as any other qualified beneficiary under the Plan.**

[ ] (b) **Covered Domestic Partners shall have no COBRA continuation coverage rights under the Plan.**

[X] (c) **Domestic Partners are not covered in the Plan.**

ARTICLE IX
MISCELLANEOUS

29. NAMED FIDUCIARY **(12.06)**. The "named fiduciary" of the Plan is the Plan Sponsor unless the following individual(s) is/are named instead as the "named fiduciary: _____.

30. STATE LAW **(12.14)**. Except to the extent superseded by Federal law, the law of the State of Kansas will determine all questions arising with respect to the provisions of the Plan.

31. PLAN NUMBER. The 3-digit plan number that the Plan Sponsor assigns to this Plan for ERISA reporting purposes (Form 5500 Series) is: _____. *Note*: If the Plan is not subject to ERISA, please check this box: [X]

32. PLAN SPONSOR'S EIN. The EIN of the Plan Sponsor is 48-6039815.

OTHER PLAN COVERAGE PROVISIONS

33. _____

_____

34. _____

_____

EXECUTION PAGE

Plan Sponsor, by executing this Adoption Agreement, hereby adopts the provisions of the Plan as set forth in this Adoption Agreement, in the Core Document, and in the Benefit Description.

Allen County
Name of Plan Sponsor

Signed: _____

Title: Allen County Commission Chairman

Date: April 26, 2016

CERTIFICATION BY THE PLAN SPONSOR TO THE GROUP HEALTH PLAN

I hereby certify on behalf of the Plan Sponsor that the Plan has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii), effective as of the Effective Date of the Plan and, more specifically, the restated Effective Date in the case of a restated Plan. I further certify on behalf of the Plan Sponsor that the Plan Sponsor agrees to comply with the provisions of the Plan, as amended, governing the use and disclosure of Protected Health Information by the Plan to the Plan Sponsor. This Certification is made pursuant to 45 C.F.R. § 164.504(f)(2)(ii).

Allen County
Name of Plan Sponsor

Signed: _____

Title: Allen County Commission Chairman

Date: April 26, 2016

INFORMATION FOR THE SUMMARY PLAN DESCRIPTION

The answers to the following questions will be used to complete the Summary Plan Description ("SPD"). The reference in parentheses refers to where this information should be added to the SPD.

1. NAME/ADDRESS OF PLAN SPONSOR. In the space below, please fill in the name and address of Plan Sponsor. If there are Participating Plan Sponsors, please also provide the name and address of each Participating Plan Sponsor.

Plan Sponsor – Name/Address	Participating Plan Sponsor – Name/Address
Allen County	_____
1 N. Washington	_____
Iola, KS 66749	_____
(620) 365-1407	_____
_____	_____
Participating Plan Sponsor – Name/Address	Participating Plan Sponsor – Name/Address
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. LEGAL SERVICE OF PROCESS. The name (and/or title) and address of the person designated as the Agent for Service of Legal Process is:

   COUNTY CLERK, ALLEN COUNTY, 1 N. WASHINGTON, IOLA, KS 66749

3. RIGHT TO AMEND/TERMINATE. If the Plan Sponsor amends or terminates the Plan and/or any of the benefits provided under the Plan by written instrument, what is the name (and/or title) of the person with the authority to sign such written instrument?

   BOARD OF DIRECTORS CHAIRMAN

4. HIPAA MEDICAL PRIVACY. As part of its HIPAA medical privacy compliance, the Plan must appoint Contact Person(s) or a Contact Office. Please indicate below the name and/or title of the Contact Person or the name of the Contact Office, along with a phone number and the address, from whom a covered person may request a Notice of Privacy Practices:

   COUNTY CLERK, ALLEN COUNTY, 1 N. WASHINGTON, IOLA, KS 66749; TELEPHONE (620) 365-1407

5. COLLECTIVE BARGAINING AGREEMENT. Is this Plan maintained pursuant to one or more collective bargaining agreements?

[ ] (a) **Yes.**

[X] (b) **No.**

If "yes," please indicate how a copy of such agreement(s) may be obtained by Plan Participants: _____
_____.

Participation Agreement

[X] Check here if not applicable and do *not* complete this page.

The undersigned Employer, by executing this Participation Agreement, elects to become a Participating Plan Sponsor in the Plan identified in Election 1 of the accompanying Adoption Agreement, as if the Participating Plan Sponsor were a signatory to that Adoption Agreement. The Participating Plan Sponsor accepts, and agrees to be bound by, all of the provisions of the Plan, except as otherwise provided in this Participation Agreement.

_____

Name of Participating Plan Sponsor

_____

Participating Plan Sponsor's EIN

Signed: _____

Title: _____

Date: _____

[*Note: Each participating plan sponsor must execute a separate Participation Agreement. If the Plan does not have a Participating Plan Sponsor, the Signatory Plan Sponsor may delete this page from the Adoption Agreement.*]

Schedule 1
HIPAA Authorized Employees (7.10)

The individuals employed by the Employer who shall be "authorized employees" for purposes of using and accessing PHI and e-PHI are listed below. *(Please list the names or titles (preferably titles) of such individuals):*

Human Resources	_____
Benefits Administrator	_____
County Clerk	_____
_____	_____
_____	_____
_____	_____

In the event there is a change in "authorized employees," this Schedule 1 may be updated by the Plan Administrator, as provided in Section 7.10 of the Core Document.

ALLEN COUNTY

ADDENDUM 1
PPACA ELIGIBILITY PROVISIONS

INTRODUCTION

The Adoption Agreement contains eligibility provisions governing who may participate in the Plan and when such participation commences. ***Unless elected otherwise in Section 6.03, this Addendum applies only during a Plan Year in which the Plan Sponsor is deemed to be an "applicable large employer" within the meaning of the federal Patient Protection and Affordable Care Act ("PPACA").*** This Addendum supplements and supersedes the Adoption Agreement's eligibility provisions with respect to Part-Time Employees, Variable Hour Employees, and Seasonal Employees, as those terms are defined in Part I of this Addendum. The rules in this Addendum shall be interpreted in a manner that is consistent with the rules set forth in the Final Regulations issued by the Department of Treasury involving the "shared responsibility" provisions of PPACA.

If the Plan Sponsor (or a Participating Plan Sponsor) desires to use different eligibility elections for different groups of employees, as permitted in Section 2.01 of this Addendum, then a separate Addendum will be necessary for each discrete employee group.

Unless otherwise indicated, all section references in this Addendum are references to sections within this Addendum. Any references to sections of the Core Document or Adoption Agreement will explicitly so indicate.

PART I
DEFINITIONS

Section 1.01 **Administrative Period.** The Administrative Period means:

(a) *Ongoing Employee*. For an Ongoing Employee, the period of time, as elected in Section 4.04, that is no longer than 90 days and that begins on the day immediately following the conclusion of the Standard Measurement Period and ends on the day immediately preceding the first day of the associated Stability Period; and

(b) *New Employee*. For a New Employee, the period(s) of time, as elected in Section 3.04, that include(s) the following:

(i) The period of time that begins on the day immediately following the conclusion of the Initial Measurement Period and ends on the day immediately preceding the first day of the associated Initial Stability Period; and

(ii) If elected by the Plan Sponsor in Section 3.04(a), the period of time that begins on the date the New Employee commences employment and ends on the day immediately preceding the first day of the Initial Measurement Period.

Section 1.02 **Full-Time Employee.** A Full-Time Employee means an Employee who is employed by the Plan Sponsor and who satisfies one of the following:

(a) *Regularly Scheduled to Work Hours Required by Welfare Benefits Plan*. The Employee is regularly scheduled to work at least the number of hours per week as the Plan Sponsor has elected in Section 6(A)(2) of the Adoption Agreement; or

(b) *Meets Eligibility Requirements Pursuant to Look-Back Measurement Method or Monthly Measurement Period*. The Employee is either a Part-Time Employee, Variable Hour Employee, or Seasonal Employee, and qualifies for full-time status by virtue of the Look-Back Measurement Method or Monthly Measurement Period, as applicable and as set forth in this Addendum.

Section 1.03 Initial Measurement Period. The Initial Measurement Period means the period of time, as elected in Section 3.03, that is used to determine if a New Employee (who is classified as a Part-Time Employee, Variable Hour Employee, or a Seasonal Employee) is eligible to participate in the Plan during his/her subsequent Initial Stability Period.

Section 1.04 Initial Stability Period. The Initial Stability Period means the period of time, as elected in Section 3.05, that follows, and is associated with, the Initial Measurement Period of a New Employee (who is either a Part-Time Employee, a Variable Hour Employee, or a Seasonal Employee).

Section 1.05 New Employee. A New Employee means an Employee who has not been employed by the Plan Sponsor for at least one complete Standard Measurement Period. Once a New Employee has been employed for at least one complete Standard Measurement Period, he/she will be deemed to be an Ongoing Employee, and his/her eligibility to participate in the Plan will be governed by the terms and conditions applicable to Ongoing Employees (unless the Employee is eligible for coverage by virtue of an Initial Stability Period). A rehired employee may be considered a New Employee or an Ongoing Employee depending on the length of time between his/her termination date and rehire date. *See* Section 6.02 for more details.

Section 1.06 Ongoing Employee. An Ongoing Employee means an Employee who has been employed by the Plan Sponsor for at least one complete Standard Measurement Period.

Section 1.07 Part-Time Employee. A Part-Time Employee means an Employee who, based on the facts and circumstances at the commencement of his/her employment, is not reasonably expected to average at least the number of hours of service per week (or month) as the Plan Sponsor has elected in Section 6(A)(2) of the Adoption Agreement.

Section 1.08 Seasonal Employee. A Seasonal Employee means an Employee who is hired into a position for which the customary annual employment is six months or less.

Section 1.09 Stability Period. The Stability Period means the period of time elected in Section 4.05 that follows, and is associated with, a particular Standard Measurement Period.

Section 1.10 Standard Measurement Period. The Standard Measurement Period means the period of time elected in Section 4.03 that is used to determine whether an Ongoing Employee is eligible to participate in the Plan.

Section 1.11 Variable Hour Employee. A Variable Hour Employee means a New Employee who, based on the facts and circumstances at the commencement of his/her employment, cannot reasonably be expected to average at least the number of hours of service per week (or month) as the Plan Sponsor has elected in Section 6(A)(2) of the Adoption Agreement.

PART II
SCOPE OF ELECTIONS IN ADDENDUM 1

Section 2.01 **Scope of Elections in Addendum 1.** The elections of the Plan Sponsor (or the Participating Plan Sponsor) in this Addendum 1 shall apply to the following group(s) of Employees: *(Choose either (a) or one of (b), (c), (d), or (e). Note that if different groups of employees will be subject to different elections (i.e., if anything other than Option (a) is elected), a separately completed Addendum will needed to be completed for each group, and that separately completed Addendum will govern the applicable group of employees.)*

[X] (a) **All Employees.**

[ ] (b) **Only Salaried Employees.**

[ ] (c) **Only Hourly Employees.**

[ ] (d) **Only Employees Whose Principal Place of Employment is the State of _____.**

[ ] (e) **Only Non-Collectively Bargained Employees.**

Note: *Federal regulations implementing PPACA permit Plan Sponsors to utilize different Standard Measurement Periods and Stability Periods and different Initial Measurement Periods and Initial Stability Periods for certain discrete groups of employees. (Different Participating Plan Sponsors that are part of the same "applicable large employer" Plan Sponsor group also may utilize measurement and stability periods that are different from other members of the same "applicable large employer" group.) The only permitted differential treatments, however, are those that are set forth in the election options above.*

Section 2.02 **Method of Measuring Employee's Full-Time Status.** With regard to the class of Employees elected in Section 2.01, the Plan Sponsor (or Participating Plan Sponsor) must elect which measurement method (i.e., Look-Back Measurement Method or Monthly Measurement Method) it will use for determining their status as a Full-Time Employee. The following measurement method will be used: *(Choose (a) or (b))*

[X] (a) **Look-Back Measurement Method.**

[ ] (b) **Monthly Measurement Method.**

Note*: If the Monthly Measurement Period is elected, then the only provisions of this Addendum that apply to the affected class of Employees elected in Section 2.01 are Sections 4.08-4.09, 5.01, and 6.03-6.05. If the Look-Back Measurement Period is elected, then the remainder of this Addendum must be completed, other than Section 5.01.*

PART III
NEW EMPLOYEE ELIGIBLITY

Section 3.01 Eligibility of New Full-Time (Non-Part-Time / Non-Seasonal / Non-Variable Hour) Employees. A New Employee, who is neither a Part-Time Employee, Seasonal Employee, nor Variable Hour Employee, will be deemed to be a Full-Time Employee (and eligible to participate in the Plan immediately following his/her completion of any Waiting Period that the Plan imposes), if he/she is reasonably expected at his/her start date to work at least the number of hours elected by Plan Sponsor in Election 6(A)(2) of the Adoption Agreement.

Note: *Federal regulations implementing PPACA require that a New Employee be deemed a full-time Employee (and thus eligible for coverage) if he/she is reasonably expected to average at least 30 hours of service per week or 130 hours of service per month. However, the Plan Sponsor may select a lower number of hours of service by which the Employee will be deemed to be a full-time Employee and thus eligible for coverage.*

Section 3.02 Eligibility of New Part-Time / Seasonal / Variable Hour Employees. Notwithstanding any eligibility exclusion under Elections 6(A)(2) or 6(A)(4) of the Adoption Agreement, a New Employee who is either a Part-Time Employee, Seasonal Employee, or Variable Hour Employee will be eligible to participate in the Plan if he/she averages, during his/her Initial Measurement Period, at least the number of hours per week (or month) as the Plan Sponsor has elected in Election 6(A)(2) of the Adoption Agreement.

(a) If a New Employee who is either a Part-Time Employee, Seasonal Employee, or Variable Hour Employee *does* average, during his/her Initial Measurement Period, at least the number of hours per week that the Plan Sponsor has elected in Election 6(A)(2) of the Adoption Agreement, then he/she may commence participation upon the first day of the Initial Stability Period applicable to his/her Initial Measurement Period as long as (and only to the extent that) he/she is still employed by the Plan Sponsor during such Initial Stability Period.

(b) If a New Employee who is either a Part-Time Employee, Seasonal Employee, or Variable Hour Employee *does not* average, during his/her Initial Measurement Period, at least the number of hours per week that the Plan Sponsor has elected in Election 6(A)(2) of the Adoption Agreement, then he/she will be excluded from participating in the Plan during the Initial Stability Period applicable to his/her Initial Measurement Period. However, if this New Employee, upon completing a full Standard Measurement Period (and thus becoming an Ongoing Employee) averages, during the Standard Measurement Period, at least the number of hours per week that the Plan Sponsor has elected in Election 6(A)(2) of the Adoption Agreement, then he/she will be eligible to participate in the Plan during the Stability Period that follows, and is associated with, the preceding Standard Measurement Period, even if such Stability Period overlaps with the Initial Stability Period during which he/she would not otherwise have been eligible to participate in the Plan; provided, however, the Employee will be eligible to participate in the Plan during such Stability Period only if he/she is still employed by the Plan Sponsor during the Stability Period.

Section 3.03 **Initial Measurement Period.** The Plan Sponsor must make the following elections to determine the applicable Initial Measurement Period for New Employees under the Plan.

(a) Commencement of Initial Measurement Period. The Initial Measurement Period for New Employees shall begin: *(Choose one of the following)*

[ ] (i) **On the date that the New Employee commences employment.**

[X] (ii) **The first day of the first month coincident with, or next following, the date that the New Employee commences employment (or, if later, the first day of the first weekly, bi-weekly, or semi-monthly payroll period that begins on or after the date that the New Employee commences employment).**

[ ] (iii) **Other**: _____

_____

Note: *The Initial Measurement Period for New Employees must commence no later than the first day of the first calendar month that begins after the New Employee commences employment (or, if later, the first day of the first weekly, bi-weekly, or semi-monthly payroll period that begins on or after the date that the New Employee commences employment).*

(b) Length of Initial Measurement Period. The Initial Measurement Period shall last for the length of time selected below: *(Choose one of the following)*

[X] (i) **Twelve Months.**

[ ] (ii) _____ **months/weeks (circle one)** *(must be between six and twelve months).*

Note 1: *The combined Administrative Period and Initial Measurement Period cannot last beyond the final day of the first calendar month that begins on or after the first anniversary of a New Employees' first day of employment*.

Note 2: *For Plan Sponsors using a payroll period methodology in determining their Initial Measurement Period, see Note 2 following Section 4.03(B).*

Section 3.04 **Administrative Period(s) for New Employees.** The Plan Sponsor must make the following elections to determine the applicable Administrative Period(s) under the Plan for New Employees. For such New Employees, the Plan shall use (an) Administrative Period(s) that run(s) from: *(Option (a) must be checked if the Plan Sponsor elected Option (A)(ii) in Section 3.03; the Plan Sponsor must fill in the appropriate period of time in Option (b) if it wishes to utilize an Administrative Period between the end of the Initial Measurement Period and the beginning of the Initial Stability Period)*

[ ] (a) **If the Plan Sponsor elected Option (A)(ii) in Section 3.03, the day that the New Employee commenced employment until the first day of his/her Initial Measurement Period.**

[X] (b) **The first day following the end of the Initial Measurement Period until the first day of the associated Initial Stability Period. The time period between these two dates shall be one (1) month.**

[ ] (c) **Other**: _____

_____

_____

Note: *The Administrative Period(s) cannot exceed a total of 90 days.*

Section 3.05 **Initial Stability Period.** The Plan Sponsor must make the following election to determine the applicable Initial Stability Period for New Employees under the Plan. The Initial Stability Period shall last for the length of time selected below: *(Choose one of the following)*

[X] (a) **Twelve Months.**

[ ] (b) **_____ months/weeks (circle one)** *(must be between six and twelve months).*

Note: *The Initial Stability Period must be at least six months and also must be the same length of time as the Initial Measurement Period. Moreover, the Initial Stability Period must be identical to the Stability Period applicable to Ongoing Employees (see Section 4.05).*

Section 3.06 **Eligibility Impact of Change in Employment Status (from Non-Full-Time to Full-Time) of New Employee During Initial Measurement Period.** If the employment position or status of a New Employee who is either a Part-Time Employee, Seasonal Employee, or Variable Hour Employee materially changes before the end of his/her Initial Measurement Period in a way that, if the Employee had originally commenced employment in such position or status, he/she would have reasonably been expected to average at least the number of hours per week that the Plan Sponsor has elected in Election 6(A)(2) of the Adoption Agreement, then such New Employee will be eligible to participate in the Plan upon: *(Check one of the following)*

[ ] (a) **The earlier of:**

(i) The first day of the fourth month following the change in employment status; or

(ii) If the New Employee averaged, during his/her Initial Measurement Period, at least the number of hours per week that the Plan Sponsor has elected in Section 4.01, the first day of the New Employee's Initial Stability Period.

[X] (b) **The conclusion of the Plan's Waiting Period that applies to Employees upon becoming initially eligible to participate in the Plan.**

[ ] (c) **The first day of the first month coincident with, or next following, the change in employment status**

[ ] (d) **The first effective day of the change in employment status.**

[ ] (e) **Other**: _____

_____

_____

Note: *Following the change in employment status described above, the formerly Part-Time Employee, Seasonal Employee, or Variable Employee must be offered coverage in the Plan no later than the time period set forth in Option (a).*

PART IV
ONGOING EMPLOYEE ELIGIBILITY

Section 4.01 Eligibility of Ongoing Employees.

(A) *Full-Time Status During Standard Measurement Period*. If an Ongoing Employee, during a Standard Measurement Period, averages at least the number of hours of service per week as were elected by the Plan Sponsor in Election 6(A)(2) of the Adoption Agreement, then he/she will be deemed to be a Full-Time Employee (and thus eligible to participate in the Plan) during the Stability Period that follows, and is associated with, such Standard Measurement Period as long as (and only to the extent that) he/she is still employed by the Plan Sponsor during such Stability Period.

(B) *Non-Full-Time Status During Standard Measurement Period*. If an Ongoing Employee, during a Standard Measurement Period, does not average at least the number of hours of service per week as were elected by the Plan Sponsor in Election 6(A)(2) of the Adoption Agreement, then he/she will not be deemed to be a Full-Time Employee (and thus will not be eligible to participate in the Plan) during the Stability Period that follows, and is associated with, such Standard Measurement Period.

Section 4.02 Change of Ongoing Employee's Employment Status During Stability Period. If an Ongoing Employee's average hours of service or position of employment changes during a Stability Period, the change will have no effect on the Ongoing Employee's eligibility to participate in the Plan during that Stability Period, except as specifically provided otherwise in Section 4.06 below. In other words, the Ongoing Employee will continue to be eligible (or continue to not be eligible, as applicable) to participate in the Plan during the entire Stability Period.

Section 4.03 Standard Measurement Period. The Plan Sponsor must make the following election(s) to determine the applicable Standard Measurement Period for Ongoing Employees under the Plan. In Part A, the Plan Sponsor may make a special one-time election to adopt a "transitional" Standard Measurement Period that has a different length in time as the Standard Measurement Period that will be used in the future. In Part B, the Plan Sponsor must elect the time period for its non-transitional Standard Measurement Period.

(a) **Transitional Standard Measurement Period.** The transitional Standard Measurement Period shall last for the following period of time: *(Choose one of the following)*

[ ] (i) **No Transitional Standard Measurement Period is Being Used.**

[X] (i) **From July 1, 2014 through the following February 28, 2015**

[ ] (iii) **Other**: _____

_____

Note 1: *The transitional Standard Measurement Period must be between six and twelve consecutive months. It must commence no later than July 1, 2014, and it must end no earlier than*

90 days before the first day of the Plan Year beginning on or after January 1, 2015. Unlike the non-transitional Standard Measurement Period, the transitional Standard Measurement Period does not have to be identical to the Stability Period.

Note 2: *For Plan Sponsors using a payroll period methodology in determining their Transitional Standard Measurement Period, see Note 2 following Section 4.03(b).*

(b) **Non-Transitional Standard Measurement Period.** The non-transitional Standard Measurement Period shall last for the following period of time: *(Choose one of the following)*

[X] (i) **From February 1 through the following January 31.** *(Choose this option only if the Standard Measurement Period being elected is twelve months long.)*

[ ] (ii) **The ____ month/week** *(circle one) (select time period that is at least six but less than twelve months)* **period of time that begins on the day immediately after the conclusion of each Stability Period. However, the first Standard Measurement Period shall begin on** _____ *(insert specific month, day and year) (Example: July 1, 2014).*

[ ] (iii) **Other**: _____

_____

Note 1: *The non-transitional Standard Measurement Period must be between six and twelve consecutive months. Moreover, the non-transitional Standard Measurement Period must be identical to the Stability Period.*

Note 2: *The Plan Sponsor may treat as a measurement period a period that ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the measurement period, provided that the measurement period begins on the first day of the payroll period that includes the date that would otherwise be the first day of the measurement period. The Plan Sponsor may also treat as a measurement period a period that begins on the first day of the payroll period that follows the payroll period that includes the date that would otherwise be the first day of the measurement period, provided that the measurement period ends on the last day of the payroll period that includes the date that would otherwise be the last day of the measurement period. For example, a Plan Sponsor using the calendar year as a measurement period could exclude the entire payroll period that included January 1 (the beginning of the year) if it included the entire payroll period that included December 31 (the end of that same year), or, alternatively, could exclude the entire payroll period that included December 31 of a calendar year if it included the entire payroll period that included January 1 of that calendar year.*

Section 4.04 Administrative Period for Ongoing Employees. The Plan Sponsor must make the following election to determine the applicable Administrative Period under the Plan for Ongoing Employees. For such Ongoing Employees, the Plan shall use an Administrative Period that encompasses the following period of time: *(Choose (i) or (ii))*

[X] (a) **From the first day following the end of the Standard Measurement Period until the first day of the associated Stability Period. (***Choose this option if the Standard Measurement Period and Stability Period elected in Sections 4.03 and 4.05 are twelve months.)*

[ ] (b) **For a period of time equal to _____ days/months.** *(Choose this option only if the Standard Measurement Period and Stability Period elected in Sections 4.03 and 4.05 are less than twelve months.)*

Note: *In order to prevent any gaps in coverage, the Administrative Period following a Standard Measurement Period must overlap with the preceding Stability Period. This will ensure that any Ongoing Employees who are covered under the Plan by virtue of their hours worked during the preceding Standard Measurement Period will continue to be covered for the full Stability Period*.

