PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR THE

HOUSING BENEFITS PLAN

EFFECTIVE DATE OF THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION:

January 1, 2018

TABLE OF CONTENTS

Page

INTRODUCTION 3

Your Role In Controlling Health Care Costs 4

ELIGIBILITY FOR COVERAGE 5

General Eligibility Provisions 5
Eligible Employees 5
Retirees 6
Eligible Dependents 7
Age Limitation for Eligible Dependent Children 7
Initial Eligibility Date 7
Coverage Election 8
Open Election/Enrollment Period 8
Enrollment Rules 8
Special Enrollment Periods 8
Qualified Medical Child Support Orders 10
Participant Eligibility 11
Participant Effective Date 12
Participant Termination 12
Participant Reinstatement 13
Dependent Eligibility 13
Dependent Effective Date 14
Dependent Termination 14

UTILIZATION MANAGEMENT SERVICE (UMS) 15

Second Opinions 17
Case Management Program 17
Specialty Care Benefit 17

MEDICAL EXPENSE BENEFITS 18

Comprehensive Major Medical Benefits 18
Preferred Provider Benefit (PPO) 18
Overall Maximum Benefit for All Benefits 18
Schedule of Medical Benefits 19
Premier PP`O Plan 19
Premier Partial PPO Plan 22
Value PPO Plan 25
Out-of-Area Plan 28
Coinsurance and Deductible 30
Medical Expense Covered Charges 31

OUTPATIENT PRESCRIPTION DRUG CARD BENEFIT 40

Covered Services 40
Benefit Payment for Prescription Drugs 40

DENTAL EXPENSE BENEFITS 42

Schedule of Dental Benefits 42
Covered Dental Expenses 42
Preventive Services 43
Restorative Services 43
Major Services 43
Orthodontic Services 44
Benefits After Termination 45
Dental Expense Exclusions and Limitations 45

GENERAL PLAN EXCLUSIONS AND LIMITATIONS 46

TABLE OF CONTENTS (continued)

DEFINITIONS **51**

COORDINATION OF BENEFITS PROVISION **67**

COORDINATION WITH MEDICARE **71**

FIRST AND/OR THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT **73**

PRIVACY STANDARDS **76**

SECURITY PRACTICES **78**

CLAIM PROCEDURES **79**

COBRA CONTINUATION COVERAGE **87**

STATEMENT OF ERISA RIGHTS **93**

GENERAL PLAN INFORMATION **94**

GENERAL PROVISIONS **96**

YOUR RIGHTS UNDER FEDERAL LAW **103**

- Newborns' and Mothers' Health Protection Act of 1996 (The Newborn's Act) 103
- Women's Health and Cancer Rights Act of 1998 (WHCRA) 103
- Family and Medical Leave Act (FMLA) 103
  - FMLA Eligibility 104
  - Notice of FMLA Leave 104

INTRODUCTION

The Housing Benefits Plan (herein referred to as "the Plan") has been established by the Plan Sponsor for your benefit, on the terms and conditions described in this Plan Document and Summary Plan Description.

This document is both the Plan Document and the "Summary Plan Description" or SPD required by ERISA. It has been written for your use and understanding of the broad range of benefits available to you and your Dependents under this Plan. This document is effective as of 12:00 a.m. on January 1, 2018, and is intended to replace all previously distributed materials. Any word or phrase that is capitalized in this document has a special meaning and is defined for you in the "Definitions" section or within the document.

This Plan is a self-funded plan with a Claims Administrator. The Plan Administrator is responsible for all claim decisions. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to the Claims Administrator; however, the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

The benefits of this Plan are only a part of the comprehensive employee benefits program provided for you, and are offered as tangible recognition of your contribution to your Contributing Employer's success. The Plan is designed to protect you and your Family against catastrophic health care expenses by providing reimbursement for the great majority of Covered Expenses.

This Summary Plan Description is intended to give you, our employee, a general understanding of your benefits in MOST situations; particularly the areas of most interest and concern to you. In order to provide you and your family with an explanation of our benefits plan that is both readable and comprehensive, this booklet is condensed, and not every aspect of our benefits are covered here. If you do not understand the language used in this booklet, contact your Human Resources Department for assistance. During our business hours, you may ask for more specific information on coverage, exclusions, and limitations or ask questions concerning any other area of our benefit plan. We do ask that you please read this booklet thoroughly before bringing your questions in; they may be explained to your satisfaction in this booklet.

The Plan includes a Preferred Provider Organization (PPO) Network. A current list of PPO providers is available, without charge, through the PPO web site noted on your Plan I.D. card.

Each person covered by this Plan has a free choice of any physician or surgeon, and the physician-patient relationship will be maintained. The patient, together with their physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

Verification of Benefits

A claim cannot be guaranteed until all necessary information is received and reviewed. Such information includes but is not limited to the diagnosis and codes, the exact treatment plan and codes, the dates of service, information necessary to confirm Medical Necessity and appropriate treatment patterns, and eligibility. We need to assure that the treatment is covered and not excluded or limited in some way.