Section 4.05 Stability Period for Ongoing Employees. The Plan Sponsor must make the following election to determine the applicable Stability Period for Ongoing Employees under the Plan. The Stability Period shall last for the following period of time: *(Choose one of the following)*

[X] (a) **From April 1 through the following March 31.** *(Choose this option only if the Standard Measurement Period being elected is twelve months long.)*

[ ] (b) **The ____ month/week** *(circle one and select time period that is at least six but less than twelve months)* **period of time that begins on the day immediately after the conclusion of the Standard Measurement Period and any Administrative Period elected in Section 4.04(b).**

Note: *The Stability Period must be at least six consecutive months and also must be the same length of time as the Standard Measurement Period. Moreover, the Stability Period must be identical to the Initial Stability Period applicable to New Employees*. *In most circumstances, the Stability Period will run coterminous with the Plan Year.*

Section 4.06 Eligibility Impact of Change in Employment Status from Full-Time to Non-Full-Time During Stability Period. If an Ongoing Employee who is being treated as "full-time" during a Stability Period experiences a change in employment position or status (e.g., shift to a new position, demotion, etc.) such that, in the new position or status, he/she is not reasonably expected to average at least the number of hours per week that the Plan Sponsor has elected in Election 6(A)(2) of the Adoption Agreement, then the Plan Sponsor may elect to apply the Monthly Measurement Method (rather than the otherwise applicable Stability Period under the Look-Back Measurement Method) to such Ongoing Employee beginning on the first day of the fourth full calendar month following the change in employment position or status. This election may only be made, however, if: (a) the Plan Sponsor has offered "minimum value" coverage to the Employee from at least the first day of the month following the Employee's initial three full calendar months of employment through the month in which the change in employment position or status occurs; and (b) during each of the three full calendar months following the change in employment positon or status, the Employee averages fewer hours of service per week than the Plan Sponsor elected in Election 6(A)(2) of the Adoption Agreement. If so elected, the Plan Sponsor may continue to apply the Monthly Measurement Method for that particular Employee through the end of the first full Standard Measurement Period (and any associated Administrative Period) that would have applied had the Employee remained under the applicable Look-Back Measurement Method. The Plan Sponsor elects: *(Choose one of the following)*

[ ] (a) **To use the special rule described above, allowing for the application of the Monthly Measurement Method (rather than the otherwise applicable Stability Period under the Look-Back Measurement Method) to an Ongoing Employee who has experienced a change in employment position or status from a Full-Time Employee to a Non-Full Time Employee, beginning on the first day of the fourth full calendar month following the change in employment position or status.**

[X] (b) **Not to use the special rule described above, and thus will continue to use the applicable Stability Period under the Look-Back Measurement Method for such Ongoing Employee.**

Section 4.07 Eligibility Impact of Change in Employment Status from Non-Full-Time to Full-Time During Stability Period. If an Ongoing Employee who is being treated as "non-full-time" (i.e., ineligible for benefits) during a Stability Period experiences a change in employment position or status (e.g., shift to a new position, demotion, etc.) such that, in the new position or status, he/she is reasonably expected to average at least the number of hours per week that the Plan Sponsor has elected in Election 6(A)(2) of the Adoption Agreement, then such Ongoing Employee will become eligible to participate in the Plan as of the following date: *(Choose one of the following)*

[ ] (a) **The first day of the next Stability Period, but only if the Ongoing Employee, during the Standard Measurement Period associated with that next Stability Period, averaged at least the number of hours per week/month as the Plan Sponsor elected in Election 6(A)(2) of the Adoption Agreement. (In other words, the Ongoing Employee is not entitled to any accelerated eligibility for the plan by virtue of his/her change in position or status during the Stability Period.)**

[X] (b) **Consistent with Election 18 of the Adoption Agreement, either:**

(i) **The first day of the first month coincident with, or next following, the Ongoing Employee's satisfaction of the Plan's Waiting Period; or**

(ii) **If the Ongoing Employee already has satisfied the Plan's Waiting Period or, if the Plan Sponsor does not apply the Waiting Period to employees who shift from non-full-time to full-time status, then the first day of the first month coincident with, or next following, the Ongoing Employee's change in employment position or status.**

[ ] (c) **On the effective date of the change in employment position or status.**

[ ] (d) **Other**: _____

_____

_____

Note: Do NOT elect Option (c) if the Plan Sponsor checked "Yes" in Election 18 of the Adoption Agreement.

Section 4.08 Change in Status from Position to Which Look-Back Measurement Method is Used to Position in Which Monthly Measurement Method is Used. If an Employee transfers from a position under which the Look-Back Measurement Method is used to determine his/her status as a Full-

Time Employee, to a position under which the Monthly Measurement Method is used to determine his/her status as a Full-Time Employee, the following rules shall apply:

(a) If the Employee, at the time of the change in status or position, is in a Stability Period in which he/she *is* treated as a Full-Time Employee (and thus eligible for coverage), the Plan Sponsor will continue to treat the Employee as a Full-Time Employee through the end of the Stability Period;

(b) If the Employee, at the time of the change in status or position, is in a Stability Period in which he/she is *not* treated as a Full-Time Employee (and thus not eligible for coverage), the Plan Sponsor will continue to treat the Employee as not a Full-Time Employee through the end of the Stability Period;

(c) For the Stability Period associated with the Standard Measurement Period during which the change in status or positon occurs, the Plan Sponsor will treat the Employee as a Full-Time Employee for any calendar month during which the Employee either (i) would be treated as a Full-Time Employee under the Stability Period that would have applied based on the Standard Measurement Period in which the change in status or position occurred or (ii) would be treated as a Full-Time Employee under the Monthly Measurement Method; and

(d) For any calendar month subsequent to the Stability Period identified in Subsection (c), the Monthly Measurement Method will be used to determine the Employee's status as a Full-Time Employee.

Section 4.09 Change in Status from Position to Which Monthly Measurement Method is Used to Position in Which Look-Back Measurement Method is Used. If an Employee transfers from a position under which the Monthly Measurement Method is used to determine his/her status as a Full-Time Employee, to a position under which the Look-Back Measurement Method is used to determine his/her status as a Full-Time Employee, the following rules shall apply:

(a) For the remainder of the applicable Stability Period during which the change in status or position occurs, the Plan Sponsor will continue to use the Monthly Measurement Method to determine the Employee's status as a Full-Time Employee unless the Employee's hours of service prior to the change in positon or status would have resulted in him/her being treated as a Full-Time Employee during the Stability Period in which the change in status or position occurred, in which case the Plan Sponsor will treat the Employee as a Full-Time Employee during such Stability Period;

(b) For the applicable Stability Period following the Standard Measurement Period during which the change in status or position occurred, the Plan Sponsor will treat the Employee as a Full-Time Employee for any calendar month during which the Employee either: (i) would be treated as a Full-Time Employee based on the Standard Measurement Period during which the change in status or position occurred; or (ii) would be treated as a Full-Time Employee under the Monthly Measurement Method; and

(c) For any calendar month subsequent to the Stability Period referenced in Subsection (b), the Look-Back Measurement Method will be used for determining the Employee's status as a Full-Time Employee.

Section 4.10 Impact on Eligibility of Employee's Transfer from Position in Which One Look-Back Measurement Period Applies to Position in Which a Different Look-Back Measurement Period Applies. This Section addresses changes in measurement methods under circumstances in which an Employee, who has been employed by the Plan Sponsor in a position (referred to as the "first position") for which the Plan Sponsor uses the look-back measurement method, transfers to another position (referred to as the "second position") for the same Plan Sponsor for which the Plan Sponsor also uses the look-back measurement method, but with a measurement period that is different from the measurement period applicable to the first position. For this purpose, two measurement periods are different if they are of different durations or if they start on different dates (or both).

(a) A transfer that may result in a change in the applicable measurement method includes a transfer of the Employee (i) between employers that are part of the same Plan Sponsor control group or (ii) from one category of employees identified in Section 2.01(b)-(e) to another.

(b) For purposes of this Section, following an Employee's transfer, the Plan Sponsor will include hours of service earned in the first position either by (i) counting the hours of service using the counting method applied to the employee in the first position (e.g., using a weekly equivalency method for non-hourly employees), or (ii) recalculating the hours of service earned in the first position using the hours of service counting method applied to the employee in the second position (e.g., using a monthly equivalency method for non-hourly employees), provided that the Plan Sponsor treats all similarly situated employees consistently.

(c) Beginning with the date on which an Employee transfers from the first position to the second position, the look-back measurement method will be applied as follows:

(i) *Employees in Initial Stability Period, Stability Period, or Administrative Period.* If the Employee is in an Initial Stability Period or a Stability Period applicable to the first position as of the date of transfer, his/her status as a Full-Time Employee or Non-Full-Time Employee for the first position remains in effect until the end of the applicable Initial Stability Period or Stability Period. For this purpose, an Employee will be deemed to be in an Initial Stability Period or Stability Period (as applicable) if, as of the date of transfer, the Employee has been assigned a status as a Full-Time Employee or Non-Full-Time Employee for the particular Initial Stability Period or Stability Period based on his/her having been employed by the Plan Sponsor for a full Initial Measurement Period or full Standard Measurement Period (as applicable).

If, as of the date of transfer, a New Employee is in an Administrative Period immediately following the end of the Initial Measurement Period, his/her status as a Full-Time Employee or Non-Full-Time Employee (which is based on his/her hours of service in the Initial Measurement Period under the first position) will apply from the start of the associated Initial Stability Period following the end of that Administrative Period through the end of such Initial Stability Period.

At the end of the Initial Stability Period or Stability Period (as applicable) during which the transfer occurs (or, if the Employee was in an Administrative Period at the date of transfer, the end of the immediately following Initial Stability Period or Stability Period (as applicable)), the Employee will assume the full-time or non-full-time status that would have applied under the look-back measurement

method applicable to the second position, but the calculation of hours under the look-back measurement method for the second position shall include any hours of service that the Employee accrued in the first position. For this purpose, if an Employee's status in the second position cannot be determined under the measurement method applicable to the second position because, for example, the Employee is a variable hour employee and, even including service performed in the first position, has not yet been employed for a full Initial Measurement Period for the second position (and the Administrative Period immediately following that measurement period for the second position), then the rule in Subparagraph (ii) below shall apply to the Employee in the second position.

(ii) *Employees Not in a Stability Period*. If an Employee is not in an Initial Stability Period or an Administrative Period immediately following the end of the Initial Measurement Period under the look-back measurement method applicable to the first position as of the date of transfer, the Employee's status as a Full-Time Employee or Non-Full-Time Employee will be determined solely under the look-back measurement method applicable to the second position as of the date of transfer, including all hours of service in the first position. In all other respects, the rules generally applicable to the look-back measurement method under Treas. Reg. § 54.4980H-3(d) continue to apply. However, a transfer of a New Employee (who may be classified as a Part-Time Employee, Variable Hour Employee, or Seasonal Employee) from the first position to the second position may be a change in employment status described in Section 3.06 if, after the transfer, the Employee is reasonably expected to average at least the number of hours per week in the second position as the Plan Sponsor has elected in Election 6(A)(2) of the Adoption Agreement.

Until a New Employee who is neither a Part-Time Employee, Variable Hour Employee, nor Seasonal Employee has been employed for a full Standard Measurement Period applicable to the second position (including service in the first position), the status of such Employee as a Full-Time Employee or Non-Full-Time Employee will continue to be determined on the basis of hours of service in each calendar month. If such Employee has been employed for a full Standard Measurement Period applicable to the second position but not the first position as of the date of transfer, his/her status as full-time or non-full-time will be determined on the basis of his/her average hours of service during that Standard Measurement Period for the second position (but counting the hours of service accumulated during the Standard Measurement Period for the first position), applied starting on the first day of the first month following the date of transfer and continuing through the end of the associated Stability Period.

PART V
MONTHLY MEASUREMENT PERIOD PROVISIONS

Section 5.01 **Eligibility If Full-Time For a Particular Month.** For a Plan Sponsor using the monthly measurement period, if an Employee works at least 130 hours during a month (or the number of hours described in the Note 1 below if the Plan Sponsor uses a "weekly/monthly measurement period"), then the Employee will be deemed to be a Full-Time Employee for that particular month. The Plan Sponsor must elect whether such Employee will be offered coverage in the Plan for that particular month. A Part-Time Employee, Variable Hour Employee, or Seasonal Employee who is deemed to be a Full-Time Employee for a particular month will: *(Choose one of the following)*

[ ] (a) **Be eligible for coverage for every day of that month.**

[ ] (b) **Not be eligible for coverage during any day of that month, or any other month, based strictly on the number of hours worked during that month.**

[X] (c) **Other. Not applicable**

Note 1: *If the Plan Sponsor is using the Monthly Measurement Period but calculates the hours of its Employees only on a weekly basis, the Plan Sponsor may determine an Employee's status as a Full-Time Employee based on his/her hours of service over a period that either: (i) begins on the first day of the week that includes the first day of the calendar month, provided that the period over which the hours of service are measured does not include the week in which falls the last day of the calendar month (unless that week ends with the last day of the calendar month, in which case it is included); or (ii) begins on the first day of the week immediately subsequent to the week that includes the first day of the calendar month (unless the week begins on the first day of the calendar month, in which case it is included), provided the period over which hours of service are measured includes the week in which falls the last day of the calendar month.*

Note 2: *If the Plan Sponsor is using the Monthly Measurement Period and does not extend an offer of coverage to a Part-Time Employee, Variable Hour Employee, or Seasonal Employee who works a sufficient number of hours to be deemed "full-time" for that particular month, then such Plan Sponsor may be subject to penalties under the Affordable Care Act, except as provided otherwise in Note 3. The offer of coverage must include every day of the month in order to avoid the potential for such penalties.*

Note 3: *A Plan Sponsor using the Monthly Measurement Period may avoid penalties under the Affordable Care Act if it offers coverage to an employee no later than the first day of the month following three full calendar months after the employee has met all of the eligibility conditions for coverage under the Plan, other than the completion of the Waiting Period. An offer of any "minimum value" coverage will allow the employer to avoid penalties under Code § 4980H(a), and an offer of both "minimum value" and "affordable" coverage will allow the employer to avoid penalties under Code § 4980H(b) as well. This full-three-calendar-month delay in offering coverage, however, may be used only once per period of an employee's employment. Moreover, an employee must be treated as an Ongoing employee rather than a new employee unless he/she may be treated as a New Employee under the conditions set forth in Section 6.02. (Note that the special unpaid leave and employment break period rules that apply in the context of the Look-Back Measurement Method (e.g., FMLA leave, USERRA leave, etc.) do not apply in the Monthly Measurement Method.)*

PART VI
ADDITIONAL ADMINISTRATIVE PROVISIONS

Section 6.01 Use of Payroll Periods in Calculating Employees' Hours of Service For Purposes of the Initial Measurement Period or Standard Measurement Period. For payroll periods that are one week, bi-weekly, or semi-monthly in duration, the Plan Sponsor may treat as a Standard Measurement Period a period that ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the Standard Measurement Period, provided that the Standard Measurement Period begins on the first day of the payroll period that includes the date that would otherwise be the first day of the Standard Measurement Period. The Plan Sponsor may also treat as a Standard Measurement Period a period that begins on the first day of the payroll period that follows the payroll period that includes the date that would otherwise be the first day of the Standard Measurement Period, provided that the Standard Measurement Period ends on the last day of the payroll period that includes the date that would otherwise be the last day of the Standard Measurement Period.

For example, if the Plan Sponsor was using a calendar year as the Standard Measurement Period, the Plan Sponsor could exclude the entire payroll period that included January 1 (the beginning of the year) if it included the entire payroll period that included December 31 (the end of that same year). Alternatively, it could exclude the entire payroll period that included December 31 of a calendar year if it included the entire payroll period that included January 1 of that calendar year.

Section 6.02 Eligibility of Employees Rehired After Termination of Employment or Other Extended Absence. An Employee who resumes employment with the Plan Sponsor after a period during which the Employee was not credited with any hours of service will be treated as having terminated employment and having been rehired, and thus treated as a New Employee upon his/her resumption of service, if either of the following is true:

(a) Significant Break-In-Service. The Employee did not work at least one hour of service for the Plan Sponsor during the 13-consecutive-week period immediately preceding the Employee's resumption of services with the Plan Sponsor (unless the Plan Sponsor is an educational organization, in which case it is the 26-consecutive-week period immediately preceding the Employee's resumption of services with the Plan Sponsor); or

(b) Rule of Parity. The period of time during which the Employee did not work at least one hour of service is less than twenty-six (26) weeks, but is at least four (4) weeks long and is longer than the Employee's period of employment immediately preceding that period with no credited hours of service. (Example: If an Employee works for three weeks for the Plan Sponsor, terminates employment, and is later rehired by the Plan Sponsor ten weeks after terminating employment, the rehired Employee will be treated as a New Employee because the ten-week period with no credited hours of service is longer than the immediately preceding three-week period of employment.)

If neither Subsection (a) nor Subsection (b) is satisfied, the rehired Employee will be treated as a continuing Employee upon resuming active employment. For an Employee who is treated as a continuing Employee, the measurement and stability period that would have applied to the Employee had he/she not experienced the period of no credited hours of service would continue to apply upon the Employee's resumption of service. (*Example*: If a continuing Employee returns during a Stability Period in which he/she is treated as being eligible to participate in the Plan because he/she had averaged at least 30 hours of service during a prior Standard Measurement Period, then the Employee will be treated as eligible to participate in the Plan upon resuming active employment and will remain in that status through the end of

that Stability Period.) In such circumstances, the Employee must be offered coverage as of the first day that he/she is credited with an hour of service, or, if later, as soon as administratively practicable.

Section 6.03 Applicability of Addendum to Plan Years in Which Plan Sponsor is Not an Applicable Large Employer. The eligibility provision in this Addendum shall apply: *(Choose (a) or (b))*

[X] (a) **Only during a Plan Year in which the Plan Sponsor is deemed to be an "applicable large employer" within the meaning of PPACA.**

[ ] (b) **During all Plan Years.**

Section 6.04 Benefits/Coverage Governed by this Addendum. The eligibility provisions in this Addendum shall govern the following benefits/coverage provided by the Plan Sponsor: *(Choose (a) or one or more of (b) through (e))*:

[ ] (a) **All benefits.**

[X] (b) **Medical Benefits (including Prescription Drug Benefits, if applicable).**

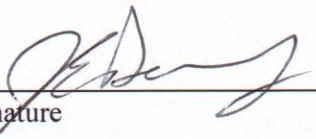
[ ] (c) **Stand-Alone Dental Benefits.**

[ ] (d) **All non-HIPAA-Excepted Benefits.**

[ ] (e) **Other.** _____

Note: *To the extent that Dental Benefits are included as part of the standard Medical Benefits (i.e., the Dental Benefits are not provided as part of a stand-alone coverage), the Dental Benefits will be subject to the eligibility provisions in this Addendum to the same extent as the Medical Benefits.*

Section 6.05 Addendum Supersedes Contrary Provisions in Adoption Agreement or Core Document. To the extent the provisions of this Addendum are inconsistent with the terms and conditions set forth in the Core Document or the Plan Sponsor's Adoption Agreement, the terms of this Addendum shall control.



Signature

Chairman

Title

April 26, 2016

Date

BENEFIT MANAGEMENT, LLC
CORE DOCUMENT

BENEFIT MANAGEMENT, LLC

CORE DOCUMENT

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BENEFIT MANAGEMENT, LLC

CORE DOCUMENT

This Benefit Management, LLC Core Document (hereinafter, the "Core Document"), together with the Adoption Agreement and the Benefit Description, constitute the "Plan." Plan Sponsor establishes and maintains this self-insured Plan for the benefit of its Eligible Individuals by executing the Adoption Agreement and incorporating the Benefit Description by reference into this Core Document.

ARTICLE I
INTRODUCTION

Section 1.01 Name of Plan. The full name of this Plan is stated on the accompanying Adoption Agreement. It shall be referred to as the "Plan" in this Core Document, the Adoption Agreement, and the Benefit Description.

Section 1.02 Purpose of Plan. The purpose of this Plan is to provide Eligible Individuals of Plan Sponsor (and its affiliated entities, if applicable) with the type or types of benefits elected by Plan Sponsor in the Adoption Agreement.

Section 1.03 Health Plan Status. Plan Sponsor intends that the Plan qualify as a health plan within the meaning of Code § 105(e) and Treasury Reg. § 1.105-5(a). Plan Sponsor further intends that the benefits payable under the Plan be eligible for exclusion from gross income under Code § 105(b).

Section 1.04 Plan Operation. The Plan shall continue without interruption, subject to the right of the Plan Sponsor to amend or terminate the Plan, as set forth in Article XI.

Section 1.05 Funding Policy and Method. The benefits under the Plan are funded by Plan Sponsor. The cost of providing these benefits is paid through contributions by Plan Sponsor and/or Covered Persons. Plan Sponsor, in its sole discretion, may purchase one or more policies of insurance to offset some portion of the cost of funding benefits under the Plan.

Section 1.06 Character of Benefits Provided. The Plan does not provide treatment or advice for the type or types of benefits elected in the Adoption Agreement. It merely pays for the cost of the selected benefits as described in and in accordance with the corresponding provisions of the Benefit Description. The fact that a particular treatment or benefit may not be eligible for reimbursement under the Plan does not mean that a Covered Person under the Plan should not receive that treatment or benefit.

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ARTICLE II
DEFINITIONS

In addition to the following definitions, this Core Document incorporates by reference the definitions found in the Benefit Description.

Section 2.01 **"Adoption Agreement"** means the document executed by Plan Sponsor in adopting the Plan. Plan Sponsor's Adoption Agreement, this Core Document, and the Benefit Description together constitute the Plan. Each elective provision of the Adoption Agreement corresponds (by its parenthetical section reference) to a provision in this Core Document.

Section 2.02 **"Allowed Amount"** means the amount that the Plan determines to be the maximum amount payable for a service or supply provided. For services provided by Network Providers, the Allowed Amount is a negotiated amount that the Network Providers have agreed to accept as payment in full for services received by a Covered Person. For services received from providers who are not participating in the network, the Plan will either limit the amount it allows for Covered Charges to the lesser of (i) the provider's billed charge or (ii) an amount equal to 120% of the current Medicare allowable fee for the appropriate area, as such information is made publicly available. The Plan Administrator may, in its discretion, elect to issue an additional payment, in an amount not to exceed 150% of current Medicare allowable fees for the appropriate area, as such information is made publicly available, if doing so is found to be in the best interest of the Covered Person. If there is no corresponding Medicare reimbursement rate for a charge from a non-network provider, the Allowed Amount will be an amount which is Usual and Customary, and Reasonable and Appropriate. The Covered Person is responsible for payment of deductibles, copayment/coinsurance amounts and non-covered services.

Section 2.03 **"Alternate Recipient"** means any Child of a Participant who is recognized under a Qualified Medical Child Support Order as having a right of enrollment under this Plan.

Section 2.04 **"Benefit Description"** means the document setting forth (1) the benefits to which a Covered Person is entitled, (2) to whom benefits are payable, (3) limits on and exclusions of benefits, and (4) the requirements for having benefits paid. If Plan Sponsor has elected in the Adoption Agreement to provide more than one type of benefit, each type of benefit will be described in the Benefit Description. The Benefit Description, this Core Document, and the Adoption Agreement together constitute the Plan.

Section 2.05 **"Benefit Year"** means the period of time, as elected by Plan Sponsor in the Adoption Agreement, on which Claims will be paid under the Plan. The Benefit Year may be, but is not necessarily, the same period of time as the Plan Year.

Section 2.06 **"Calendar Year"** means the period of twelve (12) consecutive months beginning on January 1 and ending on December 31.

Section 2.07 **"Child" or "Children"** means the Participant's natural child, lawfully adopted child (including a child placed with the Participant for adoption but for whom the adoption is not yet final), stepchild, or other child for whom the Participant has obtained legal guardianship pursuant to a court order, prior to such Child attaining age 26 . In addition, "Child" or "Children" also includes a Spouse's lawfully adopted child (prior to the Child attaining age 26) or other child for whom the Spouse has obtained legal guardianship. If elected in the Adoption Agreement, this definition of "Child" or "Children" shall also include a child who is older than age 26 and who is disabled.

Section 2.08 **"Claim"** means any formal request for a Plan benefit or benefits made by a Claimant or his/her representative in accordance with the Plan's procedures for filing benefit claims as set forth in Article VI of this Core Document. A Claim includes Urgent Care Claims, Pre-Service Claims and Post-Service Claims (See the definitions of Urgent Care Claims, Pre-Service Claims and Post-Service Claims in Article VI). A claim does not include a request for a determination of an individual's eligibility to participate in the Plan, nor does it include a casual inquiry regarding the scope of the Plan's coverage. A communication regarding benefits that is not made in accordance with the Plan's claims procedures will not be treated as a Claim.

Section 2.09 **"Claimant"** means a Covered Person who files a Claim for benefits pursuant to Article VI of this Core Document.

Section 2.10 **"Claims Administrator"** means Benefit Management, LLC

Section 2.11 **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Section 2.12 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.13 **"Coinsurance"** means the percentage of the allowed charge (which takes into consideration the Allowed Amount for the services provided) for which payment is made after any applicable deductible and/or copayment amount has been satisfied.

Section 2.14 **"Copayment" or "Copay"** means the amount of money that is paid each time a particular service is used. Some services will require copayments while others will not.

Section 2.15 **"Core Document"** means this document and any attached Appendices. Plan Sponsor's Adoption Agreement, this Core Document, and the Benefit Description together constitute the Plan.

Section 2.16 **"Covered Charge"** means those Medically Necessary services or supplies that are covered under this Plan.

Section 2.17 **"Covered Person"** means an Eligible Individual and his/her Dependents who satisfy the eligibility conditions of Article III and has entered the Plan.

Section 2.18 **"Dependent"** has the meaning set forth in the Adoption Agreement. Dependent does not include any person who is a member of the armed forces of any country or who is not a permanent resident of the United States. Notwithstanding anything herein to the contrary, Children placed with a Participant for adoption and Children who are the subject of a Qualified Medical Child Support Order will be considered Dependents in accordance with the provisions of Section 4.16. The Plan Administrator reserves the right to require whatever documentation may be necessary in order to establish, to the satisfaction of the Plan Administrator, an individual's status as a Dependent.

Section 2.19 **"Domestic Partner"** has the meaning set forth in the Adoption Agreement. A Domestic Partner shall not be included in the definition of "Dependent" (and therefore is not eligible for coverage) unless Plan Sponsor elects in its Adoption Agreement to include Domestic Partners as Covered Persons under this Plan. The Plan Administrator reserves the right to require whatever documentation may be necessary in order to establish, to the satisfaction of the Plan Administrator, an individual's status as a Domestic Partner.

Section 2.20 **"Effective Date"** means the date specified in the Adoption Agreement, unless otherwise provided for a specified purpose in this Plan, including in any Participation Agreement or addenda.

Section 2.21 **"Eligible Individual"** means an Employee of the Plan Sponsor who has satisfied the eligibility conditions set forth in Article III of this Core Document and the applicable provisions of the Adoption Agreement. An Eligible Individual also includes any person who is considered to be self-employed with respect to the Plan Sponsor (such as a partner in a partnership). An Eligible Individual may further include any person who is within a class of individuals that is elected by Plan Sponsor in the Adoption Agreement, provided that the eligibility conditions set forth in Article III are otherwise satisfied.

Section 2.22 **"Employee"** means an individual employed by the Employer as a common law employee.

Section 2.23 **"Employer"** means the Plan Sponsor as well as any Participating Plan Sponsor that has executed a valid Participation Agreement to the Adoption Agreement.

Section 2.24 **"Enrollment Date"** means the date on which coverage begins or, if there is a Waiting Period, the first day of the Waiting Period.

Section 2.25 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended, and includes applicable Department of Labor regulations.

Section 2.26 **"Family Coverage"** means coverage for the Participant and any Dependents.

Section 2.27 **"FMLA"** means the Family and Medical Leave Act of 1993, as amended from time to time.

Section 2.28 **"Group Health Plan"** means, for purposes of HIPAA, COBRA, and FMLA, this Core Document and the Adoption Agreement together with the Benefit Description that provides health care to Covered Persons.

Section 2.29 **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.30 **"Medically Necessary"** care and treatment is recommended or approved by a Physician (or Dentist, with regard to dental care); is consistent with the patient's condition or accepted standards of good medical (and dental practice); is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical (and dental) services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Section 2.31 **"Medicare"** means the programs known as Health Insurance for the Aged under Title XVIII of Federal Social Security Act of 1965, as amended.

Section 2.32 **"Network Provider"** means a Provider that has a written agreement with the health care network in which the Plan participates to provide services to Participants in the Plan and to accept discounted payments for services, usually with no additional billing to the Participant other than any applicable Coinsurance, Copayment, and/or deductible. A Plan may have multiple Network Providers.

Section 2.33 **"Open Enrollment Period"** means a period during which Eligible Individuals may enroll in the Plan. An Open Enrollment Period will occur at least once every consecutive 12 months. The specific timeframe of the Open Enrollment Period is set forth in the Adoption Agreement.

Section 2.34 **"Orientation Period"** means the period of time that starts on the date that the Eligible Individual most recently commenced service with Plan Sponsor and that is used to conduct standard orientation and training processes and to evaluate whether the employment situation is satisfactory for each party. The Orientation Period, if any, is elected by Plan Sponsor in the Adoption Agreement.

Section 2.35 **"Participant"** means an individual (a) who is either employed by Plan Sponsor or falls within a class of individuals eligible for coverage under the Plan by virtue of Plan Sponsor's election in the Adoption Agreement, (b) who has entered the Plan pursuant to the Plan's eligibility provisions, and (c) whose participation in the Plan has not been terminated pursuant to the termination provisions in the Plan.

Section 2.36 **"Plan"** means, collectively, all of the following documents and the elections, rights and benefits provided within:

(a) The Benefit Description and any Appendices attached thereto;

(b) This Core Document and any Appendices; and

(c) The Adoption Agreement.

Notwithstanding the above, "Plan," as used in the coordination of benefits provisions of the Benefit Description, shall have the meaning given in those provisions.

Section 2.37 **"Plan Administrator"** means Plan Sponsor. Plan Sponsor may designate from time to time one or more individuals or other persons to carry out various administrative and other duties with respect to the Plan in a manner consistent with the terms of the Plan and, if applicable, ERISA.

Section 2.38 **"Plan Sponsor"** means the entity that has established and adopted the Plan as stated in the Adoption Agreement. The Plan Sponsor, for purposes of acting as Plan Administrator, making Plan amendments, terminating the Plan, and/or performing other settlor functions, refers to the signatory entity that established and adopted the Plan in the Adoption Agreement; it does not include any Participating Plan Sponsors. However, for all other purposes, including for purposes of ERISA and the Code, the Plan Sponsor and all Participating Plan Sponsors are each considered to be co-sponsors of the Plan.

Section 2.39 **"Plan Year"** means the period Plan Sponsor specifies in the Adoption Agreement.

Section 2.40 **"Reasonable and Appropriate"** means an amount of Covered Charges that is identified as eligible for payment by the Plan Administrator in accordance with the terms of the Plan. These amounts may be determined and established by the Plan, at the Plan Administrator's discretion, using normative data such as, but not limited to, the fee(s) which the provider most frequently charges the majority of patients for the service or supply, amounts the provider most often agrees to accept as payment in full either through direct negotiation or through a preferred provider organization network, average wholesale price,

and/or manufacturer's retail pricing, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, rates negotiated with the Plan, and/or Medicare reimbursement rates. Medicare rates plus 20% are generally considered to be the Reasonable and Appropriate (and thus maximum payable amount, however, the Plan Administrator may in its discretion, taking into consideration specific circumstances and negotiated terms, deem a greater amount to be payable, up to 150% of Medicare rates. For purposes of defining "Reasonable and Appropriate," the terms(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, person or organizations rendering such treatment, services, or supplies for which a specific charge is made.

Reasonable and Appropriate claims shall be limited to those claims that, in the Plan Administrator's discretion, are services or supplies or fees for services or supplies that are necessary for the care and treatment of Illness or Injury not unreasonably caused by the treating provider. The determination whether fee(s) or services are Reasonable and Appropriate will be made by the Plan Administrator, taking into consideration such factors as,, but not limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) the Food and Drug Administration. To be Reasonable and Appropriate, services(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable and Appropriate. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable and Appropriate based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Appropriate.

Section 2.41 **"Retiree"** means an individual who, in the event Plan Sponsor has elected to provide coverage to Retirees under this Plan, satisfies the conditions required to be considered a Retiree, as specified by Plan Sponsor in the Adoption Agreement.

Section 2.42 **"Single Coverage"** means coverage for the Participant only.

Section 2.43 **"Special Enrollee"** means an individual who applies for coverage outside the Open Enrollment Period and who satisfies the conditions in (a), (b), (c), (d), or (e) below:

(a) The individual acquires a Dependent through birth, adoption, or placement for adoption; or

(b) The individual acquires a Spouse; or

(c) The individual meets each of the following three conditions:

(1) The individual was covered under another "group health plan" or health insurance policy that provided hospital, medical, or surgical expense benefits (as defined under ERISA § 733(a)(1)) at the time he/she was eligible to enroll; and

(2) The individual stated at the time of the Open Enrollment Period that the reason he/she declined coverage under this Plan was because he/she had coverage under another group health plan or health insurance policy that provided hospital, medical, or surgical expense benefits. The Plan may require that this explanation of declination be in writing, but only if the individual was first provided notice of this requirement and the consequences of failing to provide it; and

(3) The individual has lost coverage under another health insurance policy or "group health plan" (including Tricare) that provides hospital, medical or surgical expenses benefits (as defined under ERISA § 733(a)(1)) as a result of a termination of employment, reduction in the number of hours of employment, termination of employer contributions toward such coverage, death of a spouse, divorce, legal separation, end of active military service, or exhaustion of COBRA continuation coverage;

(i) A loss of coverage based on the failure to pay required premiums under the alternative coverage is not a valid basis for creating special enrollment rights in this Plan; and

(ii) An individual who has been receiving coverage pursuant to Tricare will be entitled to special enrollment rights under this Plan only upon the loss of his/her Tricare coverage. Special enrollment rights are not automatically triggered merely by virtue of the end of active military service; or

(d) The individual becomes eligible for a state premium assistance subsidy under a group health plan of the Plan Sponsor from either Medicaid or a state's children's health insurance program (SCHIP); or

(e) The individual loses eligibility for coverage under Medicaid or SCHIP.

In addition, enrollment must be requested within the timeframe specified in the Adoption Agreement. In no case will the period be shorter than 30 days for the event described in (a), (b) or (c) above, nor will the period be shorter than 60 days for the events described in (d) and (e) above.

Additionally, a Spouse or minor Child will be treated as a Special Enrollee if a court of competent jurisdiction has ordered coverage to be provided for the Spouse or minor Child and the Spouse and/or minor Child are otherwise eligible to be covered as Dependents of an Eligible Individual.

Section 2.44 **"Spouse"** means a person of the same or opposite sex to whom the Participant is legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which the couple currently resides. A person will not be considered a Spouse for purposes of this Plan if (i) his/her marriage to the Participant has been terminated by a court having jurisdiction over one or both parties to the marriage, (ii) he/she is legally separated from the Participant, or (iii) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

A common law marriage to a person of the opposite sex shall be considered to be a legal marriage if the common law marriage was entered into in a state that recognizes common law marriage and if the common law marriage is recognized as valid under the laws of that state. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of legal marriage (including, as may be applicable, the existence of a common law marriage).

Section 2.45 **"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Section 2.46 **"Usual and Customary" ("U&C")** means an amount of Covered Charges that is identified as eligible for payment 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. For purposes of defining "Usual and Customary," 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" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred. The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale. The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted), nor does it necessarily refer to the specific service or supply furnished to a Covered Person 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 using normative data such as, but not limited to, Medicare cost-to-charge ratios, average wholesale price for prescriptions. and/or manufacturer's retail pricing for supplies and devices.

Section 2.47 **"Utilization Review Organization"** means a team of medical personnel, under contract with the Plan Administrator or, if so provided by contract, the Claims Administrator, whose function is to evaluate the medical necessity for Hospital confinement or other medical services. The evaluation is made solely for purposes of the payment of benefits in accordance with this Plan.

Section 2.48 **"Waiting Period"** means the period of time starting on the date that the Eligible Individual most recently commenced service with Plan Sponsor (or, if later, the date that the Eligible Individual completed his/her Orientation Period), and ending on the date that the individual is eligible for coverage under the Plan. The Waiting Period, if any, is elected by Plan Sponsor in the Adoption Agreement.

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ARTICLE III
ELIGIBILITY

Section 3.01 Open Enrollment. Eligible Individuals who wish to enroll in the Plan or make changes to their Plan coverage must submit completed applications to the Plan Administrator during the Open Enrollment Period, unless some special enrollment right exists or, in the case of eligible Dependents, the Plan Sponsor has elected an additional enrollment opportunity in the Adoption Agreement.

Section 3.02 Eligibility to Participate. An Eligible Individual shall become a Covered Person in the Plan after completing the required enrollment application and satisfying any applicable Waiting Period. The specific effective date of the Eligible Individual's coverage (and the coverage of any Dependents of such Eligible Individual) shall be the date elected by Plan Sponsor in Article III of the Adoption Agreement.

Section 3.03 Requirement of Documentation. Plan Sponsor reserves the right to require whatever documentation is necessary to determine, to the satisfaction of Plan Sponsor, an individual's status as a Dependent.

Section 3.04 Eligible Individual/Dependent. If a husband and wife are both eligible for coverage under the Plan by virtue of being employed by Plan Sponsor, they may elect one of the following options:

(a) Husband and wife may each enroll in Single Coverage;

(b) Either husband or wife may be enrolled in Family Coverage and cover the other Spouse and any additional Dependents; or

(c) Either husband or wife may enroll in Single Coverage with the other Spouse enrolled in Family Coverage covering additional Dependents.

An Eligible Individual may elect to be covered only as a Participant or a Dependent, but not both simultaneously. Under no circumstances will any Dependent be covered as a Dependent of more than one Participant.

Section 3.05 Eligible Retiree. If Plan Sponsor has elected to cover Retirees under the Plan, the eligibility conditions for a Retiree are as set forth in the Adoption Agreement. Individuals receiving COBRA continuation coverage shall not be eligible for Retiree coverage under this Plan. An individual whose coverage as a Retiree under this Plan is subsequently terminated for any reason shall thereafter not be eligible again for coverage as a Retiree under this Plan.

Section 3.06 Special Rule for Persons Who Are Eligible Individuals as of the Plan's Effective Date. If coverage has not been provided to Eligible Individuals prior to adoption of the Plan, the Plan Sponsor shall elect in the Adoption Agreement whether individuals who meet the definition of an Eligible Individual on the Effective Date will be immediately eligible to participate in this Plan (along with their Dependents, if applicable) as of the Effective Date, without regard to whether such Eligible Individuals have completed the requisite Waiting Period.

Section 3.07 Special Rule for Changing from Part-Time to Full-Time Employment. If elected in the Adoption Agreement, each individual employed by Plan Sponsor who was not an Eligible Individual due to his or her status as a part-time worker (*see* definition of Eligible Individual), but who changes to full-time employment, having already completed the Waiting Period while working part-time with Plan Sponsor, shall become a Participant in the Plan without completing the Waiting Period as a full-time worker. In addition, if enrolled, such individual's Dependents shall become Covered Persons without completing the Waiting Period. For example, if Eligible Individuals are permitted to enter the Plan on the first day of the month following a thirty (30) day Waiting Period, an individual changing from part-time to full-time on February 22nd, would become a Participant on March 1st. Likewise, his/her Dependents, if also enrolled, would become Covered Persons on March 1st as well.

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ARTICLE IV
COVERAGE UNDER THE PLAN

Section 4.01 Medical Benefits. The medical benefits under the Plan shall be identical to those described in, and shall be paid pursuant to the terms of, the Benefit Description. The provisions of the Benefit Description, as it may be amended from time to time, are incorporated herein by reference, and the rights and conditions with respect to the benefits payable under the Plan shall be determined from the Benefit Description; provided, however, that in the event of an inconsistency between the Benefit Description and the Core Document, the Benefit Description will control.

Section 4.02 Prescription Drug Benefits. If Plan Sponsor has elected in the Adoption Agreement to provide prescription drug benefits in addition to major medical benefits, the prescription drug benefits under the Plan shall be identical to those described in, and shall be paid pursuant to the terms of, the Benefit Description. The provisions of the Benefit Description, as it may be amended from time to time, are incorporated herein by reference, and the rights and conditions with respect to the prescription drug benefits payable under the Plan shall be determined from the Benefit Description; provided, however, that in the event of an inconsistency between the Benefit Description and the Core Document, the Benefit Description will control.

Section 4.03 Dental Benefits. If Plan Sponsor has elected in the Adoption Agreement to provide dental benefits in addition to major medical benefits, the dental benefits under the Plan shall be identical to those described in, and shall be paid pursuant to the terms of, the Benefit Description. The provisions of the Benefit Description, as it may be amended from time to time, are incorporated herein by reference, and the rights and conditions with respect to the dental benefits payable under the Plan shall be determined from the Benefit Description; provided, however, that in the event of an inconsistency between the Benefit Description and the Core Document, the Benefit Description will control.

Section 4.04 Election to Participate. If an Eligible Individual wishes to participate in this Plan, he/she must complete the benefit election form provided by the Plan Administrator and make any necessary arrangements to pay his/her share of the premiums. An Eligible Individual cannot become a Covered Person in the Plan unless he/she timely returns a properly completed benefit election form to the Plan Administrator.

Section 4.05 Cost of Coverage. The Participant's monthly premiums are determined by Plan Sponsor. Plan Sponsor may change the premiums from time to time. Plan Sponsor will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section 4.06 Effective Date of Coverage for Eligible Individuals (Other than Retirees). An Eligible Individual's coverage under the Plan shall take effect as elected by Plan Sponsor in Article III of the Adoption Agreement.

Section 4.07 Effective Date of Coverage for Retirees. If Plan Sponsor has elected to cover Retirees under the Plan, an individual who meets the Plan's eligibility conditions for Retirees and who timely submits to the Plan Administrator a properly completed application for Retiree coverage shall begin coverage as a Retiree on the first day of the month coincident with or next following the date on which the individual terminated employment with the Employer at a time that he/she satisfied the Plan's conditions for Retiree coverage. The deadline for submitting an application for Retiree coverage shall be the same deadline that is applicable to all other new enrollees (other than Special Enrollees) in the Plan, as elected by Plan Sponsor in the Adoption Agreement. An individual who fails to submit a timely application for Retiree coverage shall thereafter be prohibited from enrolling in the Plan as a Retiree.

Section 4.08 Coverage for Dependents of Retirees. The Dependents of a Retiree who is eligible to, and does, continue his/her coverage under the Plan shall be eligible to continue their participation in the Plan if, and only if, they were covered under the Plan at the time of the Retiree's termination of employment with Plan Sponsor.

Section 4.09 Coverage for Newborn and Adopted Children. If a Participant acquires a new Dependent as a result of birth, adoption, or appointment of legal guardianship, and wishes to cover him/her under the Plan, Participant must enroll the newly acquired Dependent as a Special Enrollee within the time period set forth in Article II of the Adoption Agreement, which in no case will be less than thirty (30) days from the date of birth, adoption or placement for adoption. The Plan, however, may allow a longer period of time if elected by Plan Sponsor in the Adoption Agreement. In no case will coverage for a new Dependent be automatically provided (e.g., even if the Participant already has family coverage).

If a Participant has a form of coverage that does not cover the new Dependent Child at the time of the birth, adoption, or appointment of legal guardianship, no additional premium will be charged for the month in which the birth, adoption, or appointment of legal guardianship takes place unless the birth, adoption, or appointment of legal guardianship occurs on the first day of the month. If the birth, adoption, or appointment of legal guardianship takes place on a day other than the first day of month, no premium charges will take effect until the 1st day of the following month.

A Dependent who is eligible to be enrolled during the time period described above, but who is not enrolled within such time period, will not be permitted to enroll until the next Open Enrollment Period. A claim submitted for a Dependent described in this Section 4.09 does not constitute notification of a request for enrollment.

Section 4.10 Effective Date of Coverage for Newborn and Adopted Children. If a newborn or newly acquired Child (via adoption or appointment of legal guardianship) is properly enrolled in accordance with Section 4.09, coverage will begin on:

(a) The date of birth for the natural or adopted newborn Child; or

(b) In the case of a child other than a newborn, the date the child is placed in the Participant's home for adoption, or the date a court awards legal guardianship to the Participant and/or his/her Spouse.

Section 4.11 Coverage for Dependent who is a Newly Acquired Spouse. If Participant acquires a new Dependent through marriage, the new spouse may enroll in this Plan as a Special Enrollee within the time period set forth in Article II of the Adoption Agreement, which in no case will be less than thirty (30) days from the date of marriage. The Plan, however, may allow a longer period of time if elected by Plan Sponsor in the Adoption Agreement. In no case will coverage for a newly acquired Spouse be automatically provided (e.g., even if the Participant already has family coverage). No additional premiums will be charged for the month in which the marriage occurs unless the marriage takes place on the first day of the month. If the marriage takes place on a day other than the first day of month, no premium charges will take effect until the 1st day of the following month.

Section 4.12 Effective Date of Coverage for Dependent who is a Newly Acquired Spouse. If Participant acquires a new Dependent through marriage, coverage shall be effective as elected by Plan Sponsor in Article III of the Adoption Agreement.

Section 4.13 Loss of Other Coverage and the Right to Enroll. If an Eligible Individual or Dependent has elected not to participate in the Plan because he/she was covered under another group health plan or health insurance policy that provided hospital, medical, or surgical expense benefits (as defined under ERISA § 733(a)(1) at the time he/she was eligible to enroll), the Eligible Individual and/or Dependent may enroll in this Plan outside the Open Enrollment Period if he/she satisfies the requirements of a Special Enrollee in Section 2.41(c) of this Core Document.

The right to this special enrollment must be exercised within thirty (30) days from the date that the alternative coverage terminates unless a longer time period has been elected by Plan Sponsor for Special Enrollees in the Adoption Agreement. The coverage for an individual who enrolls pursuant to this Section will commence on the date elected by Plan Sponsor in the Adoption Agreement.

Section 4.14 Premium Assistance from Medicaid or SCHIP / Loss of Medicaid or SCHIP Coverage. If an Eligible Individual or Dependent becomes eligible for a state premium assistance subsidy under the Plan from either Medicaid or a state's children's health insurance program (SCHIP) or loses eligibility for coverage under Medicaid or SCHIP, the Eligible Individual and/or Dependent may enroll in the Plan as a Special Enrollee if the Eligible Individual and/or Dependent is otherwise eligible to be covered under the Plan. Coverage elected pursuant to this Section will commence on the date elected by Plan Sponsor in the Adoption Agreement.

Section 4.15 HIPAA Special Enrollment and the "Tag-Along Rule." If an Employee (or a member of a specific class of individuals elected by Plan Sponsor in the Adoption Agreement to be eligible to enroll in this Plan) enrolls in this Plan, all other Dependents of the Employee (or applicable class member) who are eligible but not enrolled in the Plan may enroll pursuant to this Article IV, provided that Plan Sponsor has elected to allow coverage for Dependents of such individuals in the Adoption Agreement.

Section 4.16 Coverage for Children Subject to QMCSO. Children who are the subject of a Qualified Medical Child Support Order ("QMCSO") as defined by Section 609 of ERISA shall become "alternate recipients" of medical benefits under the Plan in accordance with Section 609 of ERISA. (For purposes of the Plan, a properly completed National Medical Support Notice ("NMSN") will be deemed to be a QMCSO.) Plan Sponsor shall establish reasonable procedures to determine the qualified status of a medical child support order. Upon receiving a medical child support order, Plan Sponsor shall promptly notify in writing all involved parties of its receipt and shall inform such parties of the Plan's procedures for determining if the order is a QMCSO. Within a reasonable period of time, Plan Sponsor shall determine the qualified status of the order and notify all parties of the decision. Notwithstanding anything to the contrary in the Plan, the Plan shall provide coverage for "alternate recipients" in accordance with the terms of the relevant QMCSO and/or NMSN and the requirements of ERISA and any applicable federal regulations.

Section 4.17 Continuation Coverage During Family and Medical Leave.

(a) *General Rule.* Notwithstanding any provision to the contrary in the Plan, if a Participant goes on a qualifying unpaid leave under the FMLA, Plan Sponsor will, to the extent required by the FMLA, continue to maintain Participant's benefits under the Plan on the same terms and conditions as if Participant were still actively employed by Plan Sponsor (e.g., Plan Sponsor will continue to pay its share of the premium to the extent Participant opts to continue his/her coverage).

(b) *Options for Payment of Participant's Share of the Premium.* If a Participant opts to continue coverage, he/she may pay his/her share of the premium in one or more of the following ways:

(1) Participant may pay his/her share of the premiums with after-tax dollars while on leave.

(2) If elected by Plan Sponsor in the Adoption Agreement, the Participant has the option to pay all or a portion of his/her share of the premium for the expected duration of his/her leave prior to his/her leave.

(3) If elected by Plan Sponsor in the Adoption Agreement, the Participant has the option to pay all or a portion of his/her share of the premium upon the termination of his/her leave.

(4) If elected by Plan Sponsor in the Adoption Agreement, the Participant may pay his/her share of the premium pursuant to such other arrangement as may be agreed upon between the Participant and the Plan Administrator.

(c) *Return from FMLA Leave.* If a Participant's coverage ceases while he/she is on FMLA leave, he/she will be permitted to reenter the Plan immediately upon his/her return from FMLA leave on the same basis that he/she was participating in the Plan prior to the FMLA leave, or as otherwise required by the FMLA.

(d) *Failure to Return from FMLA Leave.* If a Participant fails to return from FMLA leave, coverage will end upon the earliest of the following events:

(1) The last day of the month during which the Plan Administrator receives notice from the Participant that he/she does not intend to return to work in a capacity in which he/she would be an Eligible Individual; or

(2) The end of the period for which the Participant last paid his/her required premium (if any) by the applicable deadline, if the premium for the subsequent period is not paid by the applicable deadline; or

(3) The last day of the calendar month in which FMLA ends and the Participant does not return to work in a capacity in which he/she is an Eligible Individual under the Plan.

(e) *FMLA and Other Leaves.* FMLA leave runs concurrently with any other type of leave (including, but not limited to, short-term disability leave) for which a Participant may be eligible.

Section 4.18 USERRA Continuation Rights. A Participant who is absent from employment as a result of qualified military service shall have the right to elect continuation coverage under the Plan pursuant to USERRA.

(a) *Maximum Period of Coverage.* The maximum period of USERRA continuation coverage for a Participant (and his/her Dependents) under a USERRA election is the lesser of:

(1) The twenty-four (24) month period beginning on the date on which the Participant's qualified military leave commences; or

(2) The day after the date on which the Participant was required by USERRA to apply for reemployment with Plan Sponsor.

(b) *Premiums*. A Participant who elects to continue coverage under USERRA may be required to pay up to 102% of the applicable premium under the Plan; provided, however, a Participant on active duty for 30 days or less shall not be required to pay more than the standard share of the premium applicable to Participants who are not on leave.

(c) *Exclusions or Waiting Periods Upon Reinstatement*. The Plan shall not impose any Pre-Existing Condition exclusion or Waiting Period upon a Participant or Dependent following his/her reinstatement of traditional coverage subsequent to the conclusion of qualified military service, unless such a Pre-Existing Condition exclusion or Waiting Period would have been imposed in the absence of the Participant's qualified military service. However, the Plan may impose a Pre-Existing Condition exclusion or Waiting Period for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the Participant's performance of qualified military service.

(d) *Reasonable Procedures*. The Claims Administrator shall have the authority to adopt such reasonable procedures as it may consider necessary or advisable in order to implement the provisions of this Section.

Section 4.19 Approved Leaves of Absence (Other than FMLA and USERRA). A Participant on an approved leave of absence (other than FMLA or USERRA) shall remain eligible for coverage under the Plan for such period of time as Plan Sponsor elects in the Adoption Agreement.

Section 4.20 Termination of Coverage. A Covered Person's coverage shall terminate on the earliest of:

(a) As elected by Plan Sponsor in the Adoption Agreement, either (i) at the end of the last day of the month coincident with or next following the date on which the Participant terminates employment with Plan Sponsor or (ii) at 12:01 a.m. following the date on which the Participant terminates employment with Plan Sponsor, unless the Plan's eligibility conditions, as elected by Plan Sponsor in the Adoption Agreement, permit participation of certain retired Participants and/or former Participants and the Participant meets the requirements for retired and/or former Participants. The coverage of a Dependent shall terminate simultaneously with the termination of coverage of the Participant through whom the Dependent was receiving coverage under the Plan;

(b) The end of a period for which a required contribution by Participant was last paid, taking into account any grace periods required by law;

(c) As elected in the Adoption Agreement, either the end of the last day of the month coincident with or next following the date on which such Covered Person ceases to satisfy the eligibility requirements of the Plan or at 12:01 a.m. immediately following such event, including ceasing to satisfy the Plan's definition of Participant or Dependent;

(d) In the event of Participant's death, the last day of the period for which payments have been made by or on behalf of Participant;

(e) Retroactively, upon written notice by the Plan, or immediately with no advance notice, if a Covered Person commits a fraud against the Plan or intentionally misrepresents a material fact in applying for or seeking any benefits under the Plan. Fraud includes permitting the use of a Covered Person's Plan identification card by any other person; or

(f) The date on which the Plan terminates.