Any verification of benefits given to a provider, Plan participant or other party, in writing or orally, in person or by telephone, **is not a guarantee of payment under the Plan**.

Claims Incurred upon this written or oral advice may not be payable and, if determined to be not payable under the Plan, will become your responsibility.

Your Role In Controlling Health Care Costs

Making choices about your health can sometimes be difficult. When you seek health care, take the same approach you use for buying anything else. Ask questions. Make sure you get the most appropriate care for your Condition. Use the following guidelines to help you be a wise health care consumer:

Practice Good Health Habits

Staying healthy is the best way to control your medical costs. Eat a balanced diet, exercise regularly and get enough sleep. Learn how to handle stress. Avoid smoking and excessive use of alcohol.

See Your Doctor Early

Don't let a minor problem become a major one. This makes treatment more difficult and expensive.

Make Sure You Need Surgery

If your Physician recommends Surgery, get a second opinion if you're unsure about the Surgery you face. If you need Surgery, ask about same day Surgery. Many procedures can be performed safely without a Hospital stay. You have these Surgeries as an Outpatient or at a place other than a Hospital and go home the same day.

Use Outpatient Services for X-ray or Laboratory Tests

Outpatient preadmission and diagnostic tests can save costly Room and Board charges.

Compare Prescription Drug Prices

Discuss the use of Generic Drugs with your doctor or pharmacist. Generic Drugs are often less expensive than Brand-Name Drugs for the same quality.

Consider Hospital Stay Alternatives

Home health care, nursing facilities and Hospice care services offer quality care in comfortable surroundings for less cost than staying in the Hospital.

Review Medical Bills Carefully

Make sure you understand all charges and receive itemized bills for all services you receive. Keep your medical records up-to-date.

Talk to Your Doctor

Discuss the need for treatment with your doctor. It's your body. To make wise health care decisions, you must understand the treatment and any risks or complications involved. Ask about treatment costs too. With today's health care costs, your doctor will understand your concerns about your medical expenses.

Be a wise health care consumer. Review your benefits carefully so you can make informed health care decisions. You can help control health care costs while getting the most your health care plan has to offer.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan will be in accordance with the eligibility, effective date and termination provisions of this Summary Plan Description.

Any change in the coverage available to you or your Dependents due to a change in your classification will become effective automatically on the classification change date.

If provided under your Contributing Employer's policy, your coverage will be continued during an approved leave of absence, disability or temporary layoff. However, in no event will this coverage be continued for longer than six months or, if sooner, the date the Contributing Employer ends the continuance. While continued, coverage will be that which was in force on the last day you were actively at work. However, if benefits are changed or reduced for others in the class, your benefits will also be changed or reduced.

Regardless of the established leave policies mentioned above, the Plan will at all times comply with the Family and Medical Leave Act of 1993 ("FMLA"). During any leave taken under FMLA, your coverage will be maintained under this Plan on the same conditions as coverage would have been provided if you had been continuously employed during the entire leave period.

General Eligibility Provisions

Eligible Employees

Employees eligible for Plan coverage (hereafter referred to as "Eligible Employees") are all common-law Employees of a Contributing Employer who are regularly scheduled to work a minimum of 20 hours per week and satisfy any additional requirements (if applicable) as may be defined, and communicated to the employee, by his/her Contributing Employer.*

The following Employees are not eligible to participate in the Plan:

1. Employees regularly scheduled to work fewer than 20 hours per week;
2. Except as otherwise eligible pursuant to the Employer Shared Responsibility rules, Employees who are hired on a temporary basis, with the classification temporary meaning any Employee hired to fill a job vacancy for a limited time, as designated by the Plan Administrator. Such determination shall be made in accordance with the rules set forth in Treasury Regulation Section 54.4980H-1(49)(ii)(A);
3. Except as otherwise eligible pursuant to the Employer Shared Responsibility rules, Employees who are hired on a seasonal basis, with the classification seasonal meaning hired to fill a job vacancy related to or occurring during a particular season, as designated by the Plan Administrator. Such determination shall be made in accordance with the rules set forth in Treasury Regulation Section 54.4980H-1(38);
4. Leased employees, as defined in Code section 414(n);
5. Employees in an employee unit covered by a collective bargaining agreement between Employee representatives and one or more Contributing Employers if this Plan's benefits were the subject of good faith bargaining between the Employee representatives and the Employer, unless such agreement provides for coverage for such bargaining employees in the Plan; and
6. Nonresident aliens who receive no earned income (with the meaning of Code section 911(d)(2)) from an Employer that constitutes income from sources within the United States, as defined in Code section 861(a)(3).