Notwithstanding anything in this section to the contrary, an individual who would normally be required to terminate participation may continue to be covered under this Plan if and to the extent such individual elects continuation of benefits in accordance with the provisions of Article VIII.

The Plan will not refund any renewal premium payments received on behalf of a Covered Person(s) for coverage prior to the effective date of termination. In addition, the Participant or other Covered Person(s) will be responsible for reimbursement of any services covered by the Plan after the effective date of the termination of such Participants or Covered Person(s).

Section 4.21 Reinstatement of Former Participant. If a former Participant terminates employment, is later rehired, and becomes an Eligible Individual after being rehired, the Waiting Period may or may not be waived, depending on Plan Sponsor's election in the Adoption Agreement. If the Waiting Period is waived, the former Participant shall enter the Plan on the first day of the month coincident with or next following the date of his/her rehire. If the Waiting Period is not waived, the former Participant must again complete any applicable eligibility requirements in order to participate in this Plan. However, a former Participant who returns to employment with the Employer as an Eligible Individual after an approved, unpaid leave of absence may become a Participant in this Plan on the first day of the first month coincident with or next following such return.

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ARTICLE V
ADMINISTRATION OF THE PLAN

Section 5.01 Plan Administration. Plan Sponsor, as the Plan Administrator, is charged with supervision of the administration of the Plan. The Plan Administrator shall have the responsibility of ensuring that the Plan is carried out in accordance with its terms for the exclusive benefit of Covered Persons.

Section 5.02 Powers of the Plan Administrator. The Plan Administrator shall have such powers and duties as it considers necessary or appropriate to discharge its duties under the Plan. The powers of the Plan Administrator include, but are not limited to, the following:

(a) Establish rules and procedures for the purpose of administration of the Plan;

(b) Require Covered Persons to supply such information and sign such documents as may be necessary to administer the Plan;

(c) Interpret, construe and carry out the provisions of the Plan and render decisions on the administration of the Plan, including factual and legal determinations as to whether any individual is entitled to receive any benefit under the terms of the Plan; and

(d) Appoint such agents, attorneys, accountants, consultants, Claims Administrators and any other persons as may be needed for proper administration of the Plan.

In exercising these powers, the Plan Administrator shall act in its sole discretion, giving due regard for the reason and purpose for which the Plan is established and maintained. Any construction of the terms of the Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. The Plan Administrator shall have no power to waive, alter or fail to apply the terms of the Plan.

Section 5.03 Plan Must Be Nondiscriminatory. The Plan Administrator shall administer the Plan in a nondiscriminatory manner so that all similarly situated Covered Persons will receive substantially the same treatment.

Section 5.04 Claims Administration. Benefit Management, LLC ("BMI") will act as the Claims Administrator pursuant to an Administrative Services Agreement between Plan Sponsor and BMI. In this capacity, BMI is delegated all authority in connection with the Plan's internal claims appeal process, which thus authorizes BMI to make benefit determinations with respect to the administration and payment of benefit Claims in accordance with the terms of the Plan. BMI shall have the sole and exclusive discretionary authority to make decisions regarding final benefit determinations before External Review procedures are instituted, as further described in Article VI.

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ARTICLE VI
CLAIMS ADMINISTRATOR AND CLAIMS PROCEDURES

Section 6.01 Claims Administrator. The Claims Administrator of the Plan is Benefit Management, LLC

Section 6.02 Duties of Claims Administrator. The Claims Administrator shall have the discretionary power and authority to perform the following duties:

(a) Make determinations as to the eligibility of individuals to participate in this Plan and/or to be considered as a Dependent;

(b) Make determinations relating to individuals' coverage under the Plan, including termination and continuation of Participants' coverage;

(c) Receive Claims for benefits and render initial decisions respecting such Claims under this Plan;

(d) Compute the amounts payable for any Participant or other person in accordance with the provisions of this Plan, determine the manner and time of payment, and determine and authorize the person or persons to whom such payments will be paid;

(e) Whenever it may be necessary, investigate and determine the eligibility for coverage of an applicant where the existence of any fact, status, or circumstance is a condition of coverage;

(f) Make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of Claims under this Plan;

(g) Adopt such rules and procedures relating to the administration of Claims as it deems necessary or desirable;

(h) Be responsible for all Claims administration reporting and disclosure requirements for this Plan under the law;

(i) Receive from the Employer, Employees, Participants and other persons such information as shall be necessary for the proper administration of Claims under this Plan;

(j) Furnish to the Employer upon request, reports with respect to the administration of Claims under this Plan;

(k) Maintain all Claims administration records of this Plan; and

(l) Provide for and administer a mechanism for the Appeal of denied Claims in accordance with the provisions of this Plan.

PART I – GENERAL PROCEDURES FOR FILING CLAIMS

Section 6.03 Where to File Claims. Any Claim for benefits which arises under the Plan shall be filed with the electronic data interchange that has been assigned to the Plan. If filing with the electronic data interchange is not feasible, the Claim shall be filed with the Claims Administrator.

Section 6.04 Persons Who May File Claims. Claims may be filed by the Claimant or by the Claimant's duly authorized representative.

(a) Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.

(b) Notwithstanding the foregoing rule, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant with respect to Urgent Care Claims (as defined in Section 6.10).

(c) For purposes of these claims procedures, the deadlines applicable to a Claimant shall apply to his/her authorized representative in the event he/she elects to use an authorized representative in filing any Claim or Appeal.

Section 6.05 Important Definitions in Claims Procedures. The following definitions apply to the claims procedures set forth in this Article of the Plan:

(a) *Adverse Benefit Determination*. If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively on the basis of fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

(b) *Appeal*. A Claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." An Appeal will be recognized as valid only if it is submitted by a Claimant or his/her authorized representative in accordance with the Plan's procedures for filing an Appeal of an Adverse Benefit Determination.

(c) *External Review*. After receiving a Final Adverse Benefit Determination under the Plan's internal Appeal procedure, a Claimant has the right to request an External Review of his/her Claim pursuant to the Plan's External Review procedures, which are set forth in Part VII of this Article below.

(d) *Final Adverse Benefit Determination*. If a Claim is denied at the end of the internal Appeal process, the Plan's final decision is known as a "Final Adverse Benefit Determination."

(e) *Receipt/Received*. The Plan Administrator (or its designee) will be deemed to be in "Receipt" of (or to have "Received") a Claimant's Claim, Appeal, or other information submission only after the Claim, Appeal, or other information submission is received – through electronic means or otherwise – in the physical offices of the Plan Administrator (or its designee). A Claimant will be deemed to be in Receipt of a request for additional information or other notification from the Plan upon *the earlier of* (i) the date that the request/notification is communicated to him/her electronically, or (ii) five (5) days after the request/notification is mailed to his/her mailing address.

Section 6.06 Mandatory Exhaustion of Administrative Remedies. Prior to initiating legal action concerning a Claim in any court, state or Federal, against this Plan, any trust used in conjunction with this Plan, the Employer, the Claims Administrator, and/or the Plan Administrator, a Claimant must first exhaust the internal administrative remedies provided in this Article. Failure to exhaust the internal administrative remedies provided in this Article shall be a bar to any civil action concerning a Claim for benefits under this Plan.

Section 6.07 Litigation Following Exhaustion of Administrative Remedies. Once a Claimant has exhausted his/her administrative remedies as set forth in this Article, he/she may file a lawsuit challenging the denial of the Claim. Such lawsuit must be commenced, however, no later than 180 days after the Plan issues a Final Adverse Benefit Determination or, if External Review is sought by the Claimant, no later than 180 days after the Claim is denied in whole or in part on External Review.

Sections 6.08 Compliance with Federal Regulations Governing Claims Procedures. The claims procedures in this Article VI are intended to comply with all applicable federal regulations governing claims procedures for group health plans. The provisions in this Article shall be interpreted, therefore, to comply with all applicable federal regulations and guidance.

PART II – URGENT CARE CLAIMS

Section 6.09 Application of Part II. Sections 6.09 through 6.20 apply to Urgent Care Claims, as defined below.

Section 6.10 Definition of Urgent Care Claim. An Urgent Care Claim is a Claim for medical care or treatment in which:

(a) The Plan conditions the receipt of benefits, in whole or in part, on advance approval of the particular care or treatment; and

(b) Using the timetable for deciding non-Urgent Care determinations (e.g., Pre-Service Claims and Post-Service Claims):

(1) Could, in the judgment of a prudent layperson with average knowledge of health and medicine, seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or

(2) Would, in the opinion of a Physician with knowledge of the Claimant's medical condition, subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Section 6.11 How to File an Urgent Care Claim. An Urgent Care Claim must include the following information:

(a) The medical care or treatment for which approval is being sought;

(b) The name of the person, organization, or entity to which the expense is to be paid;

(c) The name of the Claimant for whom the approval is being sought and, if such person is not the Employee (or covered class member) requesting the benefit, the relationship of such Claimant to the Employee (or covered class member);

(d) An explanation of why the medical care or treatment in question should be considered to be urgent;

(e) The amount expected to be recovered under any insurance arrangement or other plan with respect to the expense;

(f) A statement that the expense (or portion thereof for which reimbursement is sought under this Plan) has not been reimbursed and is not reimbursable under the Plan; and

(g) Any other information relating to the medical care or treatment in question that the Claimant considers relevant and wishes the Claims Administrator to consider in reviewing the Claim.

An Urgent Care Claim may be filed in writing. If the circumstances make the filing of a written Claim impractical, however, an Urgent Care Claim may also be submitted to the Claims Administrator electronically, over the telephone, or in some other way that is similarly expeditious and that ensures that the Urgent Care Claim is Received by the Claims Administrator on a timely basis.

Section 6.12 Time Period for Filing an Urgent Care Claim. An Urgent Care Claim must be filed with the Claims Administrator as quickly as possible after the Claimant becomes aware of the existence of the Claim.

Section 6.13 Failure to Follow Proper Procedures in Filing an Urgent Care Claim. If the Claimant fails to follow the proper procedures in filing an Urgent Care Claim, the Claims Administrator shall notify the Claimant as quickly as possible. In no event, however, will the notification be made more than 24 hours after the time the failure took place.

Section 6.14 Failure to Submit Necessary Information. If the Claimant fails to submit information that is necessary to process an Urgent Care Claim, the Claims Administrator shall notify the Claimant of such failure no more than 24 hours after Receipt of the Urgent Care Claim and shall identify the specific information that is necessary to complete the Urgent Care Claim.

(a) Upon Receipt of such notification, the Claimant shall have 48 hours to provide the requested information to the Claims Administrator.

(b) During the period between the date the additional information is requested and the date it is Received by the Claims Administrator, the deadline for deciding the Urgent Care Claim, as set forth in Section 6.15, shall be suspended.

(c) Following Receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the Urgent Care Claim as soon as possible, but no later than 48 hours after Receipt of the additional information.

Section 6.15 Deadline for Deciding an Urgent Care Claim. Following the submission of an Urgent Care Claim that has been filed in accordance with the provisions of this Article, the Claims Administrator shall decide the Urgent Care Claim as quickly as possible, but no later than 72 hours after the Urgent Care Claim was Received.

Section 6.16 Notification Regarding Initial Benefit Determination on an Urgent Care Claim. The Claims Administrator shall notify the Claimant of the decision that has been made on the Urgent Care Claim. If the Urgent Claim was denied in whole or in part – which is considered an Adverse Benefit Determination – the notice provided to the Claimant shall be provided in a manner that is calculated to be understood by the Claimant. The notification regarding the approval or denial of an Urgent Care Claim may be provided orally if a written notification is provided within three days after the oral notification. (If the Plan is non-grandfathered, the written notice shall also be provided in a "culturally and linguistically appropriate" format, as required by Department of Labor Regulations.) In all events, the notice shall set forth the following:

(a) Information sufficient to identify the Claim (e.g., date of service, health care provider, Claim amount, diagnosis and treatment codes (and meaning of such codes));

(b) The specific reason(s) for denial of the Claim (including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim);

(c) A reference to the specific Plan provisions upon which the denial is based;

(d) A description of any additional material or information necessary for the Claimant to perfect the Claim, along with an explanation why such material or information is necessary;

(e) A description of the Plan's Claim review procedures and the time limits applicable to such procedures, including a statement of the expedited review process applicable to Urgent Care Claims. This description will include information on how to initiate an Appeal under the claim's procedures and the time limits applicable to such an Appeal. The description will also include a statement regarding the Claimant's right to bring a civil action under ERISA § 502(a) (if applicable) following a Final Adverse Benefit Determination;

(f) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to the Claimant free of charge upon request;

(g) If the Claim is denied on the basis that it is not Medically Necessary or that it is Experimental or Investigational treatment, or some similar exclusion or limit, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided to the Claimant free of charge upon request;

(h) A statement of the Claimant's right to present evidence and written testimony as part of the Appeal process;

(i) A statement of the Claimant's right to receive, free of charge, any new or additional evidence that was considered, relied upon, or generated by the Plan in connection with the Claimant's Urgent Care Claim and an opportunity to respond to such evidence;

(j) A description of the available internal Appeals and External Review procedures; and

(k) The availability of (and contact information for) any office of health insurance consumer assistance or ombudsman.

Section 6.17 Deadline for Filing an Appeal for an Urgent Care Claim. Although a Claimant is encouraged to file any Appeal of an Adverse Benefit Determination on an Urgent Care Claim as soon as possible, the Claimant shall have up to 180 days following his/her Receipt of the notice of Adverse Benefit Determination to file the Appeal. Any Appeal shall be filed with the Claims Administrator.

Section 6.18 Procedures for Appealing Adverse Benefit Determination of Urgent Care Claim. In any Appeal of an Adverse Benefit Determination on an Urgent Care Claim, the following procedures shall be observed:

(a) If requested by the Claimant, the Claims Administrator shall permit the Claimant to submit – where feasible – any information relevant to his/her Appeal either orally or in writing in order to expedite the processing and consideration of the Appeal. All necessary information shall be transmitted between the Claims Administrator and the Claimant by telephone, facsimile, electronic mail, or similar delivery method;

(b) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(c) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(e) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(f) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(g) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(h) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section 6.19 Deadline for Deciding Appeal of Denial of Urgent Care Claim. An Appeal of an Adverse Benefit Determination on an Urgent Care Claim shall be decided within 72 hours following the Claims Administrator's Receipt of the Claimant's request for the Appeal.

Section 6.20 Notification Regarding Decision on Appeal of Denial of Urgent Care Claim. The Claims Administrator shall notify the Claimant in writing of the decision made on his/her Appeal of an Adverse Benefit Determination of an Urgent Care Claim. If the Appeal is denied in whole in part – which would be considered a Final Adverse Benefit Determination – the written notice to the Claimant shall set forth the following:

(a) Information sufficient to identify the Claim (e.g., date of service, health care provider, Claim amount, diagnosis and treatment codes (and meaning of codes));

(b) The specific reason(s) for the Adverse Benefit Determination (including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim);

(c) A reference to the specific plan provisions upon which the determination is based;

(d) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. This description will include a statement of the Claimant's right to bring a civil action under ERISA § 502(a) (if applicable) following a Final Adverse Benefit Determination;

(e) A statement that the Claimant is entitled to review his/her Claim file and to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim. "Relevant" information includes any information that was considered, relied upon, or generated by the Plan in connection with the Claimant's Claim;

(f) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to the Claimant free of charge upon request;

(g) If the Claim is denied on the basis that it is not Medically Necessary or that it is Experimental or Investigational treatment, or some similar exclusion or limit, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided to the Claimant free of charge upon request;

(h) The following statement if the Employer is subject to ERISA: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.";

(i) The availability of (and contact information for) any office of health insurance consumer assistance or ombudsman.

PART III – PRE-SERVICE CLAIMS

Section 6.21 Application of Part III. Sections 6.21 through 6.32 apply to Pre-Service Claims, as defined below.

Section 6.22 Definition of Pre-Service Claim. A Pre-Service Claim is a Claim for which each of the following conditions is satisfied:

(a) The benefit payable by the Plan depends, in whole or in part, upon the pre-approval (or pre-certification) of the underlying medical care or treatment in advance of obtaining the medical care or treatment; and

(b) The Claim is not an Urgent Care Claim (as defined in Section 6.10).

Note: A total rescission of Plan coverage as a result of alleged fraud or misrepresentation is treated separately under Part VI and is not considered a Pre-Service Claim.

Section 6.23 How to File a Pre-Service Claim. A Pre-Service Claim shall include the following information:

(a) The amount, date and nature of each expense;

(b) The name of the person, organization or entity to which the expense is to be paid;

(c) The name of the Claimant for whom the approval is being sought and, if such person is not the Employee (or covered class member) requesting the benefit, the relationship of such Claimant to the Employee (or covered class member);

(d) An explanation of why the medical care or treatment in question should be approved;

(e) The amount expected to be recovered under any insurance arrangement or other plan with respect to the expense;

(f) A statement that the expense (or portion thereof for which reimbursement is sought under this Plan) has not been reimbursed and is not reimbursable under the Plan; and

(g) Any other information relating to the medical care or treatment in question that the Claimant considers relevant and wishes the Claims Administrator to consider in reviewing the Claim.

Section 6.24 Time Period for Filing a Pre-Service Claim. A Pre-Service Claim must be Received by the Claims Administrator sufficiently in advance of the proposed treatment date that the Claims Administrator is able to process the Claim.

Section 6.25 Failure to Follow Proper Procedures in Filing a Pre-Service Claim. If the Claimant fails to follow the proper procedures in filing his/her Pre-Service Claim, the Claims Administrator shall notify the Claimant as quickly as possible. In no event, however, will the notification be made more than five days after the time the failure took place. The Claimant shall then have 45 days to resubmit his/her Claim following the proper procedures.

Section 6.26 Failure to Submit Necessary Information. If the Claimant fails to submit information that is necessary to process a Pre-Service Claim, the Claims Administrator shall notify the Claimant of such failure no more than 15 days after Receipt of the Claim and shall identify the specific information that is necessary to complete the Claim.

(a) Upon Receipt of such notification, the Claimant shall have 45 days to provide the requested information to the Claims Administrator.

(b) During the period between the date the additional information is requested and the date it is Received by the Claims Administrator, the deadline for deciding the Claim, as set forth in Section 6.27, shall be suspended.

(c) Following Receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the Claim within the number of days that were remaining in the original 15-day period (as extended) as of the date the additional information was requested.

(d) If the requested information is not Received by the Claims Administrator within 45 days after the Claimant or the Claimant's authorized representative Received the Claims Administrator's request for such information, the Claims Administrator shall deny the Claim.

Section 6.27 Deadline for Deciding a Pre-Service Claim. Following the submission of a Pre-Service Claim that has been filed in accordance with the provisions of this Article, the Claims Administrator shall decide the Pre-Service Claim not later than 15 days following the Receipt of the Claim. The Claims Administrator may extend this 15-day period, however, for up to 15 additional days if (a) such an extension is necessary due to matters beyond the control of the Plan, *and* (b) the Claimant is notified of the extension prior to the expiration of the original 15-day period. A situation that is beyond the control of the Plan includes, but is not limited to, a situation in which the Claimant fails to submit information that is necessary to decide a Claim.

Section 6.28 Notification Regarding Initial Benefit Determination on Pre-Service Claim. The Claims Administrator shall notify the Claimant in writing of the decision that was made on the Pre-Service Claim. If the Claim was denied in whole or in part – which is considered an Adverse Benefit Determination – the notice provided to the Claimant shall be written in a manner calculated to be understood by the Claimant. (If the Plan is non-grandfathered, the notice shall also be written in a "culturally and linguistically appropriate" format, as required by Department of Labor Regulations.) In all events, the notice shall set forth the following:

(a) Information sufficient to identify the Claim (e.g., date of service, health care provider, Claim amount, diagnosis and treatment codes (and meaning of codes));

(b) The specific reason(s) for denial of the Claim (including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim);

(c) A reference to the specific Plan provisions upon which the denial is based;

(d) A description of any additional material or information necessary for the Claimant to perfect the Claim, along with an explanation why such material or information is necessary;

(e) A description of the Plan's Claim review procedures and the time limits applicable to such procedures. This description will include information on how to initiate an Appeal under the claim's procedures and the time limits applicable to such an Appeal. The description will also include a statement regarding the Claimant's right to bring a civil action under ERISA § 502(a) (if applicable) following a Final Adverse Benefit Determination;

(f) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to the Claimant free of charge upon request;

(g) If the Claim is denied on the basis that it is not Medically Necessary or that it is Experimental or Investigational treatment, or some similar exclusion or limit, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided to the Claimant free of charge upon request;

(h) A statement of the Claimant's right to present evidence and written testimony as part of the Appeal process;

(i) A statement of the Claimant's right to receive, free of charge, any new or additional evidence that was considered, relied upon, or generated by the Plan in connection with the Claimant's Pre-Service Claim, and an opportunity to respond to such evidence; and

(j) The availability of (and contact information for) any office of health insurance consumer assistance or ombudsman.

Section 6.29 Deadline for Filing Appeal of Adverse Benefit Determination on Pre-Service Claim. The Claimant shall have 180 days following the Receipt of a notice of an Adverse Benefit Determination of a Pre-Service Claim to file an Appeal. Any Appeal shall be filed with the Claims Administrator in writing.

Section 6.30 Procedures for an Appeal. In any Appeal of an Adverse Benefit Determination on a Pre-Service Claim, the following procedures shall be observed:

(a) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(b) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(c) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(d) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(e) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(f) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(g) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section 6.31 Deadline for Deciding Appeal of Denial of Pre-Service Claim. An Appeal of an Adverse Benefit Determination on a Pre-Service Claim shall be decided within 30 days following the Claims Administrator's Receipt of the Claimant's request for the Appeal.

Section 6.32 Notification Regarding Decision on Appeal of Pre-Service Claim. The Claims Administrator shall notify the Claimant of the decision made on his/her Appeal of the Adverse Benefit Determination of the Pre-Service Claim. If the Appeal is denied in whole in part – which would be considered a Final Adverse Benefit Determination – the written notice to the Claimant shall set forth the following:

(a) Information sufficient to identify the Claim (e.g., date of service, health care provider, Claim amount, diagnosis and treatment codes (and meaning of codes));

(b) The specific reason(s) for the Adverse Benefit Determination (including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim);

(c) A reference to the specific plan provisions upon which the determination is based;

(d) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. This description will include a statement of the Claimant's right to bring a civil action under ERISA § 502(a) (if applicable) following a Final Adverse Benefit Determination;

(e) A statement that the Claimant is entitled to review his/her Claim file and to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim. "Relevant" information includes any information that was considered, relied upon, or generated by the Plan in connection with the Claimant's Claim;

(f) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to the Claimant free of charge upon request;

(g) If the Claim is denied on the basis that it is not Medically Necessary or that it is Experimental or Investigational treatment, or some similar exclusion or limit, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided to the Claimant free of charge upon request;

(h) The following statement if the Employer is subject to ERISA: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.";

(i) The availability of (and contact information for) any office of health insurance consumer assistance or ombudsman.

PART IV – CONCURRENT CARE DECISIONS

Section 6.33 Application of Part IV. Sections 6.33 through 6.41 apply to Concurrent Care Decisions, as defined below.

Section 6.34 Definition of Concurrent Care Decision. A Concurrent Care Decision is a decision by the Plan to reduce, terminate, or refuse to extend an ongoing course of treatment (for which pre-approval is required and was previously granted) which is to be provided over a specified period of time or for a specified number of treatments. All Concurrent Care Decisions constitute Adverse Benefit Determinations.

Section 6.35 Notification Regarding Concurrent Care Decisions by Plan Involving Reduction or Termination of Covered Treatment. Any reduction or termination by the Plan of an approved, ongoing course of treatment before the end of the approved period of time or number of treatments is an Adverse Benefit Determination. Notification of such a Concurrent Decision shall be given to a Covered Person sufficiently in advance of the reduction or termination of the course of treatment to allow him/her to Appeal and to obtain a determination on review of that Adverse Benefit Determination before it takes effect. The notice provided to the Covered Person/Claimant shall follow the requirements, as applicable, to either Urgent Care Claims (as set forth in Section 6.16) or Pre-Service Claims (as set forth in Section 6.32).

Section 6.36 Requested Extension of Course of Treatment. The following rules apply if a Claimant requests an extension of a course of treatment (for which pre-approval is required and was previously granted) beyond the period of time or number of treatments that have been previously approved:

(a) If the course of treatment involves Urgent Care (as defined in Section 6.10), the request shall be decided as soon as possible, taking into account the medical exigencies. If the request was Received at least 24 hours prior to the expiration of the approved course of treatment, the Claims Administrator shall notify the Claimant of its decision on the Claim no more than 24 hours after Receipt of the request. If the request was not Received at least 24 hours prior to the expiration of the approved course of treatment, the Claims Administrator shall notify the Claimant of its decision on the Claim no more than 72 hours after Receipt of the request.

(b) If the course of treatment does not involve Urgent Care, the request will be treated as a Pre-Service Claim and shall be decided within the time frame applicable to Pre-Service Claims (as set forth in Section 6.27).

Section 6.37 Notification Regarding Concurrent Care Decisions by Plan Involving Denial of Requested Extension of Course of Treatment. Any denial of a Covered Persons' request for an extension of an ongoing course of treatment (for which pre-approval is required) is an Adverse Benefit Determination. The notice provided to the Covered Person/Claimant shall follow the requirements, as applicable, to either Urgent Care Claims (as set forth in Section 6.16) or Pre-Service Claims (as set forth in Section 6.28).

Section 6.38 Deadline for Filing an Appeal of a Concurrent Care Decision. Although a Claimant is strongly encouraged to file any Appeal of an Adverse Benefit Determination on a Concurrent Care Decision as soon as possible, the Claimant shall have up to 180 days following his/her Receipt of the Adverse Benefit Determination to file the Appeal. Any Appeal shall be filed with the Claims Administrator.

Section 6.39 Procedures for Appealing Adverse Benefit Determination Involving Concurrent Care Decision. In any Appeal of an Adverse Benefit Determination involving a Concurrent Care Decision, the following procedures shall be observed:

(a) If requested by the Claimant, the Claims Administrator may permit the Claimant to submit – where feasible – any information relevant to his/her Appeal either orally or in writing in order to expedite the processing and consideration of the Appeal. Where such expedited processing is necessary and appropriate, any information relevant to the Appeal may be transmitted between the Claims Administrator and the Claimant by telephone, facsimile, electronic mail, or similar delivery method;

(b) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(c) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(e) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(f) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(g) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(h) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section 6.40 Deadline for Deciding Appeal of Concurrent Care Decision. An Appeal of a Concurrent Care Decision (which is, by definition, an Adverse Benefit Determination) shall be decided, as applicable, within the time frame governing either Urgent Care Claims (as set forth in Section 6.19) or Pre-Service Claims (as set forth in Section 6.31).

Section 6.41 Notification Regarding Decision on Appeal of Concurrent Care Decision. The Claims Administrator shall notify the Claimant in writing of the decision made on his/her Appeal of a Concurrent Care Decision. If the Appeal is denied in whole in part – which would be considered a Final Adverse Benefit Determination – the written notice to the Claimant shall set forth the following:

(a) Information sufficient to identify the Claim (e.g., date of service, health care provider, Claim amount, diagnosis and treatment codes (and meaning of codes));

(b) The specific reason(s) for the Adverse Benefit Determination (including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim);

(c) A reference to the specific plan provisions upon which the determination is based;

(d) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. This description will include a statement of the Claimant's right to bring a civil action under ERISA § 502(a) (if applicable) following a Final Adverse Benefit Determination;

(e) A statement that the Claimant is entitled to review his/her Claim file and to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim. "Relevant" information includes any information that was considered, relied upon, or generated by the Plan in connection with the Claimant's Claim;

(f) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to the Claimant free of charge upon request;

(g) If the Claim is denied on the basis that it is not Medically Necessary or that it is Experimental or Investigational treatment, or some similar exclusion or limit, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided to the Claimant free of charge upon request;

(h) The following statement if the Employer is subject to ERISA: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.";

(i) The availability of (and contact information for) any office of health insurance consumer assistance or ombudsman.

PART V – POST-SERVICE CLAIMS

Section 6.42 Application of Part I. Sections 6.42 through 6.53 apply to Post-Service Claims, as defined below.

Section 6.43 Definition of Post-Service Claim. A Post-Service Claim is a Claim that is submitted after the underlying medical care or treatment has already been provided.

Section 6.44 Previously Approved Pre-Service Claims and Urgent Care Claims. A Pre-Service Claim (as defined in Section 6.22) that has been approved in accordance with the provisions applicable to Pre-Service Claims or an Urgent Care Claim (as defined in Section 6.10) that has been approved in accordance with the procedures applicable to Urgent Care Claims will be treated as a Post-Service Claim once the underlying medical care or treatment has been provided and will be subject to the provisions of the Plan that apply to Post-Service Claims. In such an event, however, the Claims Administrator will not deny coverage for any medical care or treatment that had previously been approved under the procedures applicable to Pre-Service Claims or Urgent Care Claims.

Section 6.45 How to File a Post-Service Claim. Claims must include the following information:

(a) The name and address of the Claimant for whom the expense was incurred and, if such person is not the Employee (or covered class member) requesting the benefit, the relationship of such Claimant to the Employee (or covered class member);

(b) The name and address of the Employee (or covered class member);

(c) The Plan's group number;

(d) The identity of the Employee's (or covered class member's) Employer;

(e) The name, address, telephone number, and tax ID number of the service provider to whom the payment is to be made;

(f) The amount, date, and nature of each expense, along with any corresponding diagnosis and service codes;

(g) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) may be reimbursable under some other plan coverage; and

(h) Any other information relating to the medical care or treatment in question that is relevant and that should be considered in evaluating the Claim.

Section 6.46 Time Period for Filing Post-Service Claims. Claims must be filed within 365 days after the charge for the particular medical care or treatment was incurred by the Covered Person. A Claim that is not filed within this time period will be denied or reduced.

Section 6.47 Failure to Submit Necessary Information. If the Claimant fails to submit information that is necessary to process a Post-Service Claim, the Claims Administrator shall notify the Claimant of such failure within 30 days following the Receipt of the Claim and shall identify the specific information that is necessary to complete the Claim.

(a) Upon Receipt of such notification, the Claimant shall have 45 days to provide the requested information to the Claims Administrator.

(b) During the period between the date the additional information is requested and the date it is Received by the Claims Administrator, the deadline for deciding the Claim, as set forth in Section 6.48, shall be suspended.

(c) Following Receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the Claim within the number of days that were remaining in the original 30-day period (as extended) as of the date the additional information was requested.

(d) If the requested information is not Received by the Claims Administrator within 45 days after the Claimant Received the Claims Administrator's request for such information, the Claims Administrator shall deny the Claim.

Section 6.48 Deadline for Deciding a Post-Service Claim. Following the submission of a Post-Service Claim that has been filed in accordance with the provisions of this Article, the Claims Administrator shall decide the Post-Service Claim not later than 30 days following the Receipt of the Claim. The Claims Administrator may extend this 30-day period, however, for up to 15 additional days if (a) such an extension is necessary due to matters beyond the control of the Plan, *and* (b) the Claimant is notified of the extension prior to the expiration of the original 30-day period. A situation that is beyond the control of the Plan includes, but is not limited to, a situation in which the Claimant fails to submit information that is necessary to decide a Claim.

Section 6.49 Notification Regarding Initial Adverse Benefit Determination on Post-Service Claim. The Claims Administrator shall notify the Claimant in writing of the decision that was made on the Post-Service Claim. If the Claim was denied in whole or in part – which is considered an Adverse Benefit Determination – the notice provided to the Claimant shall be written in a manner calculated to be understood by the Claimant. (If the Plan is non-grandfathered, the notice shall also be written in a "culturally and linguistically appropriate" format, as required by Department of Labor Regulations.) In all events, the notice and shall set forth the following:

(a) Information sufficient to identify the Claim (e.g., date of service, health care provider, Claim amount, diagnosis and treatment codes (and meaning of codes));

(b) The specific reason(s) for denying the Claim (including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim);

(c) A reference to the specific Plan provisions upon which the denial is based;

(d) A description of any additional material or information necessary for the Claimant to perfect the Claim, along with an explanation why such material or information is necessary;

(e) A description of the Plan's Claim review procedures and the time limits applicable to such procedures. This description will include information on how to initiate an Appeal under the claim's procedures and the time limits applicable to such an Appeal. The description will also include a statement regarding the Claimant's right to bring a civil action under ERISA § 502(a) (if applicable) following a Final Adverse Benefit Determination;

(f) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to the Claimant free of charge upon request;

(g) If the Claim is denied on the basis that it is not Medically Necessary or that it is Experimental or Investigational treatment, or some similar exclusion or limit, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided to the Claimant free of charge upon request;

(h) A statement of the Claimant's right to present evidence and written testimony as part of the Appeal process;

(i) A statement of the Claimant's right to receive, free of charge, any new or additional evidence that was considered, relied upon, or generated by the Plan in connection with the Claimant's Post-Service Claim, and an opportunity to respond to such evidence; and

(j) The availability of (and contact information for) any office of health insurance consumer assistance or ombudsman.

Section 6.50 Deadline for Filing Appeal of Adverse Benefit Determination on Post-Service Claim. The Claimant shall have 180 days following the Receipt of a notice of an Adverse Benefit Determination of a Post-Service Claim to file an Appeal. Any Appeal shall be filed with the Claims Administrator in writing.

Section 6.51 Procedures for an Appeal. In any Appeal of an Adverse Benefit Determination on a Post-Service Claim, the following procedures shall be observed:

(a) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(b) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(c) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(d) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(e) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(f) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(g) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section 6.52 Deadline for Deciding Appeal of Denial of Post-Service Claim. An Appeal of an Adverse Benefit Determination on a Post-Service Claim shall be decided within 60 days following the Claims Administrator's Receipt of the Claimant's request for the Appeal.

Section 6.53 Notification Regarding Decision on Appeal of Post-Service Claim. The Claims Administrator shall notify the Claimant of the decision made on his/her Appeal of the Adverse Benefit Determination of the Post-Service Claim. If the Appeal is denied in whole in part – which would constitute a Final Adverse Benefit Determination – the written notice to the Claimant shall set forth the following:

(a) Information sufficient to identify the Claim (e.g., date of service, health care provider, Claim amount, diagnosis and treatment codes (and meaning of codes));

(b) The specific reason(s) for the Adverse Benefit Determination (including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim);

(c) A reference to the specific plan provisions upon which the determination is based;

(d) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. This description will include a statement of the Claimant's right to bring a civil action under ERISA § 502(a) (if applicable) following a Final Adverse Benefit Determination;

(e) A statement that the Claimant is entitled to review his/her Claim file and to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim. "Relevant" information includes any information that was considered, relied upon, or generated by the Plan in connection with the Claimant's Claim;

(f) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to the Claimant free of charge upon request;

(g) If the Claim is denied on the basis that it is not Medically Necessary or that it is Experimental or Investigational treatment, or some similar exclusion or limit, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided to the Claimant free of charge upon request;

(h) The following statement if the Employer is subject to ERISA: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."; and

(i) The availability of (and contact information for) any office of health insurance consumer assistance or ombudsman.

PART VI – RESCISSION OF COVERAGE

Section 6.54 Definition of Rescission of Coverage. A "Rescission of Coverage" refers to the Plan's total rescission of a Claimant's coverage under the Plan on the basis of fraud or intentional misrepresentation of material fact.

Section 6.55 Notice of Rescission. In the case of a Rescission of Coverage, the Plan must provide notice to a Covered Person of the rescission of his/her coverage at least 30 days prior to the effective date of the rescission. This notice serves as an Adverse Benefit Determination.

Section 6.56 Deadline for Filing an Appeal. The Claimant shall have 180 days following the Receipt of a notice of a Rescission of Coverage to file an Appeal. Any Appeal shall be filed with the Claims Administrator in writing.

Section 6.57 Required Procedures In Connection with Filing and Deciding Appeal of Rescission of Coverage. The procedures for a Claimant to Appeal a Rescission of Coverage, and the deadline and notice obligations of the Claims Administrator in deciding such an Appeal, shall be the same as those that govern Post-Service Claims, as set forth in Sections 6.51-6.53.

PART VII – EXTERNAL REVIEW PROCESS

If a Claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, the Claimant may (but does not have to) request that the Claim be reviewed under the Plan's External Review process. As described in detail below, the External Review process entails a review of the Claim by an independent third-party organization.

Section 6.58 Deadline for Requesting External Review of Final Adverse Benefit Determination. A request for External Review of a Final Adverse Benefit Determination must be filed by the Claimant or his/her authorized representative in writing within 4 months after Receipt of the Final Adverse Benefit Determination.

Section 6.59 Determination Whether Claim is Eligible for External Review. Within 5 days after Receiving a Claimant's request for External Review, the Plan Administrator shall determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

(a) The Claimant is or was covered under the Plan at the time the Claim was made or incurred;

(b) The denial relates to the Claimant's failure to meet the Plan's eligibility requirements. (If the Claim involves an eligibility issue, External Review is not available);

(c) The Claimant has exhausted the Plan's internal Claims and Appeal procedures; and

(d) The Claimant has provided all the information required to process an External Review.

Within one (1) business day after completion of this preliminary review, the Claims Administrator will provide written notification to the Claimant of whether the Claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Claims Administrator will notify the Claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the Claims Administrator's notice will describe the information needed to complete it. The Claimant will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

Section 6.60 Assignment to Independent Review Organization for External Review. If the Claimant's request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Claimant, in writing, that the request for External Review has been accepted. The notice will include a statement that the Claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

Section 6.61 Evaluation of Claim by IRO. If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(a) The Claimant's medical records;

(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider;

(d) The terms of the Plan;

(e) Appropriate practice guidelines;

(f) Any applicable clinical review criteria developed and used by the Plan; and

(g) The opinion of the IRO's clinical reviewer.

Section 6.62 Claim Decision by IRO. The IRO must provide written notice to the Plan and the Claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(a) A general description of the reason for the External Review, including information sufficient to identify the Claim;

(b) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(c) References to the evidence or documentation the IRO considered in reaching its decision;

(d) Discussion of the principal reason(s) for the IRO's decision;

(e) A statement that the determination is binding (except to the extent other remedies may be available under State or Federal law);

(f) A statement that judicial review may be available to the Claimant; and

(g) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

In addition, if the Claimant resides in a county where 10% or more of the population does not speak English, the notice must be set forth in the applicable non-English language.

Section 6.63 Availability of Expedited External Review. Generally, a Claimant must exhaust the Plan's Claims and Appeal procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review. Expedited External Review is available if either of the following two conditions is satisfied:

(a) *Requiring Appeal of Adverse Benefit Determination Under Plan's Internal Claims and Appeal Procedure Timetable Would Seriously Jeopardize Claimant's Life or Health*. The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

(b) *Final Adverse Benefit Determination Involves Emergency Services and Claimant Remains Hospitalized*. The Claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO.

The IRO must then make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours.

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ARTICLE VII
HIPAA MEDICAL PRIVACY

PART I – PREAMBLE

Section 7.01 Purpose and Effective Date. This HIPAA Medical Privacy Article is adopted in response to the provisions of the Medical Privacy Regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Section 7.02 Application of this Article. This Article shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Article.

PART II – DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER

Section 7.03 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by this Part II, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose PHI to the Employer.

Section 7.04 Definitions. For purposes of this Part II, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in Parts 160 and 164 of Title 45 of the Code of Federal Regulations ("C.F.R.").

(a) *"Breach"* means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use or disclosure are excluded from the definition of a "breach:"

(1) Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the Group Health Plan if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such Employee or individual, respectively, with the Group Health Plan, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the HIPAA Medical Privacy or Security Rules;

(2) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the HIPAA Medical Privacy or Security Rules; and

(3) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.

(b) *"De-identified Health Information"* means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed. Information that must be removed, pursuant to this section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.

(c) *"Electronic Media"* means:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

(d) *"Electronic Protected Health Information" ("e-PHI")* is PHI that is transmitted or maintained in electronic media.

(e) *"Individually Identifiable Health Information"* means information for which each of the following conditions is met:

(1) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse;

(2) The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and

(3) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.

(f) *"Plan Administration Functions"* means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan.

(h) *"Protected Health Information (PHI)"* means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.

(h) *"Security Incident"* (as defined in 45 C.F.R. § 164,304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(i) *"Security Rule"* shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Part 160 and Part 164, subpart C.

(j) *"Summary Health Information"* means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed, except that geographical locations may be described using a five digit ZIP code.

(k) *"Unsecured PHI"* means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section 7.05 Enrollment / Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been disenrolled in, the medical coverage provided under the Group Health Plan.

Section 7.06 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

(a) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any business associates of the Group Health Plan;

(b) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any Appeals that are filed with respect to claims that are denied in whole or in part;

(c) Overseeing the coordination of benefits and pursuing and/or responding to claims for subrogation;

(d) Conducting cost management and planning related analysis, including the forecasting of expected healthcare costs based on current utilization of benefits;

(e) Detecting fraud or abuse;

(f) Determining whether charges for services are appropriate or justified;

(g) Requesting underwriting or premium rating and other activities related to the creation, renewal or replacement of a contract of health insurance;

(h) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part;

(i) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate;

(j) Providing assistance, upon request, to Participants and their covered dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;

(k) Reporting corporate finances with respect to current and projected healthcare costs;

(l) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and

(m) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section 7.06 is subject to the provisions of Section 7.07.

Section 7.07 Conditions for Disclosure for Plan Administration Functions. With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 7.06, the Employer agrees to do the following:

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

(b) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI;

(c) Not to use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;

(d) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. If and as required by any applicable HHS regulations, this reporting requirement will also include reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s), the media (if applicable), and the Department of Health and Human Services ("HHS") may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications;

(e) Restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out-of-pocket in full;

(f) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his or her own information as that right is set forth in 45 C.F.R. § 164.524;

(g) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by 45 C.F.R. § 164.526;

(h) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by 45 C.F.R. § 164.528;

(i) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy and security requirements;

(j) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

(k) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III;

(l) Provide a certification to the Group Health Plan as required by Section 7.08; and

(m) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;

(2) Ensures that any agents (including subcontractors) to whom it provides such e-PHI agrees to implement reasonable and appropriate security measures to protect the information; and

(3) Report to the Group Health Plan any Security Incident of which it becomes aware.

Section 7.08 Certification by the Employer. In the absence of an authorization, the Group Health Plan may not disclose any PHI or e-PHI to the Employer unless and until the Group Health Plan is in receipt of a certification from the Employer. The Plan Sponsor must certify in the certification that the Group Health Plan has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii). The Plan Sponsor must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section 7.07 and in Part III.

PART III – ADMINISTRATIVE SAFEGUARDS

Section 7.09 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the "authorized employees" have access to e-PHI. Further, this Part III does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 7.10 Authorized Employees. The Employees ("Authorized Employees") listed on Schedule 1 to the Adoption Agreement are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions (as set forth in Part II above) that the Employer performs for the Group Health Plan in order to provide benefits to participants. In the event there is a change in the Authorized Employees, such Schedule may be updated by the Plan Administrator. Such update shall not constitute a plan amendment for purposes of Article XI.

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the IT department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel's support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy and security rules and shall comply fully with the Plan's policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 7.11 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 7.12 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

ARTICLE VIII
COBRA COVERAGE

Section 8.01 Construction of Article VIII. For purposes of interpreting the specific provisions of this Article VIII, it is understood that Plan Sponsor intends to satisfy the currently applicable technical requirements of the group health care continuation rules first enacted as part of COBRA. Currently, these rules are set forth in Code § 4980B and in certain regulations issued by the Treasury Department and by the Department of Labor. In the event of a conflict between the provisions of this Article and the rules set forth in Code § 4980B or the regulations issued pursuant thereto, this Article shall be interpreted in accordance with the then-current applicable rules and regulations.

Section 8.02 Continuation of Coverage under COBRA. If a "qualified beneficiary" loses (or would lose) coverage under this Plan as a result of a "qualifying event," the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a COBRA election form and by paying the applicable premium. The qualified beneficiary's right to continue coverage under this Plan is subject to the following:

(a) *Qualified Beneficiary.* For purposes of this section, a "qualified beneficiary" means the Participant, the Participant's Spouse, and the Participant's Dependents, but only if such persons were covered under this Plan on the day before the "qualifying event." The term "qualified beneficiary" shall also include any children who are born to or adopted by the Participant while the Participant is continuing his/her coverage under COBRA. If a Domestic Partner is covered under the Plan, he/she shall have the same COBRA continuation coverage rights as any other qualified beneficiary, unless Plan Sponsor elects otherwise in the Adoption Agreement.

(b) *Qualifying Event.* For purposes of this section, a "qualifying event" means one of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Plan as a result of such an event:

(1) Termination of the Participant's employment (other than for "gross misconduct") or a reduction in the number of hours the Participant normally works.

(2) Death of the Participant.

(3) Divorce or legal separation of the Participant and the Participant's covered Spouse.

(4) The Participant's entitlement to Medicare.

(5) A covered Dependent no longer satisfies the conditions for being covered as a Dependent of the Participant.

(6) The Employer files a Chapter 11 bankruptcy (but only as to coverage that is being provided to a retired Participant and his/her Spouse and covered Dependents *and* only if the Employer is terminating this Plan while continuing to offer group health coverage to some other group of Employees).

(c) *Election to Continue Coverage.* Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the COBRA statute and must be made in accordance with such reasonable procedures as the Plan Administrator may establish.

(d) *Premium for COBRA Continuation Coverage.* A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional 2% charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional 50% charge. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the Plan Administrator may establish.

(e) *Maximum Coverage Period.* The maximum period of time for which COBRA continuation coverage will be provided shall be as follows:

(1) *Termination of Employment or Reduction in Hours.* If coverage is lost as a result of termination of the Participant's employment or a reduction in the Participant's hours, the maximum period of COBRA continuation coverage will be 18 months.

(2) *Disability Extension.* If a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage and the qualified beneficiary notifies the Plan Administrator of such determination (i) within 60 days of such determination and (ii) while COBRA continuation coverage is still in effect and in accordance with such reasonable procedures as the Plan Administrator may establish, the maximum period of COBRA continuation coverage will be 29 months.

(3) *Employer Bankruptcy.* The maximum period of COBRA continuation coverage will be the lifetime of the Participant *if:*

(i) The Employer is providing coverage after the Participant has retired;

(ii) The Employer files a Chapter 11 bankruptcy;

(iii) The Employer terminates this Plan (or substantially eliminates coverage under this Plan with respect to a qualified beneficiary within a one year period before or after such bankruptcy proceeding was filed); and

(iv) The Employer continues to maintain a group health plan for any other group of Employees.

In such an event, the surviving spouse and surviving covered dependents of the Participant shall further be entitled to elect COBRA continuation coverage for an additional 36 months following the death of Participant.

(4) *Second Qualifying Event.* If a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of the Participant's employment or a reduction in the Participant's hours, the maximum period of COBRA continuation coverage will be 36 months.

(5) *Any Other Qualifying Event.* The maximum period of COBRA continuation coverage will be 36 months for any qualifying event for which a shorter maximum coverage period is not set forth in this subsection (e).

(f) *Termination of COBRA Continuation Coverage.* COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period under any of the following circumstances:

(1) *Covered Under Another Group Health Plan*. The qualified beneficiary becomes covered under another group health plan;

(2) *Premium Not Paid*. A required premium is not paid within the applicable deadline (including any applicable grace period);

(3) *Plan is Terminated with No Other Coverage Offered in its Place*. The Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees;

(4) *Entitlement to Medicare*. After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);

(5) *No Longer Disabled*. During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(6) *Other Analogous Reasons for Terminating Coverage*. Coverage would have been terminated under the same circumstances for a Covered Person who is not receiving COBRA continuation coverage (e.g., if the Covered Person engages in fraudulent activities against the Plan).

(g) *Coverage Provided During COBRA Continuation Period.* The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.

(h) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.

(i) *Construction and Application.* This section shall be construed and applied in a way that is consistent with the requirements of the COBRA statute and COBRA regulations issued by the Internal Revenue Service and the Department of Labor.

(j) *Employers Not Required to Offer COBRA Continuation Coverage.* This section shall not apply to the Employer if the Employer is not required by law to offer COBRA continuation coverage. The Employer, for example, will not be not required to offer COBRA continuation coverage if the Employer qualified for the "small employer" exception to COBRA based on the number of employees that it employed during the previous calendar year. Generally, if this number is less than 20, then the Employer is not subject to COBRA. In the event, however, that the Employer has 20 or more employees as determined under COBRA (considering "controlled group" rules and special rules for part-time employees), this Article will apply as described above.

Section 8.03 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to 24 months. The Participant's right to continue coverage is subject to the following:

(a) *Payment of Premium.* The Participant must pay the applicable premium for any USERRA continuation coverage. For a leave of absence of less than 31 days, the Participant may not be required to pay more than the Participant would have paid had the Participant not been on leave. For a leave of absence of more than 30 days, Participant must pay the entire cost of coverage plus an additional 2%.

(b) *Failure to Apply for Reemployment.* Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

(c) *Reasonable Procedures.* The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this section.

(d) *Construction and Application.* This section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute and any applicable regulations that may be issued by the Department of Labor.

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ARTICLE IX
THIRD PARTY LIABILITY/SUBROGATION AND REIMBURSEMENT

Section 9.01 Subrogation/Reimbursement Rights of the Plan.

(a) Plan's Right to Subrogation. The Plan shall be subrogated to all rights that a Covered Person, or his/her assignee has against any person, firm, corporation, insurer (including, but not limited to, worker's compensation or any other occupational disease act or law, uninsured motorist coverage, and business/homeowners medical liability insurance coverage or payments) or other entity with respect to *any and all benefits* previously paid by the Plan, or on behalf of the Plan, to such individual for any injuries, expenses, or loss which may be caused by the negligence or wrongful act of a third party.

(b) Plan's Right to Reimbursement. The Covered Person(s), or assignees agree to include the amounts of any and all benefits paid by the Plan (or any amount considered to be for future medical expenses) in any claim such individual brings against any person, firm, corporation, insurer, or other entity. Upon any recovery made by the Covered Person(s) or assignees from any source of compensation, whether by judgment, settlement, compromise, or otherwise, the Plan shall have first lien upon such recovery and be entitled to immediate reimbursement to the extent of any and all benefits paid by the Plan. The Plan shall also have the right to reimbursement from any Covered Person(s) or assignee for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which the Covered Person was not entitled.

Section 9.02 Amount of Recovery. The Plan has the right to recovery, whether by subrogation or reimbursement, for any and all benefits paid by the Plan. The amount due shall not be reduced due to attorney's fees and/or costs incurred in pursuing a claim, subrogation, or reimbursement. In addition, these rights take priority over the Covered Persons' or assignees' right to be made whole.

Section 9.03 Condition of Payment. By accepting benefits from the Plan, the Covered Person(s) or his/her assignee agree to the following:

(a) The Plan may require the Covered Persons, assignees, or someone legally qualified and authorized to act for such persons, to agree to the provisions in this Article in writing, and execute any and all other instruments reasonably necessary for the Plan to assert its rights under this Article. If such an agreement is not signed within 30 days after the request is made by the Plan Administrator, the Covered Persons and/or assignees shall permanently forfeit his/her right to receive benefits on account of the injury or condition in question;

(b) Any amounts recovered by such individual or by the Plan by judgment, settlement, or otherwise will be applied first to reimburse the Plan;

(c) The Plan shall be subrogated to all claims, demands, actions, and rights of recovery against a third party to the extent of any and all payments made by the Plan; and

(c) At the Plan's request, the Covered Person(s) or assignees must take any action, give information, and/or execute instruments required by the Plan, in its discretion, in order to aid the Plan in its enforcement of its rights of recovery, reimbursement, and subrogation. If such individual(s) fail to comply with such requests, the Plan may withhold benefits, services, payments, or credits due under the Plan.