Applicable to Housing Authorities with 50 or More Full-Time Equivalents

If you are not reasonably expected to meet the eligibility requirements of this Plan when you are initially hired, your eligibility for medical coverage will be subject to the Initial Measurement and Initial Stability Periods prescribed by the Shared Responsibility for Employers Regarding Health Coverage rules under § 4980H of the Internal Revenue Code, enacted by the Affordable Care Act. Ongoing employees will also be subject to Standard Measurement and Standard Stability Periods prescribed by those same rules.

Specific details on timing and duration of each Measurement and Stability Period, including both Initial periods for new hires and Standard periods for ongoing employees are communicated to employees in new hire and open enrollment materials, as well as in the Plan's SPD.

To the extent that these eligibility rules do not address a specific eligibility issue, a Contributing Employer hall have discretion to make eligibility determinations consistent with applicable law and regulations, including special rules for changes in employment status and special unpaid leaves of absence in Treas. Reg § 54.4980H.

*Failure of the Contributing Employer to properly communicate its additional eligibility requirements to its employees will waive any eligibility requirement additional to paragraph (A).

Retirees

To be eligible to make self-contribution payments for retiree and retiree dependent benefits, the retiree must meet the following requirements:

1. The retiree must be an Eligible Employee who terminated employment and receives retirement income either from his/her Contributing Employer or as a result of service with his/her Contributing Employer, and is qualified to receive the monthly primary insurance amount stated to be payable to him or her under the Federal Social Security Act. (A person must be at least 62 years of age to meet this definition); or

2. The retiree must be an Eligible Employee who terminated employment and who is at least 55 years of age and who was employed by his or her present Housing Authority for at least 10 consecutive years.

A retiree who meets either of the above qualifications will be considered an "Eligible Retiree" under this Plan.

Should a Contributing Employer cease to participate in this Plan, Eligible Retirees who were former employees of that Contributing Employer will no longer be eligible to participate in this Plan.

Eligible Retirees are eligible for retiree coverage immediately following the date they retire from Active Service or exhaust their COBRA coverage.

If you are an Eligible Retiree, you will be provided with information regarding the premium amount and payment procedures when you retire. If you elect retiree coverage, coverage will be continued under the same plan option you were enrolled prior to retirement (plan options may be changed during the Open Election/Enrollment Period). Retiree coverage will continue until the earliest of the following dates:

1. Date of expiration of the last period for which you have made a timely payment of any required premium for coverage;

2. Date of your death;

3. Date on which a claim is denied in whole or in part because you have met or exceeded a lifetime limit on all benefits;

4. Date an Eligible Retiree's former Contributing Employer ceases to participate in this Plan; or,

5. Date the Plan is terminated, or with respect to any benefits of the Plan, the date of termination of such benefits.

Coverage for your Dependent(s) will automatically terminate on the date your coverage ends or, if sooner, the date a Dependent cease to be an eligible Dependent as defined in the following section.

Plan benefits will be coordinated as described in this Plan and, with regard to Medicare, as described in the section "Coordination With Medicare". You or your Dependent are not required to enroll in a Medicare Part D prescription drug plan as a condition for coverage under this Plan.

Note: *Retired employees and their Dependents will not be eligible at a later date if they initially decline retiree coverage or are not covered under the Housing Benefits Plan.*

Eligible Dependents

If you are an Eligible Employee you may elect to cover your eligible Dependents. An eligible "Dependent" is defined to mean:

1. Your legal spouse, as evidenced by a valid marriage certificate, who is a resident of the same country as you. Such spouse must be recognized under the laws of the state where you live. This will include common law marriage if recognized as a valid marriage in your state but does not include any other arrangements which may be recognized by the state in which you reside, including a civil union or domestic partnership. The Plan Administrator may require documentation proving your legal marital relationship.
2. Your child who is less than age 26 and who is:
    a. A natural child;
    b. A legally adopted child;
    c. A child who has been placed under your Legal Guardianship;
    d. A child for whom you are responsible by court decree for principal support or medical care; or,
    e. A step-child, provided you remain married to the child's natural parent.

    A Dependent child will continue to be eligible beyond age 26 if the child is mentally or physically handicapped and incapable of self-sustaining employment, unmarried and financially dependent upon you for support and maintenance. The child need not be covered under the Plan on the date the incapacitating handicap occurred. However, such Condition must have begun prior to the child's attainment of age 26, and must be of such severity as to incapacitate the child for an extended period of time. Proof of incapacity acceptable to the Plan Administrator must be furnished upon request and as may be required thereafter.
3. Any child who is placed with you under an interim court order prior to finalization of adoption.
4. Any children as required by a Qualified Medical Child Support Order (QMCSO).

The Plan Administrator may require documentation concerning a Dependent's relationship to you such as birth certificates or court orders.