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ARTICLE X
COORDINATION OF BENEFITS

Section 10.01 Purpose of Coordination of Benefits. This coordination of benefits article sets out the rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan, or the couple's Covered Dependents are covered under two or more plans, the plans will coordinate benefits when a Claim is received. The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charge.

Section 10.02 Benefit Plan. For purposes of this Article, the term "Benefit Plan" refers to this Plan and any of the following other types of plans:

(a) Group, blanket, or franchise coverage, whether insured or uninsured, including coverage that is provided through:

(1) Health Maintenance Organizations ("HMOs") and other prepayment group or individual practice plans; and

(2) Automobile "no fault" and "fault" insurance, including individual insurance.

(b) Federal government plans or programs (e.g., Medicare and Tricare), but *not* including:

(1) Coverage provided under Medicaid; or

(2) Any plan which, by law, does not allow for coordination of benefits.

(d) Other plans required or provided by law; and

(e) Any coverage under:

(1) Union welfare plans;

(2) Labor-management trusteed plans; or

(3) Employer organization plans or employee benefit organization plans.

Section 10.03 Allowable Charge. For a charge to be allowable, it must be an Allowed Amount and at least part of it must be covered under this Plan. In the case of an HMO or other in-network-only plans, this Plan will not consider any charges in excess of what the HMO or Network Provider has agreed to accept as payment in full. When an HMO or in-network-only plan is primary and the Covered Person does not use the HMO or Network Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or in-network-only plan had the Covered Person used the services of an HMO or Network Provider. In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Section 10.04 Vehicle Insurance Limitations. When medical payments are available under vehicle insurance, this Plan shall always be considered the secondary carrier regardless of the Participant's (or Covered Person's) election under PIP (personal injury protection) coverage with the auto carrier.

Section 10.05 Benefit Plan Payment Order. When two or more Benefit Plans provide benefits for the same Allowable Charge, benefit payments will follow these rules:

(a) Benefit Plans that do not have a coordination provision, or one like it, will pay first. Benefit Plans that do have such a provision will be considered after those without one.

(b) Benefit Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(1) The benefits of the plan which covers the person directly (i.e., as an employee, member, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(2) The benefits of a Benefit Plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other Benefit Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(3) The benefits of a Benefit Plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a Benefit Plan which covers the person as a COBRA beneficiary.

(4) When a Child is covered as a Dependent and his/her parents are not separated or divorced, the following rules apply:

(i) The benefits of the Benefit Plan of the parent whose birthday falls earlier in a year are determined before those of the Benefit Plan of the parent whose birthday falls later in that year.

(ii) If both parents have the same birthday, the benefits of the Benefit Plan which has covered the parent for the longer time are determined before those of the Benefit Plan which covers the other parent.

(5) When a Child's parents are divorced or legally separated, the following rules apply:

(i) If the parent with custody of the Child has not remarried, the Benefit Plan of the parent with custody will be considered before the Benefit Plan of the parent without custody.

(ii) If the parent with custody of the Child has remarried, the Benefit Plan of the parent with custody will be considered first, the Benefit Plan of the stepparent that covers the Child as a dependent will be considered next, and the Benefit Plan of the parent without custody will be considered last.

(iii) If court decree states which parent is financially responsible for medical and dental benefits of the Child, it shall take precedence over the rules set forth in Subparagraphs (5)(i) and (5)(ii) above. In such circumstances, the Benefit Plan of that parent will be considered before other Benefit Plans that cover the child as a dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the Benefit Plans covering the Child shall follow the order of benefit determination rules outlined above when a Child is covered as a dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(6) If there is still a conflict after these rules have been applied, the Benefit Plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, this Plan will never pay more than 50% of Allowable Charges when paying secondary.

(c) Medicare Coordination.

(1) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. This Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(2) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and its implementing regulations, Medicare is both secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(d) If a Plan Participant is under a disability extension from a previous Benefit Plan, that Benefit Plan will pay first and this Plan will pay second.

(e) This Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Section 10.06 Right to Receive or Release Necessary Information. This Plan may give or obtain needed information from another insurer or any other organization or person in order to facilitate the proper coordination of benefits. This information may be given or obtained without the consent of, or notice to, any other person. A Covered Person must provide to this Plan the information it asks for about other Benefit Plans and their payment of Allowable Charges.

Section 10.07 Facility of Payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. Such repayment will count as a valid payment under this Plan.

Section 10.08 Right of Recovery. In the event that this Plan pays benefits that should have been paid by another Benefit Plan, this Plan shall have the right to recover the amount paid from the other Benefit Plan or the Covered Person. Such repayment will count as a valid payment under the other Benefit Plan. In the event that this Plan pays benefits that are later found to be greater than the Allowable Charge, this Plan shall have the right to recover the amount of the overpayment from the source to which it was paid.

Section 10.09 Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

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ARTICLE XI
TERMINATION AND AMENDMENT OF THE MEDICAL PLAN

Section 11.01 Right to Amend. Plan Sponsor may modify, alter, or amend the Plan, in whole or in part, at any time, by a written instrument signed by an authorized individual on behalf of the Plan Sponsor. Any such modification, alteration, or amendment shall be binding upon the Plan Administrator, the Claims Administrator, any adopting plan sponsors, Participants, Covered Persons and all persons; provided, however, that the duties, powers and liabilities of the Plan Administrator and the Claims Administrator shall not be substantially increased without the Plan Administrator's and Claim Administrator's written consent. Written copies of any Plan amendments must be transmitted to the Plan Administrator and the Claims Administrator not less than 10 days prior to the amendment's effective date.

In the event that the Plan is amended, the Plan may be simultaneously restated to incorporate such amendment(s) without the need for Participating Plan Sponsors to execute new Participation Agreements. The previously executed Participation Agreements for all Participating Plan Sponsors shall be fully applicable to any post-amendment restated Plan.

Section 11.02 Retroactive Amendments. Nothing herein shall be deemed or construed to prevent the adoption of any modification, alteration, or amendment hereof, even if the same shall: (a) be made effective retroactively, or (b) alter, reduce, or eliminate rights of any Participant or Covered Person so long as such modification, alteration, or amendment shall have been made to make this Plan conform with or satisfy any conditions of any law or regulation relating to the establishment or maintenance of this Plan as a health care plan under the Code or other applicable Federal or state laws.

Section 11.03 Termination of Plan. Plan Sponsor has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but Plan Sponsor will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time without liability to Covered Persons.

Section 11.04 Termination Procedures. The Plan may be terminated at any time by written instrument duly adopted and signed by an authorized individual of Plan Sponsor. Upon termination of this Plan, Plan Sponsor shall give notice of the same to all Covered Persons under the Plan, the Plan Administrator, the Claims Administrator, and any other affected person. Further, upon termination of the Plan, all elections and salary reduction agreements, if any, related to the Plan shall terminate.

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ARTICLE XII
MISCELLANEOUS

Section 12.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 12.02 Employment Not Guaranteed. Nothing contained in the Plan or in any other plan which is a part of the Plan, or any modification or amendment to this Plan, or in the creation of any account, or the payment of any benefit, gives any Participant, former Participant, Covered Persons, or his/her beneficiaries any right to continue employment, any legal or equitable right against Plan Sponsor, its agents, or against the Plan Administrator, except as expressly provided by this Plan.

Section 12.03 Indemnification. To the extent permitted by law, Plan Sponsor shall indemnify and hold harmless any individuals employed by Plan Sponsor to whom fiduciary responsibility with respect to the Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such individuals as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under the Plan, other than such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 12.04 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement the Plan.

Section 12.05 Limitation on Liability. A Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under the Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 12.06 Named Fiduciary. The named fiduciary of the Plan is the Plan Sponsor unless otherwise set forth in the Adoption Agreement. The named fiduciary shall have complete authority to control and manage the operation and administration of the Plan.

Section 12.07 Negative Paychecks. Plan Sponsor shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from Plan Sponsor to Participant in the event that such compensation is less than the combined total of the following:

(a) Taxes required to be withheld from Participant's compensation;

(b) The amounts Participant has elected to defer into a plan maintained by Plan Sponsor;

(c) The salary reductions elected by Participant under this Plan or under any similar plan maintained by Plan Sponsor; and

(d) Such other amounts that Plan Sponsor may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, Plan Sponsor shall deduct amounts required to be withheld for taxes and amounts necessary to pay for Participant's medical coverage prior to deducting any other amounts.

Section 12.08 No Guarantee of Tax Consequences. Neither the Plan Administrator nor Plan Sponsor makes any commitment or guarantee that any amounts paid to or for the benefit of a Covered Person under the Plan will be excludable from Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant.

Section 12.09 Nonassignability. The right of any Covered Person to receive any benefits under this Plan is not subject to alienation or assignment and is not subject to the claims of the creditors of the Covered Person except to the extent provided by law.

Section 12.10 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the Plan due to the person's classification as an independent contractor and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Plan on a prospective basis only. Except as may be required in connection with HIPAA special enrollment rights, no person shall be allowed to enter the Plan on a retroactive basis.

Section 12.11 Rights to Plan Sponsor's Assets. No Covered Person or beneficiary has any right to, or interest in, any assets of Plan Sponsor upon Participant's termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent that the benefits payable under the Plan are payable solely from the assets of Plan Sponsor.

Section 12.12 Separate Liability. Except to the extent imposed by ERISA (and provided the Employer is subject to ERISA), no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by the Plan, by ERISA (if applicable), by the Code, or by any regulations or rulings issued under ERISA or the Code. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to the Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy such breach, or, through its negligence in performing its own specific fiduciary responsibilities, it has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

Section 12.13 Clerical Errors. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

Section 12.14 State Law. Except to the extent superseded by Federal law, the laws of the state elected by Plan Sponsor in the Adoption Agreement will determine all questions arising with respect to the provisions of the Plan.

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MEDICAL • PRESCRIPTION DRUG • DENTAL

BENEFIT DESCRIPTION

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Do you know that your group health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? In the case of a Covered Person who is receiving benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to the annual deductible and co-insurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

Contact the Claims Administrator for more information: Benefit Management, LLC, PO Box 1090, Great Bend, Kansas 67530, (800) 290-1368.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Claims Administrator.

PART I - SCHEDULE OF BENEFITS

VERIFICATION OF ELIGIBLITY

Call the number below to verify eligibility for Plan benefits **before** the charge is incurred.

Verification of Eligibility (800) 290-1368

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including - but not limited to - the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are the Allowed Amount; services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced.

Hospitalization	**Inpatient Substance Abuse Treatments**
Skilled Nursing Facility stays	**Inpatient Mental Disorder Treatments**

After 48 observation hours, a confinement will be considered an inpatient confinement. Observations in excess of 48 hours require pre-certification as an inpatient stay. Pre-certification penalties may apply if observation exceeds 48 hours.

See the Cost Management section in this booklet for details. You will need to follow these sections or reimbursement from the Plan may be reduced. The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please read the section Alternate Treatment in the Dental Plan. You will need to follow this section or reimbursement from the Plan may be reduced.

PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK AND NON-NETWORK PROVIDERS

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers in the **First Health Network,** called Network Providers, who have agreed to certain reduced fees. A list of providers in the Plan's PPO Network is available free-of-charge by contacting the PPO via telephone or by visiting the PPO's website. Refer to the Covered Person's Plan identification card for the PPO Network's phone number and website address. PPO Network providers are subject to change without notification. .

When a Covered Person uses a PPO Network provider that Covered Person will receive better benefits from the Plan than when a Non-Network provider is used. It is the Covered Person's choice as to which provider to use; however, reimbursement is at the highest level when services are provided by a PPO Network provider.

In order for the claim to be appropriately filed, it is important that the provider of service have the most current identification card. It is the patient's responsibility to confirm the most current card is on file with the provider.

BENEFIT UPGRADE

Under the following circumstances, the higher PPO Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of PPO Network Providers in the specialty that the Covered Person is

seeking within the PPO service area. Additionally, benefits will be upgraded to the PPO Network level in limited situations when the Claims Administrator determines the PPO provider availability is insufficient and a person would be required to travel more than 50 miles to seek services.

If a Covered Person receives services from a Municipal Health Department.

If a Covered Person has a Medical Emergency or is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Network Physician or Medical Care Facility refers x-ray and laboratory services to a Non-Network provider.

If a Non-Network assistant surgeon performs services in a Network Facility.

If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at a Network facility.

If a Covered Person has no choice for purchasing Medical/Surgical Supplies and Durable Medical Equipment through a Network Provider.

If you receive services from a Non-Network Provider, the provider may bill you for amounts in excess of the Allowed Amount. Payment of the balanced billed amount is the responsibility of the Covered Person.

Medical and Dental Benefits are independent. If medical coverage is desired, you must elect medical coverage on the enrollment form that is provided to you by the Plan Administrator. If you do not elect medical coverage, you are not a Covered Person for Medical Benefits.

MEDICAL BENEFITS SCHEDULE

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM BENEFIT AMOUNT:	Unlimited	
DEDUCTIBLE PER BENEFIT YEAR		
Per Covered Person	$1,200	$2,400
Per Family Unit	$2,400	$4,800
CO-INSURANCE PERCENTAGE PAYABLE		
Percentage Payable by the Plan	80%	50%
CO-INSURANCE OUT-OF-POCKET MAXIMUM PER BENEFIT YEAR		
Per Covered Person	$2,000	$6,000
Per Family Unit	$4,000	$12,000
TOTAL OUT-OF-POCKET PER BENEFIT YEAR Deductible + Co-Insurance + Medical and Prescription Drug Co-payments		
Per Covered Person	$3,200	$8,400
Per Family Unit	$6,400	$16,800

IMPORTANT NOTES ABOUT DEDUCTIBLES AND CO-INSURANCE OUT-OF-POCKET MAXIMUM

- Network and Non-Network deductibles are independent of each other.
- Network and Non-Network co-insurance out-of-pocket maximums are independent of each other.
- *Prescription Drug co-payments apply toward the Network co-insurance out-of-pocket amount.*
- The following charges do not apply toward the deductible or co-insurance out-of-pocket maximum and are never paid at 100%.
  - Cost containment penalties
  - Amounts over the Allowed Amount
- After satisfaction of the deductible, the Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, then the Plan will pay 100% of the Covered Charges for the remainder of the Benefit Year unless stated otherwise.

COVERED CHARGES

Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed under a service, the Benefit Year maximum is 60 days total which may be split between Network and Non-Network providers.

BENEFIT CATEGORY	PLAN PAYS	PLAN PAYS
Hospital Services (Inpatient)		
Room and Board Payment rate is the semiprivate room rate; or Hospital's ICU charge for Intensive Care Unit admission	80% after deductible	50% after deductible

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Emergency Room Visit		
Medical Emergency or Non-Emergency Includes services billed with an emergency room place of service. (Co-payment waived if confined under observation hours or admitted inpatient.)	Participant Pays: $200 co-payment, and 20% after Network deductible Plan Pays: 80% after co-payment and Network deductible	
Urgent Care Facility (Co-payment covers the visit. All other covered services rendered during the visit are subject to applicable Plan benefits.)	Participant Pays: $25 co-payment Plan Pays: 100% after co-payment	50% after deductible
Ambulatory Surgical Center/ Outpatient Hospital Surgery Facility/ Other Freestanding Outpatient Surgical Facility	80% after deductible	50% after deductible
Skilled Nursing Facility Benefit Year maximum limit: 90 days	80% after deductible	50% after deductible
Physician Services		
Inpatient visits	80% after deductible	50% after deductible
Primary Care Office Visits (Co-payment covers the office visit. All other covered services rendered during the visit are subject to applicable Plan benefits.)	Participant Pays: $25 co-payment Plan Pays: 100% after co-payment	50% after deductible
Specialist Office Visits (Co-payment covers the office visit. All other covered services rendered during the visit are subject to applicable Plan benefits.)	Participant Pays: $50 co-payment Plan Pays: 100% after co-payment	50% after deductible
Walk-in Retail Health Clinic/Convenience Care (Co-payment covers the office visit. All other covered services rendered during the visit are subject to applicable Plan benefits.)	Participant Pays: $25 co-payment Plan Pays: 100% after co-payment	50% after deductible
Surgery/ Anesthesia (Inpatient or Outpatient)	80% after deductible	50% after deductible
Allergy Office Visit and Injections (Co-payment covers the office visit and the allergy injection. All other covered services rendered during the visit are subject to applicable Plan benefits including - but not limited to - testing, serum and antigens.)	Participant Pays: $25 co-payment Plan Pays: 100% after co-payment	50% after deductible
Spinal Manipulation/ Chiropractic Care Benefit Year maximum limit: 20 visits (Co-payment covers the office visit and the manipulation. All other covered services rendered during the visit are subject to applicable Plan benefits.)	Participant Pays: $25 co-payment Plan Pays: 100% after co-payment	50% after deductible
Outpatient Diagnostic Testing Laboratory services performed in connection with the Allen County Wellness Program are Covered Charges reimbursed at 100% without deductible and are not applied toward the $300 first dollar benefit.	First $300 per Benefit Year paid at 100%; thereafter, 80% after deductible	50% after deductible

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Home Health Care	80% after deductible	50% after deductible
Hospice Care (Includes Bereavement Counseling)	80% after deductible	50% after deductible
Ambulance Service	80% after Network deductible	
Durable Medical Equipment	80% after deductible	50% after deductible
Hearing Aids • One hearing aid per ear every three (3) Benefit Years limited to $1,500 per aid. • Four additional ear molds per Benefit Year up to two (2) years of age. *(See "Part II Medical Benefits-Audiology Services" for a complete description of this benefit.)*	80% after Network deductible	
Medical/Surgical Supplies	80% after deductible	50% after deductible
Outpatient Rehabilitation Services		
Occupational Therapy	80% after deductible	50% after deductible
Physical Therapy	80% after deductible	50% after deductible
Speech Therapy Benefit Year maximum limit: 90 daily services limited to one (1) service per day	80% after deductible	50% after deductible
Cardiac Rehabilitation	80% after deductible	50% after deductible
Pulmonary Rehabilitation	80% after deductible	50% after deductible
Respiratory Therapy	80% after deductible	50% after deductible
Neuropsychological Testing	80% after deductible	50% after deductible
Orthotics	80% after deductible	50% after deductible
Prosthetics	80% after deductible	50% after deductible
Mental Disorders and Substance Abuse Treatments		
Inpatient	80% after deductible	50% after deductible
Outpatient Visits (Co-payment covers the office visit. All other covered services rendered during the visit are subject to applicable Plan benefits.)	Participant Pays: $25 co-payment Plan Pays: 100% after co-payment	50% after deductible

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Preventive Care Services		
Preventive Care Services Preventive Care includes such services as an annual exam, mammogram, Pap smear, PSA screening, colorectal cancer screening, immunizations, sterilization procedures for women, and preventive x-ray and lab screenings. (See "Covered Charges/Preventive Care Services" in this Benefit Description for a complete list of preventive Covered Charges.)	100% deductible waived	50% after deductible
Well Newborn Nursery Care (Care while the newborn is confined after birth. Charged to the Plan of the newborn.)	80% after deductible	50% after deductible
Preventive Eye Exam (Includes refractions) Benefit Year maximum limit: one (1) exam	100% deductible waived	
Preventive Hearing Exam Benefit Year maximum limit: one (1) exam	100% deductible waived	
Pediatric Preventive Dental Exam Benefit Year maximum limit: one (1) exam *See :Part VII Dental Benefits" for additional information about dental benefits for all ages*	***Ages birth to 19 years*** 100%, deductible waived	
Surgical Sterilization (Reversals Excluded) When performed by a Network provider, sterilization procedures for women are covered at 100% without cost-sharing.	Based on type of service and place of service	Based on type of service and place of service
Organ Transplants Pre-certification required	80% after deductible	Not Covered Transplants must be received at a Transplant Network Center of Excellence
Pregnancy	Based on type of service and place of service	Based on type of service and place of service
Pregnancy benefits include prenatal, delivery, and post-partum care. Services are for routine Pregnancy and complications of Pregnancy. Prenatal obstetrical visits and certain laboratory services are covered at 100%, no cost-sharing, when performed by a Network provider. Such services as x-ray, sonograms and delivery expenses are subject to the applicable co-payment, deductible, and co-insurance. See also "Covered Charges/ Preventive Care Services" for additional information regarding preventive care Pregnancy benefits.		
Infertility Benefits	Based on type of service and place of service	Based on type of service and place of service
Includes care, supplies and services for the diagnosis of the medical condition causing infertility and charges for surgical correction of physiological abnormalities of infertility. Assisted Reproductive Technology is excluded.		
All Other Covered Charges	80% after deductible	50% after deductible

PRESCRIPTION DRUG CARD
BENEFITS SCHEDULE

<table>
<tr><th rowspan="2">PRESCRIPTION DRUG CATEGORY</th><th>NETWORK PROVIDERS</th><th>NON-NETWORK PROVIDERS</th></tr>
<tr><th>COVERED PERSON PAYS:</th><th>PLAN PAYS</th></tr>
<tr><td colspan="3">Acute Retail Medications (Up to a 30 day supply)</td></tr>
<tr><td>Generic Drugs
Includes Insulin, Byetta and Symlin</td><td>$10 co-payment</td><td rowspan="3">Reimbursement is at the Network Allowed Amount for the drug. You may have higher out-of-pocket expenses if you use a Non-Participating Pharmacy.</td></tr>
<tr><td>Formulary Drugs</td><td>$30 co-payment</td></tr>
<tr><td>Non-Formulary Drugs</td><td>$60 co-payment</td></tr>
<tr><td>Specialty Drugs</td><td>20% of the Allowed Amount up to $250 per script</td><td>Not available</td></tr>
<tr><td colspan="3">Maintenance Medications - MedTrak Performance 90 Pharmacy and Mail Order (Up to a 90 day supply)</td></tr>
<tr><td>Generic Drugs</td><td>$20 co-payment</td><td rowspan="3">Not Available</td></tr>
<tr><td>Formulary Drugs</td><td>$60 co-payment</td></tr>
<tr><td>Non-Formulary Drugs</td><td>$120 co-payment</td></tr>
</table>

Generic Program

If a Generic equivalent is available, then that equivalent is the benefit. If the patient, for whatever reason, demands the more expensive branded product be dispensed, the patient pays in addition to the appropriate co-pay, the difference in cost between the Generic and Brand Name Drugs. The difference in cost will not be used to satisfy any out-of-pocket maximum amount.

Contraception and Sterilization Agents

All Generic Food and Drug Administration ("FDA") approved contraception and sterilization agents for women are covered at 100% without cost-sharing when purchased at a Network Pharmacy. If a Generic drug is available and the patient or Physician, for whatever reason, requests a Brand Name drug, the patient will pay the applicable Formulary or Non-Formulary co-payment. If a Generic is not available, then the contraception or sterilization agent is covered at 100% without cost-sharing when purchased at a Network

Pharmacy. If a compelling medical reason exists, the Claims Administrator may approve an alternative Brand Name Drug.

Maintenance Medications

Performance 90 Program

Select retail Pharmacies in the MedTrak Network are designated as Performance 90 Pharmacies. These Pharmacies provide 90-day fills for maintenance medications (those that are taken for long periods of time) at reduced costs. When purchasing maintenance medications from a retail Pharmacy, use a Performance 90 Pharmacy to obtain the lowest cost and greater out-of-pocket savings. Contact MedTrak Services via phone at (800) 771-4648, or use their on-line look-up at www.medtrakservices.com, to locate Performance 90 Pharmacies near you.

Mail Order Drug Benefit

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time). Purchasing medications through the mail is easy, convenient and offers the best discounted price. For instruction on how to purchase Prescription Drugs through the Mail Order program or online, refer to the prescription packet provided at enrollment, visit the Pharmacy Benefit Manager's website, or contact them via phone for more information.

90/91 Day Packaged Products at Retail

Certain medications are packaged and sold in 90/91 day supplies. These medications - usually contraceptives and 90-day Estrogen - are subject to one co-payment for each 90 day supply. Generic contraceptives are covered at 100% without cost-sharing when purchased at a Network Pharmacy.

Compound Medications

Compound medications are medications whose ingredients have been combined, mixed or altered to create a medication tailored to the needs of an individual patient. Compound medications are subject to a Formulary co-payment.

Vaccines

Certain Pharmacies in the MedTrak Services Network administer vaccines and such vaccines are Covered Charges without cost-sharing. The type of vaccine available is limited; talk to your Pharmacy to learn more about its vaccine capabilities. Contact MedTrak Services at the phone number listed on the Covered Person's identification card to find out which Pharmacies participate in the MedTrak Services Network.

Specialty Drugs

Specialty Drugs means high-cost, complex pharmaceuticals (usually injectable) that have unique clinical, administration, distribution, or handling requirements that are not commonly available in traditional community and mail-order Pharmacies.

Non-Network Pharmacies

After obtaining a prescription at a non-network pharmacy or failing to show your ID card at a participating pharmacy, you may be required to submit a claim to obtain reimbursement. If so, you must obtain a Pharmacy claim form from the Pharmacy Benefit Manager, complete the form, and submit it - along with the prescription receipt - to the Pharmacy Benefit Manager. The Pharmacy Benefit Manager will process the claim and reimburse you in accordance to the Plan.

The Allowed Amount is limited to the Network Allowed Amount. You may have higher out-of-pocket costs if a Prescription Drug is purchased from a Non-Network provider. The amount over the Allowed Amount will not be used to satisfy any out-of-pocket maximum amount.

Contact MedTrak Pharmacy Services at (800) 771-4648 to locate participating Pharmacies, find out more about a specific drug, and how to use the Mail Order program. This information may also be available at www.medtrakservices.com.

DENTAL BENEFITS SCHEDULE

Medical and Dental Benefits are independent. If dental coverage is desired, you must elect dental coverage on the enrollment form that is provided to you by the Plan Administrator. If you do not elect dental coverage, you are not a Covered Person for Dental Benefits.

BENEFIT CATEGORY	PERCENTAGE PAYABLE BY THE PLAN
Class I Services – Preventive	100%
Class II Services – Basic	80%
Class III Services – Major	50%
Class IV – Orthodontia Services	Not Covered
MAXIMUM AMOUNT PAYABLE PER BENEFIT YEAR	
Per Covered Person Maximum payable for Classes I, II and III Services combined	$2,000

The dental out-of-pocket amount does not accumulate toward the medical out-of-pocket.

PART II - MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

CO-PAYMENT

A co-payment is the amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services and other services will not have any co-payments. Medical co-payments accrue toward the Total Out-of-Pocket shown in the Schedule of Benefits.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Benefit Year a Covered Person must meet the deductible shown in the Schedule of Benefits. Typically, there is one deductible amount per Plan. Deductible amounts accrue toward the Total Out-of-Pocket shown in the Schedule of Benefits.

Deductible Three Month Carryover. Covered Charges incurred in and applied toward the deductible in January, February and March will be applied toward the deductible in the next Benefit Year.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Benefit Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Benefit Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Benefit Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the percentages shown in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Each Benefit Year, Covered Charges are payable at the percentages shown in the Schedule of Benefits until the out-of-pocket maximum limit is met. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Benefit Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Benefit Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person for Essential Health Benefits during the Benefit Year.

ORDER OF CLAIMS DETERMINATION

Many times claims for covered services are not submitted in the same order the covered services are provided. Regardless of the order claims are incurred, the deductible and percentage payable will be applied to covered services in the sequence that claims are submitted and ready for payment.

COVERED CHARGES

Covered Charges are the Allowed Amounts that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

A. **Hospital Care.** The medical services and supplies furnished by a Hospital, Medical Care Facility, or Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 48 observation hours, a confinement will be considered an inpatient confinement. Observations in excess of 48 hours require pre-certification as an inpatient stay. Pre-certification penalties may apply if observation exceeds 48 hours.

Room charges made by a Hospital having only private rooms will be paid at the private room rate.

If a private room is assigned at the Covered Person's request, then the reimbursement is at the semi-private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

B. **Coverage of Pregnancy.** Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a Covered Person. The Plan covers the obstetrical and delivery expenses of the birth mother of a child adopted or placed for adoption within ninety (90) days of birth of such child. See "Preventive Care Services" under this section for additional information regarding coverage for prenatal obstetrical visits and certain laboratory services.

C. **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

1. the patient is confined as a bed patient in the facility; and

2. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

3. the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

D. **Physician Care.** The professional services of a Physician for surgical or medical services.

1. Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

2. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the charge that is allowed for the primary procedures; 50% of the charge will be allowed for each additional procedure performed through the same

incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

3. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowed Amount for that procedure; and

4. If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 25% of the surgeon's Allowed Amount.

E. **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

1. **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

2. **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

F. **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Covered Charges for Home Health Care Services and Supplies are payable as described in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by a nurse or four hours of home health aide services. Therapies are subject to the Outpatient Rehabilitation Services benefit as shown in the Schedule of Benefits.

G. **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the patient's death.

H. **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

1. Services, supplies, care or treatment in connection with an **abortion** when the life of the mother is endangered by the continued Pregnancy, the Pregnancy is the result of rape or

incest, or a fetal or chromosomal abnormality exists which was diagnosed prior to the abortion.

If complications arise after the performance of any abortion, any expenses incurred to treat those complications will be eligible, whether the abortion was eligible or not.

2. Local Medically Necessary professional land or air **ambulance** service as shown in the Schedule of Benefits. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

3. **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

4. **Audiology Services.** Hearing and balance assessment services furnished by a Physician or audiologist. Technicians or other qualified staff may furnish those parts of a service that do not require professional skills under the direct supervision of Physicians. Audiological diagnostic testing refers to tests of the audiological and vestibular systems including - but not limited to – hearing, balance, auditory processing, tinnitus and diagnostic programming of auditory prosthetics devices. Coverage includes tubing required to properly re-fit a hearing aid due to the person's physiological change and for which a charge is normally made by the provider. See also "Hearing Aids" in the Schedule of Benefits for certain limitations. Batteries are excluded and not covered by the Plan.

Hearing aids are amplifying devices that compensate for impaired hearing. Hearing aids include air conduction devices that provide acoustic energy to the cochlea via stimulation of the tympanic membrane with amplified sound. Cochlear implants, auditory brainstem implants and osseiointegrated implants are prosthetic devices. See also "Prosthetics".

5. **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

6. Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

7. **Clinical Trial.** Regardless of the Experimental and Investigational nature of the Approved Clinical Trial itself, coverage will be provided for all routine patient care costs associated with the provision of healthcare services, including drugs, items, devices, treatments, diagnostics, and services that would otherwise be covered if those drugs, items, devices, treatments, diagnostics and services were not provided in connection with an Approved Clinical Trial program for cancer or other diagnoses that are life threatening or severely and chronically disabling that have failed to respond with conventional treatments. Services covered will include those health care services typically provided to patients not participating in a clinical trial.

Excluded are:

a. The costs of the investigational drugs or devices themselves, or the costs of any non-medical services that might be required for the Covered Person to receive the treatment or intervention.

b. Healthcare services that, except for the fact that they are being provided in a clinical trial are otherwise specifically excluded from coverage under the policy or certificate.

c. Transportation and/or lodging costs incurred while receiving such treatment.

8. Initial **contact lenses** or glasses required following a Medically Necessary surgical procedure to the eye.

9. **Contraceptive injections and devices** administered in an office setting including Municipal Health Department and family planning clinic. The office visit for planning purposes, fitting, and implantation or administration of the injection or device is included. See also "Preventive Care Services" and "Prescription Drug Card Benefits" for more information about women's contraceptive and sterilization benefits.

10. **Diabetic Supplies, Equipment and Self-Management Programs** as described:

All Physician prescribed Medically Necessary and appropriate equipment and supplies used in the management and treatment of diabetes; and

Diabetes Outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with gestational, Type I and Type II diabetes.

For Covered Persons with diabetes who have documented peripheral vascular disease and/ or peripheral neuropathy, the Plan will cover one (1) pair of orthopedic shoes and two (2) pair of associated shoe inserts per Covered Person per Benefit Year as deemed Medically Necessary and ordered by a Physician.

11. Hemodialysis/Peritoneal **dialysis** treatment of a kidney disorder as an inpatient in a Hospital or Medical Care Facility, in an Outpatient dialysis facility, or in the Covered Person's home including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces inpatient or Outpatient dialysis treatments, the Plan will consider rental (or purchase as the case may be) of dialysis equipment and expendable Medical Supplies for use in the Covered Person's home. The dialysis equipment is subject to the Durable Medical Equipment benefit as shown in the Schedule of Benefits. The expendable Medical Supplies are subject to the Medical/Surgical Supplies of the Plan.

<u>Outpatient Dialysis Services</u>

The Allowed Amount for a Covered Person's first forty (40) renal dialysis visits, cumulative and not subject to annual reset, are subject to the applicable Plan deductible, co-insurance, or co-payment as shown in the Schedule of Benefits. Additional visits are subject to the applicable Plan deductible, co-insurance, or co-payment as shown in the Schedule of Benefits up to a maximum of 150% of the national Medicare allowed amount, adjusted for the geographic wage index.

If a Covered Person has End-Stage Renal Disease ("ESRD"), the Plan's medical programs primary status applies during the first 30 months of dialysis, or the first 30 months of treatment in connection with a transplant. Thereafter, Medicare generally becomes the primary payer of benefits.

The Medicare Secondary Payer statute requires the Plan to identify Covered Persons in the Plan, including Dependents, who are eligible for Medicare, including those eligible based on ESRD. To ensure the correct coordination of claims payments, Covered Persons are required to provide the Plan the basis for their eligibility to Medicare (age, ESRD, or disability) and the effective date of Medicare Part A and Part B.

During the period where the Plan has primary status, Medicare Part B monthly premiums for Covered Persons and their Dependents that have become entitled, including dually entitled, to Medicare based on ESRD, will be covered by the Plan. Reimbursement for monies withheld by Medicare from Social Security, Railroad Retirement, or Office of Personnel Management payments will be made at the end of each calendar quarter.

12. Rental of **Durable Medical Equipment** if deemed Medically Necessary subject to the following:

a. The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury; and

b. These items may be bought rather than rented. Prior approval is required before the purchase of any Durable Medical Equipment. But in no case will the Plan pay rental past the purchase price (oxygen equipment is not limited to the purchase price). Any amount paid to rent the equipment will be applied towards the purchase price; and

c. Benefits will be limited to standard models, as determined by the Plan; and

d. The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medically Necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan; and

e. If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repair or replacement due to abuse or misuse, as determined by the Plan Sponsor, is not covered.

Excluded are:

a. Home traction units.
b. Equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility.
c. Equipment designed to provide the walking capability for individuals with non-functioning legs.

13. Human Growth Hormones.

14. Care, supplies and services for the diagnosis of the medical condition causing **infertility** and charges for surgical correction of physiological abnormalities of infertility. Assisted Reproductive Technology (ART) whether by chemical or mechanical means is not covered. Additionally, travel costs, donor eggs or semen and related costs including collection, preparation and storage are not covered.

15. Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

16. **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

17. Prophylactic **Mastectomy** or **Oophorectomy** (ovary removal surgery). Even though a current cancer diagnosis does not exist, risk-reducing surgery will be considered the same as any other Illness when there is an increased risk of breast or ovarian cancer, when a documented family history exists of breast or ovarian cancer, or when genetic testing demonstrates the existence of the cancer risk.

18. **Medical/Surgical Supplies.** Covered Charges for Medically Necessary Medical and Surgical Supplies. This includes gradient compression stockings and gradient compression wraps with a Physician's written order. These items may commonly be called anti-embolism, custom, circular knit, flat-knit, silver, or lymphedema compression stockings.

Excluded are:
Gradient Compression stockings or wraps used for athletic purposes, and
Support stockings, usually those with less than 18 mmHg, sold over the counter.

19. Treatment of **Mental Disorders and Substance Abuse**. These benefits may not be less than the benefits required under federal mental health and substance abuse parity requirements. All treatment is subject to the benefit payment shown in the Schedule of Benefits.

20. Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges if that care is for the following oral surgical procedures:

a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

b. Emergency repair due to Injury to sound natural teeth. This includes replacement of natural teeth lost due to an Injury.

c. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

d. Excision of benign bony growths of the jaw and hard palate.

e. External incision and drainage of cellulitis.

f. Incision of sensory sinuses, salivary glands or ducts.

g. Removal of impacted teeth.

h. X-rays related to above services.

i. General anesthesia for covered oral surgery.

j. Facility Charges determined to be Medically Necessary for dental care, and provided to the following persons:
1.) Covered Dependent Children five years of age or under; or

2.) A Covered Person who is severely disabled; or

3.) A Covered Person who has a medical or behavioral condition, which requires Hospitalization or general anesthesia when dental care is provided.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

21. **Nutritional Supplements** which are Physician prescribed or other enteral supplementation necessary to sustain life including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) including over-the-counter nutritional supplements is a Covered Charge when prescribed by a Physician. Over-the-counter nutritional supplements or infant formulas – other than for treatment of PKU - will not be considered eligible even if prescribed by a Physician. Rental or purchase of equipment is subject to the Durable Medical Equipment benefit shown in the Schedule of Benefits. The supplements are subject to the Medical/Surgical Supplies as shown in the Schedule of Benefits.

22. **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, Maintenance Therapy or supplies used in occupational therapy.

23. **Organ transplant limits**. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ, bone marrow or tissue transplant are subject to these limits:

a. The transplant must be performed to replace an organ, bone marrow or tissue.

b. The transplant must be a human-to-human organ, bone marrow, or tissue transplant.

c. All other conventional means of treatment have been unsuccessful in treating the condition.

d. The condition is covered by the Plan.

e. The Covered Person is obligated to pay for the transplant; it is not covered by a government agency or transplant program.

f. The transplant is not considered Experimental and/or Investigational.

g. The transplant including the patient evaluation for the transplant is provided through a Center of Excellence designated by a Transplant Network for the type of transplant to be received. Transplants received outside of a Transplant Network Center of Excellence are excluded.

The Transplant Network is a specialized network(s) of providers who are contracted with the Plan to provide transplant services. The Plan Sponsor has the discretionary authority to determine the Transplant Network(s). Covered Charges will be reimbursed at the PPO Network level subject to the Transplant Network negotiated rate. The Transplant Network rate supersedes any PPO Network discount.

The following charges for obtaining donor organs, marrow or tissue are Covered Charges under the Plan: **(i)** evaluating the organ, marrow or tissue; **(ii)** removing the organ,

marrow or tissue from the donor; and **(iii)** transportation of the organ, marrow or tissue from within the United States and Canada to the place where the transplant is to take place.

If the recipient is a Covered Person under this Plan but the donor is not, then this Plan will cover the donor's charges as those of the recipient. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan.

If both the donor and the recipient are Covered Persons under this Plan, eligible expenses incurred by each person will be treated separately for each person.

If the recipient is not a Covered Person under this Plan, then the donor's charges are not covered under this Plan.

When the transplant is performed:

- **a.** Reasonable travel and **lodging expenses** for the patient and one caregiver will be reimbursed at 100%. Lodging does not include the patient's room and board while hospital confined.
- **b.** The plan will allow up to $75 per day in miscellaneous travel expenses to cover the cost of **meals** for the patient and caregiver combined.
- **c.** The Plan Sponsor has the discretionary authority to determine when travel and lodging **expenses** are reasonable.

Excluded is the purchase price of any bone marrow, organ, tissue, or any similar items, which are sold rather than donated and transplants which are not medically recognized and are Experimental and/or Investigational in nature.

24. The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. In all cases, repair or replacement due to abuse or misuse, as determined by the Plan Sponsor, is not covered.

Excluded are:

- **a.** Benefits are not payable for special or extra-cost convenience features.
- **b.** Foot only Orthotics except as described under "Diabetic Supplies, Equipment, and Self-Management Program".
- **c.** Over the counter shoe inserts or orthotic devices.

25. **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

26. **Podiatry.** Treatment for the following foot conditions: **(i)** bunions, when an open cutting operation is performed; **(ii)** toenails, when at least part of the nail root is removed; **(iii)** any Medically Necessary surgical procedure required for a foot condition.

27. **Prescription Drugs** (as defined). The Plan provides coverage for Outpatient Prescription Drugs through the Prescription Drug Card program. Medications administered in the Physician's office or other Medical Care Facility are Covered Charges under the Medical Benefits subject to the exclusions and limitations of the Plan.

28. The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts as shown in the Schedule of Benefits.

Replacement devices must be Medically Necessary due to growth, other physiological change, change in the Covered Person's condition, or deterioration of the device which renders repair unacceptable. Benefits are not payable for special or extra-cost convenience features. In all cases, repair or replacement due to abuse or misuse, as determined by the Plan Sponsor, is not covered. Dental plates, bridges, orthodontic braces, and dental prosthesis are excluded under this benefit and are not considered eligible expenses by the Plan.

Coverage is available for two (2) post-mastectomy bras per Covered Person per Benefit Year. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses.

The Plan covers Cochlear implants, auditory brainstem implants and osseiointegrated implants. Cochlear implants and auditory brainstem implants mean devices that replace the function of cochlear structures or auditory nerve and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays. Osseiointegrated implants mean devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer.

Benefits are also provided for penile prosthesis required for physiological (not psychological) impotence subject to advance approval by the Plan and only in the following situations: trauma, radical pelvic surgery, diabetes, Peyronie's Disease, vascular or neurological diseases when the individual situation warrants coverage in the Plan's opinion.

29. **Reconstructive Surgery.** Correction of a Congenital Abnormality, repair of damage from an accident or Illness, and reconstructive mammoplasties will be considered Covered Charges. This mammoplasty coverage will include reimbursement for:

- **a.** reconstruction of the breast on which a mastectomy has been performed,
- **b.** surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- **c.** coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas

in a manner determined in consultation with the attending Physician and the patient.

30. **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness.

31. **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. Physical medicine modalities including - but not limited to - correction or adjustment by manual; mechanical; electrical or physical means (including the use of light, heat, water or exercise) of structural imbalance; distortion; subluxation or misplaced tissue of any kind or nature of the human body. Coverage does not include nutritional supplements.

32. **Surgical Sterilization**. Reversal of sterilization is excluded. See "Preventive Care Services" in this section for additional information regarding women's contraceptive and sterilization benefits.

33. **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

34. **Telehealth services** will be covered when interactive audio and video telecommunication is used instead of the Physician performing such service in a face to face setting with the Covered Person. Telehealth services will only be covered when the following criteria are met:

a. The Covered Person must be present for services at an originating site located in a rural health professional shortage area or non-metropolitan statistical area. Originating sites include rural hospitals, critical access hospitals, rural health clinics, federally qualified health centers, or the office of a licensed Physician or health care practitioner; and

b. The Covered Person must be attended by a Health Professional.

c. The only Physicians at the distant site who may furnish and receive payment for telehealth services are Physicians, ARNPs, physician assistants, psychologists, clinical social workers and registered dieticians.

Limitation:

The only services eligible to be offered through telehealth services are consultations, office visits, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end stage renal disease related services, and individual medical nutrition therapy.

Excluded are:

a. Consultations performed through the use of telephone, fax, or e-mail communications.
b. Consultations utilizing asynchronous "store and forward" technology.
c. Origination site fees and technical component fees.

35. Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to routine nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn.

Charges for Routine Physician Care. The benefit is limited to the charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn.

36. Diagnostic **x-rays**.

I. Preventive Care Services. See the table below:

General Preventive Health Services	
Abdominal Aortic Aneurysm Screening	Limited to ultrasonography in men who have ever smoked ages 65 to 75 years, one time only.
Alcohol Misuse Screening and Counseling	Screening for and counseling to reduce alcohol misuse. Brief behavioral counseling interventions available for persons who engage in risky or hazardous drinking. Does NOT include care, treatment, or services for alcohol or substance abuse.
Aspirin Use	Limited to the following ages: • Female: 55 to 79 years • Men: 45 to 79 years *Requires Physician's written order. Available through Prescription Drug Card, see "Part VI - Prescription Drug Card Benefits".*
Blood Pressure Screening	Available for all persons as an integral part of an annual exam.
Colorectal Cancer Screening	Limited to adults ages 50 to 75 years. If family history of colorectal cancer is present, age limitation does not apply. Limited to: • Fecal occult blood testing • Sigmoidoscopy, or • Colonoscopy. *Colorectal cancer screening performed in connection with a diagnosis or treatment of a medical condition is not considered a preventive care service.*
Depression Screening	Available for all persons.
Diabetes (Type 2) Screening	Limited to asymptomatic persons ages 18 and older with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
Healthy Diet Counseling	Counseling for a healthy diet when a person has hyperlipidemia or other known risk factors for cardiovascular and diet related chronic disease. Intensive counseling may be delivered by a Physician or Specialist working within the scope of his or her license such as a licensed nutritionist or dietician.
Falls Prevention	Limited to: • Exercise or physical therapy that is provided by a licensed health care provider, and • Vitamin D supplementation in community-dwelling adults ages 65 and older who are at increased risk for fall. *Vitamin D supplementation requires Physician's written order. Available through Prescription Drug Card, see "Part VI - Prescription Drug Card Benefits".*
Hepatitis B Screening	Available to: • Persons at increased risk • Pregnant women
Hepatitis C Screening	Available for persons with high risk for infection and a one-time screening for persons born between 1945 and 1965.

HIV Screening	Available to: • Persons ages 15 to 65 • Younger adolescents and older adults who are at increased risk • Pregnant women including those who present in labor who are untested and whose HIV status is unknown
Immunization Vaccines	Standard vaccinations are covered as recommended by the Center for Disease Control. Vaccinations for overseas travel are excluded.
Lung Cancer Screening	Limited to once per Benefit Year with low-dose computed tomography in adults ages 55 to 80 years.
Obesity Screening and Counseling	Available for persons. Intensive, multicomponent behavioral counseling intervention is available for persons with a body mass index of 30/kg/m^2 or higher.
Preventive Exam/Routine Physical	Limited to once per Benefit Year.
Preventive Laboratory Services	Limited to once per Benefit Year.
Prostate Cancer Screening	Limited to once per Benefit Year.
Sexually Transmitted Infection (STI) Counseling	High-intensity behavioral counseling to prevent sexually transmitted infections is available for all sexually active persons.
Skin Cancer Behavioral Counseling	Counseling to minimize exposure to ultraviolet radiation to reduce risk for skin cancer limited to ages 10 to 24 years.
Syphilis Screening	Available for all sexually active persons.
Tobacco Use Screening and Interventions	Tobacco use screening is completed when the clinician obtains the patient's lifestyle history. Tobacco cessation interventions are available for persons who use tobacco products. Interventions are: • Smoking cessation products, such as Chantix, limited to 2 cessation attempts per Benefit Year, • Education, • Brief counseling to prevent the initiation of tobacco use in school-age children, or • Augmented, pregnancy-tailored counseling for pregnant women who smoke. *Smoking cessation products require Physician's written order. Available through Prescription Drug Card, see "Part VI - Prescription Drug Card Benefits".*

Preventive Health Services for Women

See also "General Preventive Health Services" for additional preventive health services covered by this Plan.

Anemia Screening	Available for asymptomatic pregnant women.
Bacteriuria Screening	Screening for asymptomatic bacteriuria with urine culture for pregnant women.
BRCA Risk Assessment and Genetic Counseling/Testing (BRCA 1 and BRCA 2)	Available for women who have family members with breast, ovarian, tubal, or peritoneal cancer. Women with a positive result may receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast Cancer Mammography Screening	Limited to once per Benefit Year. *A mammogram performed in connection with a diagnosis or treatment of a medical condition is not considered a preventive care service.*

Breast Cancer Preventive Medications	Women at increased risk for breast cancer may receive counseling from their Physician about risk-reducing medications. Preventive Care Services includes coverage for the risk-reducing medication in women who are at increased risk for breast cancer and low risk of adverse medication effects such as tamoxifen and raloxifene.
Breastfeeding Comprehensive Support and Counseling	Coverage is limited to comprehensive lactation (breastfeeding) support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for breastfeeding equipment. • Breast pumps for post-partum women are limited as follows: o One manual or electric breast pump purchase per delivery is covered. o Benefit available after participant is delivered of the baby. o Breast pumps come with certain supplies, such as tubing, shields, and bottles. All supplies are excluded (i.e. creams, nursing bras, bottles, replacement tubing for breast pump). o Breast pumps must be purchased from a participating DME vendor. o Hospital grade breast pumps are excluded and not covered.
Cervical Cancer Screening	Limited to women once per Benefit Year.
Chlamydia Infection Screening	Available for women.
FDA-Approved Contraception Methods, Sterilization Procedures, and Contraceptive Counseling	Available for women as follows: Education and counseling related to contraceptives and sterilization. Surgical sterilization (hysterectomies are excluded). Contraceptive methods (devices and associated procedures), such as device removal, and pharmaceutical contraceptives for women with reproductive capacity. • OTC Contraceptives: female condoms, sponges, spermicides, emergency contraception • Cervical Caps • Diaphragms • Injections • Implantable Rods • IUDs • Oral contraceptives (generic only unless a generic is not available or compelling reason exists for the patient's use of a brand name product) • Trans-dermal contraceptives • Vaginal rings *Many contraceptive products are available through the Prescription Drug Card and require Physician's written order. See "Part VI - Prescription Drug Card Benefits".*
Folic Acid Supplementation	Folic Acid supplementation is available for women of child-bearing age. *Requires Physician's written order. Available through Prescription Drug Card, see "Part VI - Prescription Drug Card Benefits".*

Gestational Diabetes Screening	Limited to pregnant women who are asymptomatic for diabetes.
Gonorrhea Screening	Available for all sexually active women.
Human Papillomavirus (HPV) DNA Test	Limited to ages 30 years and older once every 3 Benefit Years.
Intimate Partner Violence Screening and Intervention	Available for women of childbearing age who do not have signs or symptoms of abuse including domestic violence. Includes intervention services for women who screen positive.
Osteoporosis Screening	Available for women beginning at age 60 or younger if there is an increased risk.
Rh Incompatibility Screening	Available for women. If screening is positive, RH incompatibility treatment is a Preventive Care charge.
Well Woman Visit	Annual preventive care visit to obtain recommended preventive services that are age and developmentally appropriate including preconception counseling and prenatal obstetrical office visits. Several visits may be needed to obtain all necessary recommended preventive services. *Services such as delivery, x-rays, ultrasounds, facility charges, and medications associated with pregnancy are NOT part of this Preventive Care Benefit.*
Preventive Pediatric Health Services (Birth to age 21 years)	
See also "General Preventive Health Services" for additional preventive health services covered by this Plan.	
Physical Examination	Age-appropriate physical examination for preventive pediatric health. Each exam may include a medical history and body measurements: length/height/weight, head circumference, weight for length, body mass index, and blood pressure. Some of the assessments and screenings listed below may also be integral parts of the exam.
Developmental/Behavioral Assessments	
Alcohol and Drug Use Assessments	Available to children to 21 years.
Autism Screening	Available to children to 21 years.
Behavioral/Psychosocial Assessments	Available for children to 21 years
Depression Screening	Available to children to 21 years.
Developmental Screening	Available to children to 21 years.
Developmental Surveillance	Available to children to 21 years.
Procedures	
Newborn Blood Screening	Limited to newborns using the Recommended Uniform Newborn Screening Panel as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children and state newborn screening laws/regulations.
Cervical Dysplasia Screening	Available for sexually active females.
Critical Congenital Heart Defect Screening	Limited to newborns using pulse oximetry.
Hematocrit or Hemoglobin Screening	Available to children to 21 years.
Hemoglobinopathies or Sickle Cell Screening	Limited to newborns.
Hypothyroidism Screening	Limited to newborns.
Phenylketonuria (PKU) Screening	Limited to newborns.
Lead Screening	Limited to: Birth up to 21 years of age.
Tuberculin Test	Available to children to 21 years.