Those situations specifically excluded from the definition of a "Dependent" are:

1. A spouse from whom you are legally separated by a court order;
2. A former spouse from whom you are legally divorced;
3. Any person on active military duty, unless otherwise required by law;
4. Any person covered under this Plan as an Eligible Employee;
5. Any person who is covered as a Dependent by another employee;
6. A Dependent child's spouse or child (unless a grandchild is placed under your Legal Guardianship);
7. Any other individual living in your home that is not eligible as defined in this provision.

Age Limitation for Eligible Dependent Children

A Dependent child is eligible until the end of the month in which he or she attains age 26 except as otherwise specified for a handicapped child in the section "Eligible Dependents".

Initial Eligibility Date

Your initial eligibility date for Plan coverage is the first day of the month following your first day of Active Service as an Eligible Employee or a date established by the Contributing Employer. In no event will any Contributing Employer establish the initial eligibility date for an Eligible Employee to exceed the first day of the month following 60 days of Active Service. In no event will an Eligible Employee be required to wait

more than 90 days to participate in the Plan. Active Service includes weekends, scheduled holidays and temporary short-term Illnesses. You will be deemed to be in Active Service if you are absent from work due to a health factor.

Written application for coverage, as required by the Plan, must be made within 31 days of your initial eligibility date.

Applicable to Housing Authorities with 50 or More Full-Time Equivalents

If your Contributing Employer uses the look-back measurement method for your job class and you are classified as a eligible full-time employee, your initial eligibility date for Plan coverage will be in compliance with the regulations relating to Code § 4980H of the Internal Revenue Code. Written application for coverage, as required by the Plan, must be made within 31 days of your initial eligibility date.

Coverage Election

Health coverage and dental coverage may be elected separately. Coverage elections are irrevocable and may be changed only during the Open Election/Enrollment Period or, if sooner, during a Special Enrollment Period.

Open Election/Enrollment Period

The Plan Administrator will designate an Open Election/Enrollment Period during the last quarter of each year. An enrollment or change in coverage made during the Open Election/Enrollment Period will become effective on January 1, provided such request is made by written application as required by the Plan.

Plan Participants will receive detailed information regarding Open Election/Enrollment from their Contributing Employer.

Enrollment Rules

You must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deductible authorization. Your completed application must be received by the Contributing Employer no later than 31 days of your initial eligibility date.

If you do not have eligible Dependents on the date your coverage begins, you must file your written application for Dependent Coverage within 31 days of the date you acquire your Dependent through marriage, birth, adoption, court order or decree. Once you are enrolled for Dependent Coverage, each newly acquired Dependent must also be enrolled within 31 days of the date your spouse or child becomes eligible. A newborn child is not automatically enrolled in this Plan regardless of whether you are enrolled for Dependent coverage.

If you are declining enrollment for yourself or your Dependents (including your spouse), you may in the future be able to enroll yourself or your Dependents in this Plan under the Special Enrollment Period rules defined in the following section or during the Open Election/Enrollment Period.

Special Enrollment Periods

This Plan provides Special Enrollment Periods that allow you and/or Dependents to enroll for coverage, even if coverage was previously declined.

Loss of Other Coverage

The Plan will permit you or your Dependent(s) who lose other coverage to enroll under the terms of the Plan if the following conditions are met:

1. You and your Dependent(s) are eligible for coverage under the terms of this Plan;

2. You or your Dependent already had other coverage when the Plan was previously offered;
3. If required by the Contributing Employer, you stated in writing at such time that another source of coverage was the reason for declining enrollment; and
4. a. Coverage was not under a COBRA continuation provision and was terminated as a result of:
   (1) A loss of eligibility for the coverage, other than Medicaid or State Child Health Insurance Plan. A "loss of eligibility" includes, but is not limited to, a loss that is a result of legal separation, divorce, death, termination of employment, reduction in hours of employment, a child ceasing to qualify as an eligible dependent under the other plan, or the coverage is no longer being made available to a class of similarly situated individuals. When coverage is through an HMO, a loss of eligibility will be deemed to occur when an individual no longer resides, lives or works in the HMO service area (whether or not within the choice of the individual) and no other benefit package is available to that person; or
   (2) Termination of all employer contributions towards such coverage.

   If you or your Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

   Coverage must be requested not later than 31 days after the loss of other coverage.

   b. The person was covered under COBRA continuation coverage which was exhausted and the person requested enrollment not later than 31 days after the end of the COBRA coverage.

Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received by the Contributing Employer, provided enrollment is requested within the required 31-day Special Enrollment period.

Acquiring a New Dependent

The Plan will permit a Special Enrollment Period for persons who become a Dependent through marriage, birth, adoption or placement for adoption. The Dependent Special Enrollment Period will be for 31 days following the actual event.