Other Services	
Chemoprevention of Dental Caries	Limited to: • Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption, and • Oral fluoride supplementation for children ages 6 months through 4 years of age. *Oral fluoride requires Physician's written order. Available through Prescription Drug Card, see "Part VI - Prescription Drug Card Benefits".*
Gonorrhea Prophylactic Medication	Limited to newborns.
Hearing Loss Screening	Limited to newborns.
Iron Supplements	Available for children ages 6 months to age 12 months. *Requires Physician's written order. Available through Prescription Drug Card, see "Part VI - Prescription Drug Card Benefits".*
Oral Health Risk Assessment	Available for children birth through age 10.
Sensory Screening – Vision	Available for all children. Generally, part of a well-child visit.
Sensory Screening – Hearing (beyond newborn screening)	Available for all children. Generally, part of a well-child visit.
Visual Acuity Screening	Limited to visual acuity screening for children between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors.

Mammograms

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

a. If the mammogram is performed in connection with the diagnosis or treatment of a medical condition and the provider properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the Plan dealing with diagnostic x-rays.

b. If the Covered Person is at high risk of developing breast cancer or has a family history of breast cancer and the provider properly files the claim with this information, the claim will be processed as a preventive procedure according to the benefit provisions of the Plan's Preventive Care Services.

In all other cases the claim will be subject to the provisions described for Preventive Care Services.

Colorectal Cancer Screenings

Benefits for colorectal cancer screenings vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

a. If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition and the provider properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the Plan dealing with surgical procedures. If a polyp is removed during the course of a preventive colonoscopy, the colonoscopy procedure, removal of the polyp, and the charges for pathological examination of

the specimen are considered under the Plan's Preventive Care Services.

b. If the Covered Person has a family history of colon cancer and the provider properly files the claim with this information, the claim will be processed as a preventive procedure according to the benefit provisions of the Plan's Preventive Care Services.

In all other cases the claim will be subject to the provisions described for Preventive Care Services.

The Plan intends to comply with the Affordable Care Act. Preventive Care Services may be added without notification. Contact the Claims Administrator if you have questions about these benefits.

PART III - COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Covered Person's ID card for the name of Cost Management Services and their phone number.

The provider, patient, family member or authorized representative must call this number to receive certification of certain Cost Management Services. This call must be made in advance of services being rendered or within three (3) business days after a Medical Emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Pre-certification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalization
Inpatient Substance Abuse or Mental Disorder treatments
Skilled Nursing Facility stays

After 48 observation hours, a confinement will be considered an inpatient confinement. Observations in excess of 48 hours require pre-certification as an inpatient stay. Pre-certification penalties may apply if observation exceeds 48 hours.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

Pre-certification is the process of obtaining Medically Necessary certification. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Pre-certification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **in advance of the date** the services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, authorized representative, Medical Care Facility or attending Physician must contact the utilization review administrator **within three (3) business days** after the admission.

The utilization review administrator will determine the Medically Necessary number of days of Medical Care Facility confinement or use of other listed medical services. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive pre-certification for inpatient admissions as explained in this section, the benefit payment will be reduced by $250 per confinement.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

POST-SERVICE CLAIM REVIEW

The Plan reserves the right to conduct claim review to ensure that appropriate billing and coding guidelines are applied to Covered Charges. This includes - but is not limited to - guidelines as stipulated by the Centers for Medicare and Medicaid, the American Medical Association, and the Federal Register. Code edits including - but not limited to - reductions and/or denials based on the aforementioned guidelines may be applied.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if first and second opinions are contradictory) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if first and second opinions are contradictory) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;
(2) related to the condition which causes the confinement; and
(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable at the applicable deductible and co-insurance even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;
-- contacting the family to offer assistance and support;
-- monitoring Hospital or Skilled Nursing Facility;
-- determining alternative care options; and
-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

PART IV - DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Affordable Care Act means the "Patient Protection and Affordable Act" enacted on March 23, 2010 and any amendments thereto.

Allowed Amount means the amount that the Plan determines to be the maximum amount payable for a service or supply provided. For services provided by Network Providers, the Allowed Amount is a negotiated amount that the Network Providers have agreed to accept as payment in full for services received by a Covered Person. For services received from providers who are not participating in the network, the Plan will either limit the amount it allows for Covered Charges to the lesser of (i) the provider's billed charge or (ii) an amount equal to 120% of the current Medicare allowable fee for the appropriate area, as such information is made publicly available. The Plan Administrator may, in its discretion, elect to issue an additional payment, in an amount not to exceed 150% of current Medicare allowable fees for the appropriate area, as such information is made publicly available, if doing so is found to be in the best interest of the Covered Person. If there is no corresponding Medicare reimbursement rate for a charge from a non-network provider, the Allowed Amount will be an amount which is Usual and Customary, and Reasonable and Appropriate. The Covered Person is responsible for payment of deductibles, copayment/coinsurance amounts and non-covered services.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Approved Clinical Trial means a phase I, II, III or IV trial which is:

- **(1)** Conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, and
- **(2)** Is one of the following:
  - **(a)** Federally funded**,** or
  - **(b)** Is either:
    - **i** Conducted under an investigational new drug application (IND)reviewed by the Food and Drug Administration, or
    - **ii** A drug trial that is exempt from the IND application requirements.

Assisted Reproductive Technology (ART) means any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transport, selective reduction, and cryo-preservation.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Congenital Abnormality is a medical condition that existed at birth and is diagnosed within the first five years of life.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person means an Eligible Individual and his/her Dependents who satisfy the eligibility conditions and has entered the Plan.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means a drug, device, medical treatment or procedure that meets any of the following protocols:

(1) The drugs or dosages, devices, equipment, services, supplies, tests or medical treatment or procedures (generally, individually or collectively called ("Regimens")) have not received final approval from the U.S. Food and Drug Administration for the lawful marketing of the Regimens for the specific Injury or Illness to be treated.

(2) The Regimens have not received the approval or endorsement of the American Medical Association (AMA) for the specific Injury or Illness to be treated.

(3) The Regimens have not received the approval or endorsement of the National Institutes of Health (NIH) or its affiliated institutes for the specific Injury or Illness to be treated.

(4) The Regimens are to be or are being used or studied in proposed or ongoing clinical research or clinical trials as evidenced by an Informed Consent or treating facility's protocol; or are part of a proposed or ongoing Phase I, II, or III clinical trial; or are the subject of proposed or ongoing research or studies to determine their dosage, safety, toxicity, efficacy, or their efficacy as compared to other means of treatment or diagnosis.

(5) The opinion of medical or scientific experts (as reflected in published reports or articles in medical and scientific literature; or the written protocol(s) used by the treating facility or other facilities studying substantially the same or similar drugs, devices, services, supplies, tests, treatments or other facilities studying substantially the same or similar drugs, devices, services, supplies, tests,

treatments or procedures) indicates that further studies, research, or clinical trials of the Regimens are necessary to determine their dosage, safety, toxicity, efficacy, or their efficacy as compared to other means of treatment or diagnosis.

(6) The Regimens have not been proven effective for the specific Injury or Illness as of the date the treatment is provided.

Except,

(7) A drug shall not be considered Experimental and Investigational if all of the following criteria are satisfied:

(a) The drug is approved by the U.S. Food and Drug Administration regardless of the Injury, Illness or diagnosis; and

(b) The drug is appropriate and is generally accepted for the condition being treated by two of the following:

(i) American Hospital Formulary Service Drug Information;

(ii) National Comprehensive Cancer Network's (NCCN) Drugs & Biologics Compendium;

(iii) Thomson Micromedex DrugDex;

(iv) Elsevier Gold Standard Clinical Pharmacology.

Family Unit is the covered Participant and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; Medical Supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include Inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is a legally operated institution which meets at least one of these tests:

- **(1)** Is accredited as a Hospital under the Hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
- **(2)** Is a Hospital, as defined, by Medicare, which is qualified to participate and eligible to receive payments in accordance with the provisions of Medicare, or
- **(3)** Is supervised by a staff of Physicians, has twenty-four (24) hour-a-day nursing services, and is primarily engaged in providing either:
  - **(a)** General Inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control, or
  - **(b)** Specialized Inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under this definition) or with a specialized provider of these facilities.
  - **(c)** A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health, if it meets all of the requirements set forth in clause (a) other than the major surgery requirement.
  - **(d)** A free-standing treatment facility, other than a Hospital, whose primary function is the treatment of Alcoholism or Substance Abuse provided the facility is duly licensed by the appropriate governmental authority to provide such service, and is accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Hospital Association.

In no event will the term "Hospital" include a nursing home or an institution or part of one which:

- **(1)** Is primarily a facility for convalescence, nursing, rest, or the aged, or
- **(2)** Furnishes primarily domiciliary or custodial care, including training in daily living routines, or
- **(3)** Is operated primarily as a school.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means. It does not include disease or infection (unless it's pus-producing infection that occurred from an accidental cut or wound); hernia; or injuries caused by biting or chewing.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure, or that

are provided during periods when the medical condition of the patient is not changing, or does not require continued administration by medical personnel.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments, or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medical/Surgical Supplies means items for medical use other than drugs, Prosthetic or Orthotic Appliances, Durable Medical Equipment, or orthopedic footwear which have been ordered by a Physician in the treatment of a specific medical condition and which are usually:

(1) Consumable;
(2) Non-reusable;
(3) Disposable;
(4) For a specific rather than incidental purpose; and
(5) Generally have no salvageable value.

Medically Necessary means care and treatment is recommended or approved by a Physician (or Dentist, with regard to dental care); is consistent with the patient's condition or accepted standards of good medical (and dental practice) care; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical (and dental) services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Municipal Health Department means a local health department serving a municipality that meets the requirements of State public health laws and regulations.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthotic Appliance is an external device intended to correct any defect in form or function of the human body.

Outpatient is treatment including services, supplies and medicines provided and used at a Hospital, Medical Care Facility, or Birthing Center under the direction of a Physician to a person not admitted as a registered bed

patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prosthetic Device means a device which replaces all or part of a missing body organ and its adjoining tissue, or replaces all or part of the function of a permanently useless or malfunctioning organ. Prosthetic Devices do not include devices such as eyeglasses, hearing aids, orthopedic shoes, arch supports, Orthotic Devices, trusses, or examinations for their prescription or fitting.

Reasonable and Appropriate means an amount of Covered Charges that is identified as eligible for payment by the Plan Administrator in accordance with the terms of the Plan. These amounts may be determined and established by the Plan, at the Plan Administrator's discretion, using normative data such as, but not limited to, the fee(s) which the provider most frequently charges the majority of patients for the service or supply, amounts the provider most often agrees to accept as payment in full either through direct negotiation or through a preferred provider organization network, average wholesale price, and/or manufacturer's retail pricing, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, rates negotiated with the Plan, and/or Medicare reimbursement rates. Medicare rates plus 20% are generally considered to be the Reasonable and Appropriate (and thus maximum payable amount, however, the Plan Administrator may in its discretion, taking into consideration specific circumstances and negotiated terms, deem a greater amount to be payable, up to 150% of Medicare rates. For purposes of defining "Reasonable and Appropriate," the terms(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, person or organizations rendering such treatment, services, or supplies for which a specific charge is made.

Reasonable and Appropriate claims shall be limited to those claims that, in the Plan Administrator's discretion, are services or supplies or fees for services or supplies that are necessary for the care and treatment of Illness or Injury not unreasonably caused by the treating provider. The determination whether fee(s) or services are Reasonable and Appropriate will be made by the Plan Administrator, taking into consideration such factors as, but not limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) the Food and Drug Administration. To be Reasonable and Appropriate, services(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable and Appropriate. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable and Appropriate based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Appropriate.

Reconstructive Surgery means surgery that is incidental to an Injury, Illness, or Congenital Abnormality when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such surgery as cosmetic when a physical impairment exists, and the surgery restores or improves function. The fact that a Covered Person may suffer psychological consequences, or socially avoidant behavior as a result of an Injury, Illness, or Congenital Abnormality does not classify surgery done to relieve such consequences or behavior as Reconstructive Surgery.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

Specialist means a Physician who concentrates on medical activities in a particular specialty of medicine, based on education and qualifications. A Specialist is not a General Medicine Practitioner, Internal Medicine Practitioner, Pediatrician, Family Practice Physician, Obstetrician, Gynecologist, Mental Health or Substance Abuse Practitioner.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means that due to Sickness or Injury a Participant is not able to work at any job for pay or profit and is not able to engage in the normal activities of a person of like age and gender in good health; for a Child, Total Disability means the complete inability as a result of an Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Facility means a facility location, distinct from a Hospital emergency room, an office, or a clinic,

whose purpose is to diagnose and treat Illness or Injury for unscheduled, ambulatory patients seeking immediate medical attention.

Usual and Customary ("U&C") means an amount of Covered Charges that is identified as eligible for payment 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. For purposes of defining "Usual and Customary," 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" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred. The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale. The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted), nor does it necessarily refer to the specific service or supply furnished to a Covered Person 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 using normative data such as, but not limited to, Medicare cost-to-charge ratios, average wholesale price for prescriptions. and/or manufacturer's retail pricing for supplies and devices.

Walk-in Retail Health Clinic/Convenience Care means a walk-in health clinic, other than an office, Urgent Care Facility, Pharmacy or independent clinic and not described by any other Place of Service code adopted by the Centers for Medicare and Medicaid Services that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.

PART V - PLAN EXCLUSIONS

Note: All exclusions related to the Prescription Drug Card are shown in the "Part VI - Prescription Drug Card Benefits" section. All exclusions related to dental benefits are shown in "Part VII – Dental Benefits".

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

A. **Alternative medicine,** including - but not limited to - biofeedback, aromatherapy, naturopathy, and homeopathic and holistic treatment or acupuncture/acupressure and hypnosis.

B. **Autopsies.**

C. **Chelation therapy**, except for acute arsenic, gold, mercury or lead poisoning.

D. **Communication Devices.** Charges for communication devices designed and used for enhancing or enabling communication except for an electrolarynx.

E. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

F. **Counseling Services** and treatment related to relational problems, anti-social behavior, academic or phase-of-life problems, religious counseling, marital/relationship counseling, vocational or employment counseling and sex therapy.

G. **Court Ordered testing or rehabilitation.** Charges for court ordered testing or rehabilitation are not covered. Testing and rehabilitation are not covered if a Covered Person arranges in lieu of conviction, to undergo care or treatment as an alternative to, or in addition to, a fine or imprisonment

H. **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

I. **Dental Care.** Care, treatment for dental services unless specifically stated.

J. Surgical treatment of scarring secondary to acne or chickenpox to include, but not to be limited to, **dermabrasion, chemical peel, salabrasion, and collagen injections**.

K. **Educational, recreational and vocational testing, training or therapy** services or any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies, except as may be required by applicable law. See "Covered Charges" for diabetic self-management.

L. **Evaluations and diagnostic tests** ordered or requested in connection with determinations of paternity, divorce, child custody, or child visitation proceedings.

M. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowed Amount.

N. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

O. **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

P. **External Defibrillators.** External Defibrillators which require the assistance of a third party for operation.

Q. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also excluded are lenses for the eyes and exams for their fitting. This exclusion for lenses does not apply to:

1. Intraocular lens following Medically Necessary surgical procedure of the eye,
2. Aphakic patients,
3. Soft lenses or sclera shells intended for use as corneal bandages, and
4. Initial contact lenses or initial lenses for glasses following a Medically Necessary surgical procedure of the eye.

See "Preventive Care Services" for more information about preventive vision services.

R. **Foot orthotics.** Foot orthotics including any casting or fitting charges.

S. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law. Also, this exclusion does not apply to Covered Charges rendered through the United States Veteran's Administration for non-service related Illness or Injury.

T. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

U. **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

V. **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

W. **Infertility.** Care, supplies and services for infertility except as stated.

X. **Maintenance Therapy.**

Y. **Massage Therapy.** Charges for or related to massage therapy sessions.

Z. **Milieu therapy.** Milieu therapy or any confinement in an institution primarily to change or control one's environment.

AA. **Mouth, teeth and gum.** Care and treatment for mouth, teeth and gum whether considered medical or dental in nature except a specifically stated by the Plan.

BB. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

CC. **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital, Medical Care Facility, or Skilled Nursing Facility against medical advice.

DD. No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

EE. No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

FF. Not specified as covered. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan. These services include, but are not limited to, missed appointments, completion of claim forms, professional charges for travel expenses, mileage, traveling time, telephone calls, or for services provided over the telephone. Excluded also are Physician's fees for any treatment, which is not rendered by or in the physical presence of a Physician except as described by Telehealth Services.

GG. Obesity/Morbid Obesity. Care and treatment of obesity, weight loss or dietary control. Specifically excluded are charges for bariatric surgery, including - but not limited to - gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. This exclusion does not apply to obesity/ Morbid Obesity screening, counseling and interventions specified as preventive care (see "Preventive Care Services").

HH. Occupational. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

II. Personal comfort items. Personal comfort items or other equipment including - but not limited to - air conditioners, air-purification units, humidifiers, dehumidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, hot tubs, pools, hypo-allergenic pillows, power assist chairs, railings, ramps, waterbeds, non-prescription drugs and medicines, first-aid supplies, and non-hospital adjustable beds regardless of a Physician's written order, recommendation or reason the item is to be used.

JJ. Plan design excludes. Charges excluded by the Plan design as mentioned in this document.

KK. Radioactive contamination. Radioactive contamination or the hazardous properties of nuclear materials.

LL. Relative giving services. Professional services performed by a person who is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

MM. Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

NN. Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

OO. Sex changes. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

PP. Sexual dysfunction. Charges for treatment of sexual dysfunction except as specifically stated.

QQ. Sleep disorders. Care and treatment for sleep disorders unless deemed Medically Necessary.

RR. Smoking cessation. Care and treatment for smoking cessation programs, including smoking deterrent products, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

SS. Training. Charges for orthoptics, vision training, vision therapy or subnormal vision aids.

TT. Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician. This exclusion does not apply to ambulance charges defined as a Covered Charge and travel and lodging as specifically stated for organ transplants.

UU. War. Any loss that is due to a declared or undeclared act of war.

PART VI - PRESCRIPTION DRUG CARD BENEFITS

Pharmacy Drug Charge

Participating Pharmacies have contracted with the Pharmacy Benefit Manager to charge Covered Persons reduced amounts for covered Prescription Drugs under the Plan. Refer to the Covered Person's identification card for the name of the Pharmacy Benefit Manager, telephone number and website address.

If a drug is purchased from a non-participating Pharmacy, the amount payable in excess of the amounts shown in the Schedule of Benefits will be the ingredient cost and dispensing fee.

Co-payments

The co-payment is applied to each covered Pharmacy drug or Mail Order drug charge and is shown in the Schedule of Benefits. The co-payment amount accumulates toward medical Total Out-of-Pocket amount.

Covered Prescription Drugs

(1) All legend drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one legend drug ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

(5) Smoking Cessation products.

(6) Vaccines. Limitations may apply by Pharmacy.

Under the Affordable Care Act, certain medications are covered by the Plan without cost-sharing. These medications are subject to change without notification. Following is a list of medications available without cost-sharing when prescribed by a Physician and purchased with the Prescription Drug Card:

(1) Aspirin for men from ages 45 up to 79.
(2) Aspirin for women from ages 55 up to 79.
(3) Folic acid supplementation for women of childbearing age.
(4) Oral fluoridation supplementation for Children 6 months of age up to 6 years.
(5) Iron supplementation for Children 6 months of age up to 13 months of age.
(6) Tobacco deterrents by prescription only (limitations may apply).
(7) Contraception and sterilization agents (limitations may apply).
(8) Vitamin D2 and D3 products and calcium Vitamin D <1,000 IU limited to ages 65 and older.
(9) Bowel Preps from age 50 up to age 76. (Bisacodyl, Mag Citrate, Milk of Magnesia, PEG 3350-Electrolyte.)
(10) Risk-reducing medications for breast cancer in women who are at increased risk and at low risk for adverse medication effects such as tamoxifen or raloxifene. Limitations may apply.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

The Plan Administrator reserves the right to review medications for coverage or exclusion by the Plan. Contact the Pharmacy Network listed on the Covered Person's identification card for more information about prescription drug coverage by the Plan.

This benefit will not cover a charge for any of the following:

(1) **Abortifacient.** A charge for any drug or medication used to cause/induce an abortion.

(2) **Administration.** Any charge for the administration of a covered Prescription Drug. This exclusion does not apply to the Pharmacy charge for the administration of vaccines.

(3) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription and vitamins D & K with prior authorization.

(4) **Biological sera**, antigens, blood or blood plasma, parenterals and radiologicals.

(5) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(6) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(7) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(8) **Erectile Dysfunction drugs.** Drugs used to treat erectile dysfunction.

(9) **Experimental.** Experimental drugs and medicines as defined by the Plan, even though a charge is made to the Covered Person.

(10) **FDA.** Any drug not approved by the Food and Drug Administration.

(11) **Infertility.** A charge for infertility medication.

(12) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(13) **Investigational medications as defined by the Plan.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(15) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(16) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(17) **Other Exclusions.** Such other exclusions selected by the Plan Sponsor and applied by the Pharmacy Benefit Manager pursuant to the implementation documents of the Plan, which may be updated on an annual basis. For information related to specific exclusions, please contact the Pharmacy Benefit Manager.

Prescription Drugs purchased with the drug card are not eligible for secondary coverage including coverage under Medicare Part D. The Plan will not coordinate benefits or consider deductibles, co-payments, or other out-of-pocket expenses that are the responsibility of the Covered Person under another plan.

Prior authorization is required for any Prescription Drug costing $750 or more per script.

PART VII - DENTAL BENEFITS

Dental Benefits apply when dental Covered Charges are incurred by a Covered Person. All benefits described in this Dental Benefits section are subject to the exclusions and limitations described more fully herein including - but not limited to – the Plan Administrator's or delegated party's determination that: care and treatment is Medically Necessary; charges are the Allowed Amount; services, supplies and care are not Experimental and/or Investigational. The meanings of certain capitalized terms are in the Core Documents "Definitions" section and the "Defined Terms" section of this Benefit Description.

BENEFIT PAYMENT

Each Benefit Year, benefits will be paid to a Covered Person for the dental charges at the percentages shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Amount Payable.

MAXIMUM BENEFIT AMOUNT

The Maximum Amount Payable for dental benefits is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Allowed Amount charged by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. A charge will be considered to be incurred:

(1) For Dentures or partials – on the date the impression is taken;
(2) For fixed Bridgework, Crowns, Inlays or onlays – on the date the tooth or teeth are prepared and final impressions are made;
(3) For root canal therapy – on the date the pulp chamber is opened and explored; and
(4) For all other services – on the date the service is performed.

ORDER OF CLAIMS

If a service is covered by both the Medical and Dental Benefits, the Medical Benefits are considered first. The Allowed Amount for Dental Benefits is considered after the Medical Benefits.

COVERED DENTAL SERVICES

Class I Services: Preventive Dental Procedures

The limits on Class I Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams. This includes the cleaning, polishing, and scaling of teeth. Limit of two exams per Covered Person each Benefit Year.

(2) Dental imaging services required to treat or diagnose diseases or abnormalities of the teeth, surrounding tissue, and cavity detection, including those provided in association with a covered dental implant limited as follows:
  (a) Bitewing x-ray series limited to twice per Benefit Year,
  (b) One full-mouth x-ray limited to once in every three (3) Benefit Year period.

(3) One fluoride treatment each Benefit Year limited to Covered Persons under age 23.

(4) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children age 5 through age 17 years, once per tooth in any four (4) Benefit Years.

(5) Space maintainers for covered Dependent children under age 19 to replace primary teeth.

Class II Services: Basic Dental Procedures

(1) Problem focused exams.

(2) Endodontics (root canals).

(3) Periodontics (gum treatments).

(4) All other dental imaging services as deemed dentally appropriate.

(5) Extractions. This service includes local anesthesia and routine post-operative care.

(6) General and local anesthetics, upon demonstration of Medical Necessity.

(7) Diagnostic casts, laboratory tests and other diagnostic exams.

(8) Biopsy and examination of oral tissue.

(9) Fillings, other than gold.

(10) Emergency palliative treatment for pain.

(11) Inlays, other than gold.

(12) Antibiotic drugs.

(13) Surgery of the bony structure supporting the teeth.

Class III Services: Major Dental Procedures

(1) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.

(2) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(3) Dental Implants.

(4) Installation of crowns.

(5) Onlays.

(6) Installing precision attachments for removable dentures.

(7) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during a six-month period following the installation.

(8) Addition of clasp or rest to existing partial removable dentures.

(9) Initial installation of fixed bridgework to replace one or more natural teeth.

(10) Rebasing or relining of removable dentures.

(11) Re-cementing bridges, crowns or inlays.

(12) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The replacement or addition of teeth is required because of one or more natural teeth being extracted.
(b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
(c) The existing denture is of an immediate temporary nature.

(13) Repair of crowns, bridgework and removable dentures.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause, which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment, which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Bone grafts.** Bone grafts for alveolar ridge augmentation.

(3) **Broken appointments.** Charges for broken or missed dental appointments.

(4) **Chemotherapeutic agent(s).** Chemotherapeutic agent(s) inserted into a periodontal pocket.

(5) **Cosmetic Dentistry.** Facings on crowns or pontics beyond the second bicuspid are considered cosmetic, except for Injuries or Medically Necessary care and treatment of cleft lip and palate.

(6) **Crowns for teeth that are restorable** by other means or for the purpose of Periodontal Splinting.

(7) Services related to: **equilibration, bite registration or bite analysis**.

(8) **Excluded under Medical.** Services that are listed as excluded under Medical Benefits section of the Plan.

(9) Home Sealant Kits.

(10) Hospital, healthcare facility or medical emergency room charges.

(11) Oral hygiene, plaque control programs or dietary instructions.

(12) Orthodontic Services.

(13) Orthognathic surgery. Surgery to correct malpositions in the bones of the jaw.

(14) Patient education services.

(15) Personalization of dentures.

(16) Recall visits for checking sealant application.

(17) Replacement of lost or stolen appliances.

(18) Replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items. This exclusion does not apply if replacement is required because of an accidental bodily Injury.

(19) Services which are **not included** in the list of covered dental services.

(20) Splinting. Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

(21) Charges for the treatment of Temporal Mandibular Joint dysfunction **(TMJ).**

(22) Temporary or Provisional dental services and procedures including – but not limited to – Provisional Crowns, Provisional splinting, interim complete or partial Dentures.