If you are eligible for enrollment, but not enrolled, you may also enroll at this time. In the case of the birth or adoption of a child, your spouse also may be enrolled as a Dependent, if your spouse is otherwise eligible for coverage but not already enrolled. If you enroll a Dependent during the 31-day Dependent Special Enrollment Period, coverage will become effective:

1. In the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
2. In the case of a Dependent's birth, as of the date of birth; or
3. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Medicaid or State Child Health Insurance Plan

The Plan will permit Special Enrollment if you or your Dependent(s) are eligible but not enrolled in the following circumstances:

1. Your coverage or your Dependent's coverage under Medicaid or a State Child Health Insurance Plan (i.e. CHIP) has terminated as a result of loss of eligibility and you request coverage under the Plan within 60 days after the termination; or

2. You or your Dependent become eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and you request coverage under the Plan within 60 days after eligibility is determined.

If you enroll during the 60-day Special Enrollment Period defined above, coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received by the Contributing Employer.

Qualified Medical Child Support Orders

The Plan Administrator will enroll for coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order or "National Medical Support Notice" (NMSN) that is a "Qualified Medical Child Support Order" (QMCSO) if such an individual is not already covered by the Plan as an eligible Dependent. Coverage will become effective on the first day of the month following the date the Plan Administrator has determined that such order meets the standards for qualification set forth below or upon the employee's completion of the eligibility Waiting Period, if later. If the employee is not currently enrolled in this Plan, the employee will also be enrolled as of such date.

"Alternate Recipient" means any child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient will be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient will have the same status as a Participant.

"Medical Child Support Order" means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Person's child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" means a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Person or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Person and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice will be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. a. Identifies either the specific type of coverage or all available group health coverage. If the Contributing Employer receives an NMSN that does not designate either specific type(s) of

coverage or all available coverage, the Contributing Employer and the Plan Administrator will assume that all are designated;

   b. Informs the Plan Administrator that, if a group health plan has multiple options and the Covered Person is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Covered Persons and eligible beneficiaries without regard to this section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator will, as soon as administratively possible:

1. Notify the Covered Person and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator will:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
   a. Whether the child is covered under the Plan; and
   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator will:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

Participant Eligibility

A Participant eligible for coverage under the Plan will include an individual who meets the following conditions:

1. Is employed by a Contributing Employer on a regular basis, is available to work the number of hours per week outlined in the General Eligibility Provisions, has been in Active Service for the initial eligibility period outlined in the General Eligibility Provisions and has begun work for the Contributing Employer;
2. Is a Participant who extends coverage under COBRA; or
3. Qualifies under other classifications, as stated in the General Eligibility Provisions.

If you are an Eligible Employee who becomes employed by a Contributing Employer after the effective date of the Plan, your initial date of eligibility is outlined in the General Eligibility Provisions.

If your Dependent(s) meet the Plan's definition of a Dependent you will become eligible for Dependent Coverage on the latest of the following:

1. The date you become eligible for Participant Coverage; or
2. The date on which you first acquire a Dependent or the Dependent first becomes eligible for coverage.

If both you and your spouse are employed by a Contributing Employer, either you or your spouse, (but not both) may elect Dependent Coverage. If you choose to enroll for coverage as your spouse's Dependent, you are not eligible to also enroll for Single Coverage. If there are no eligible children, you and your spouse may each elect Single Coverage. If coverage is terminated on one of the individuals, this coverage may be transferred to the remaining spouse's coverage without loss of any benefits or coverage.

The Plan Sponsor may make special eligibility arrangements for new or separating employees when necessary to serve a valid business purpose.

Participant Effective Date

Your Participant Coverage under the Plan will become effective at 12:00 a.m. on the date of your initial eligibility, provided written application for coverage is made **on or within 31 days of such date.** All Dependent Coverage under the Plan will commence at 12:00 a.m. on the date such coverage is effective.

Participant Termination

Your coverage will automatically terminate at 12:00 midnight upon the earliest of the following dates:

1. End of the month in which termination of your employment occurs;
2. End of the month in which you cease to be in a class eligible for coverage. This includes the death of a covered employee or termination of Active Service. It also includes an employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods;
3. Date of expiration of the last period for which you have made a contribution, in the event you fail to make any required contribution for coverage or you file a written election to discontinue coverage;

   Note: If you elect to make your contribution for coverage on a pre-tax basis under a Section 125 Plan, you will be allowed to discontinue coverage only if permitted in the Section 125 Plan.
4. End of the month corresponding to that calendar month for which a contribution by the employee's Contributing Employer was not made on the employee's behalf;
5. Date the Plan is terminated, or with respect to any Participant benefits of the Plan, the date of termination of such benefits.

Upon the termination of coverage, there is no extension of any benefits under this Plan for any reason unless specifically noted in the Plan. However, in certain circumstances, a covered employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled "COBRA Continuation Coverage".

Participant Reinstatement

A terminated employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements, unless otherwise stated in this section.

Applicable to Housing Authorities with 50 or More Full-Time Equivalents

You will be considered a new employee if you are returning to work as an Eligible Employee following a period of unpaid absence (including termination of employment) of 13 consecutive weeks or more.

A Contributing Employer will apply the rule of parity for a period of unpaid absence that is less than 13 weeks. Under the rule of parity, you will be treated as a continuing employee if the period with no credited Hours of Service is less than 4 weeks; or, is more than 4 weeks but less than your period of employment immediately before the period with no credited Hours of Service. For example, if you previously worked for the Contributing Employer for 6 years and you are rehired 12 weeks after terminating employment, you will be considered a continuing employee because the 12-week period does not exceed 13 weeks and is less than your prior 6-year period of employment. However, if you previously worked for the Contributing Employer for 6 weeks and you are rehired 10 weeks after terminating employment, you will be considered a new employee when you are rehired because the 10-week period exceeds your prior 6-week period of employment.

The Waiting Period defined under the General Eligibility Provisions will not apply if you are considered a continuing employee. If the Contributing Employer uses the look-back measurement method for your job class, you will be considered continuing in the Measurement Period and Stability Period that applied when the absence began.

Dependent Eligibility

A Dependent will be considered eligible for coverage on the date you become eligible for Dependent Coverage, subject to all limitations and requirements of this Plan, and in accordance with the following:

1. Newborn children will be eligible for coverage from the moment of birth for Injury or Illness, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, **provided you properly enroll the child as a Dependent within 31 days of the child’s date of birth.** This provision does not apply to nor in any way affect the normal maternity provisions applicable to the mother.

   Enrollment of a newborn child is required regardless of whether full Family coverage (including children) is in effect prior to the date of birth of the newborn. You must enroll a new Dependent within 31 days.

2. An adopted child will be eligible for coverage on the date the child is legally adopted or placed with you in anticipation of adoption, provided the child is properly enrolled as a Dependent within 31 days.

3. A spouse will be considered an eligible Dependent on the first day of the first month beginning on the date the completed request for enrollment is received, provided the spouse is properly enrolled within 31 days of the date of marriage. If an otherwise eligible spouse is not a resident of the same country as you, your spouse will be considered an eligible Dependent on the date he or she satisfies this residence requirement provided your spouse is properly enrolled within 31 days of such date.

4. If a Dependent is acquired other than at the time of birth, due to a court order, decree or marriage, that Dependent will be considered an eligible Dependent from the date of such court order, decree or marriage, provided that this new Dependent is properly enrolled prior to or within 31 days of such an event and is otherwise eligible.

5. A Dependent who continues coverage under COBRA.

In order to enroll your eligible spouse and Dependent children, it will be necessary to comply with the Plan’s rules and procedures to verify Dependent eligibility status.

Dependent Effective Date

If you file your written request for Dependent Coverage on a form approved by the Plan Administrator, your Dependent(s) will become covered at 12:00 a.m. as follows:

1. If you make such written request within 31 days of your earliest eligibility date, any person who is then your Dependent will become covered on the date your Participant Coverage begins.
2. If you acquire an eligible Dependent after your Participant Coverage begins, your Dependent will become covered on the date the Dependent becomes eligible provided the newly acquired spouse or child is properly enrolled for coverage within 31 days of such date. Please refer to the sections "Special Enrollment Period" and "Dependent Eligibility" for additional information.

If Dependent Coverage under the Plan is requested and you make such written request after the end of the applicable 31-day period or after your previous termination of Dependent Coverage, you may enroll your Dependent during the Open Election/Enrollment Period.

Dependent Termination

Coverage for your Dependent(s) will automatically terminate at 12:00 midnight upon the earliest of the following dates:

1. Date of termination of your coverage under the Plan for any reason including death;
2. Date on which the Dependent ceases to be an eligible Dependent under the Plan. Except as otherwise specified for a handicapped child in item 2 of the section "Eligible Dependents", a Dependent child is considered eligible until the end of the month in which he or she attains age 26;
3. Date you cease to be in a class of Participants eligible for Dependent Coverage;
4. Date of expiration of the last period for which you have made a contribution, in the event you fail to make any required contribution for Dependent Coverage or you file a written election to discontinue Dependent Coverage;

   Note: If you elect to make your contribution for coverage on a pre-tax basis under a Section 125 Plan, you will be allowed to discontinue coverage only if permitted in the Section 125 Plan.

5. Date the Plan is terminated, or with respect to any Dependent benefit of the Plan, the date of termination of such benefit; or
6. Date the Dependent dies.

Upon the date of termination of coverage, there is no extension of any benefits under this Plan for any reason unless specifically noted in the Plan. However, in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled "COBRA Continuation Coverage".

UTILIZATION MANAGEMENT SERVICE (UMS)

This Plan includes a utilization management requirement. This means that subject to all other provisions of the Plan, each proposed Hospital admission, or other Inpatient admission, will be reviewed on behalf of the Plan. The Plan Administrator has retained the service of a Utilization Review Manager to perform this utilization management review.

Please refer to your Plan I.D. Card
for the name and phone number of the Utilization Review Manager.

The purpose of utilization management is to assist in the management of the claim. When you have an emergency admission and are released within 24 hours or when you have an emergency visit to an emergency room, there is no reason or requirement to call.

Pre-Notification is not required when the Covered Person has other coverage which is considered the primary payer and this Plan is the secondary payer.

The Utilization Review Manager must be contacted:

1. When you have to go into the **HOSPITAL OR OTHER FACILITY AS AN INPATIENT**.
2. Upon notification of the need for **SURGERY**, other than for diagnostic and therapeutic endoscopic procedures, on an Inpatient basis. It is recommended that the call be made 5 to 7 days prior to the scheduled Surgery.
3. **FOR MATERNITY CASES**, it is recommended that you call the later of four months prior to the medically diagnosed date of delivery or 30 days from the date you first become covered under the Plan. You should also call within 48 hours or by the end of the next business day following the date of confinement.

The Utilization Review Manager, on behalf of the Plan, will certify:

1. The Medical Necessity of such treatment;
2. The appropriate location for such treatment to be provided; and
3. A length of stay for each Inpatient confinement. If the Utilization Review Manager is advised of the need for confinement for a period of time longer than was originally certified, the patient's Physician will be asked to provide additional medical information. If the extended stay is Medically Necessary, an extension to the length of stay will be approved.

The person calling the Utilization Review Manager will need to provide:

1. Your name, telephone number, individual identification number printed on the Plan I.D. Card and the name of the Plan Sponsor.
2. The name, address and birthdate of the patient.
3. The names, addresses and telephone numbers of the doctor and the Hospital or other facility.
4. The reason for the Inpatient confinement or Surgery.

In the case of emergency or Urgent Care need, get treatment.

You are not required to call the Utilization Review Manager first. You will not be penalized if you do not call before getting emergency or Urgent Care treatment.

However, the Utilization Review Manager must be contacted:

1. In advance of elective treatment being rendered; or
2. In the case of an Urgent Care need or an emergency, within 48 hours or by the end of the next regular work day following the date of the Urgent Care or emergency admission.

The term "emergency" means an Accident or Illness which requires immediate treatment on an Inpatient basis.

Note: ***If the Utilization Review Manager is not contacted within the stated time frame following the Urgent Care or emergency Inpatient admission, you will be subject to the penalty outlined below and your claim will be retrospectively reviewed to determine which expenses are eligible for payment under the Plan.***

The Utilization Management Non-Compliance PENALTY of $250:

1. Is in addition to any Deductible under the Plan;
2. Will not be used to satisfy the Out-of-Pocket limit; and
3. Does not apply to maternity cases that do not exceed the requirements of the Newborns' and Mothers' Protection Act of 1996, as amended (that is, 48 hours or less following a vaginal delivery or 96 hours or less following a cesarean section). However, the non-compliance penalty will be applied if the Utilization Review Manager is not notified of any hospital stay that exceeds the allowed 48 or 96 hour confinement.

CAUTION: Any certification made under these cost management procedures is not to be construed or interpreted as a confirmation of eligibility or that the Inpatient confinement or Surgery is an eligible medical expense.

The utilization management process is not intended to constitute a medical diagnosis or to interfere with any individual's decision to have a particular course of treatment.

If you do not follow the Plan's utilization management review requirements, or if the Plan determines that a particular treatment is not "Medically Necessary," your level of benefits available under the Plan will be impacted.

Ineligible Expenses

To be eligible for benefits under the Plan, an expense must be Medically Necessary. The addition of utilization review does not change this requirement. If an expense is found to be ineligible, it is not covered under this Plan. Ineligible expenses not reimbursed under the Plan will not be used to satisfy the Plan Deductible or the Out-of-Pocket limit.

If certain Inpatient days are determined by Utilization Review Manager Physicians to be not Medically Necessary, then the Hospital/facility Room and Board charges for those days will be considered ineligible expenses.

If the treatment received is determined by the Utilization Review Manager to be not Medically Necessary, then all treatment, services or supplies related to such treatment will be considered to be ineligible expenses.

Right to Appeal a Utilization Management Decision

You have the right to appeal a Utilization Management decision if a requested Inpatient confinement or an extension to the length of stay is denied, whether in whole or in part. Please refer to the "Claim Procedures" section for information on how to file an appeal for a post-service claim.

Since the Plan does not require that you obtain approval of a medical service prior to getting treatment for an Urgent Care or emergency situation, there are no "pre-service urgent care claims" under the Plan. All claims are considered to be "post service claims". In an Urgent Care or emergency situation, you should seek treatment and then file the claim as a post-service claim.

Second Opinions

The Utilization Review Manager may require a second opinion before granting pre-certification for certain medical or surgical treatment.

Benefits will be provided for a second (and third, if necessary) 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 necessary) opinion will be paid as any other Illness.

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.

Case Management Program

In certain circumstances, typically in the case of a serious illness or injury, the Plan may make available to you the services of a case manager. The case manager is a medical professional who can be a valuable information resource to you. The case manager will also work with the treating Physician and other providers with the objective of achieving the best and most cost effective course of treatment.

If you or your Dependent is selected as a candidate for case management, you will be contacted by a case manager. If you agree to participate, the case manager will then contact the treating Physician.

Participation in this program is encouraged but is strictly voluntary; no Covered Person is obligated to participate and your benefits will not be adversely affected.

Please contact Professional Benefit Administrators, Inc. (PBA) at (800) 435-5694 if you have questions about how case management works. You should also contact PBA in advance of any major treatment if you are interested in determining if you or a member of your family qualifies for this program.

Specialty Care Benefit

The Plan Administrator has arranged for resources for very specialized care through certain selected facilities, providers and medical management organizations. This specialized care and/or coordination is designed to offer enhanced outcomes for specific Injuries, Illnesses and treatment types. The arrangements will allow Covered Persons to receive the best care available at negotiated rates. Any Covered Person who is about to undergo treatment of the types listed below may be a candidate for this specialized care.

<u>These services are freestanding and are separate from any PPO or non-PPO contracts or benefits.</u>

Contact Professional Benefit Administrators, Inc. (PBA) at (800) 435-5694 in order to find out if you qualify for specialized care for any of the following Illnesses or Injuries or in advance of any major or ongoing course of treatment to see if specialty providers may be available to you:

- Cancer treatment
- Hemophilia
- Transplants
- Renal disease
- Premature babies
- Severe burns

In addition, if the Plan Administrator identifies additional Conditions for which specialty provider services are available, the Covered Person will be given the opportunity to receive care and treatment through the specialty provider and thereby receive full benefits under the Plan.

Please note that each Covered Person has a free choice of any provider, and the Covered Person, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The specialty care providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any provider.

Do not delay seeking medical care for any Covered Person who has a serious Condition that may jeopardize his life or health because of the requirements of this provision. For Urgent Care, emergency admissions, follow your Physician’s instructions carefully, and contact Professional Benefit Administrators, Inc. as soon as possible thereafter.

MEDICAL EXPENSE BENEFITS

All Plan expenses are subject to the following requirements:

1. They must be Medically Necessary, unless otherwise stated; and
2. They must be Usual and Customary charges; and
3. They must be considered Covered Charges by the Plan; and
4. They are subject to the exclusions and limitation provisions.

Comprehensive Major Medical Benefits

Comprehensive Major Medical Benefits are payable for Covered Expenses Incurred for an Injury or Illness while covered by this Plan and are subject to all of the Plan provisions.

Preferred Provider Benefit (PPO)

The Plan includes a Preferred Provider Organization (PPO) network. PPO networks offer health care services and supplies to you at discounted rates which will result in lower costs. A listing of the preferred providers is available without charge through the PPO's website as noted on your Plan I.D. card. Although the Plan provides access to the PPO as an alternative to other providers, the Plan Sponsor in no way recommends or endorses these or any other provider. It is the responsibility of the patient or Family to determine the ability of any provider to render care or treatment.

Benefits will be payable at the PPO level shown in the Schedule of Medical Benefits when charges are Incurred with a PPO Provider. Charges Incurred with a Non-PPO Provider will be payable at the PPO benefit level only in the following circumstances unless otherwise specified in the Schedule of Medical Benefits:

- If a Covered Person has no choice of PPO providers in the specialty that the Covered Person is seeking within the PPO service area.
- If a Covered Person has a Medical Emergency requiring immediate care. A "Medical Emergency" means the sudden onset of a Condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.
- If a Covered Person receives Physician or anesthesia services by a Non-PPO provider at a PPO facility. Such services include anesthesiologists, pathologists, radiologists, assistant surgeons or emergency room Physicians.
- If a PPO provider refers eligible routine laboratory or X-ray services or interpretation to a Non-PPO provider.

All PPO benefits payable by the Plan are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. All other benefits payable by the Plan may be assigned at your option. Payments made in accordance with an Assignment of Benefits are made in good faith and release the Plan's obligation to the extent of the payment.

Overall Maximum Benefit for All Benefits

This Plan does not include an overall lifetime or annual limit on the dollar value of Essential Health Benefits. However, limits on specific treatments, services or supplies may apply if stated in this Schedule of Medical Benefits.

Schedule of Medical Benefits

Premier PPO Plan

Premier PPO Plan

Calendar Year Deductible

	PPO Providers	*Non-PPO Providers*
Per Covered Person	$ 450	$ 900
Per Family (aggregate)	$1,350	$2,700

If a combination of PPO Providers and Non-PPO Providers are used, your combined total Deductible will not exceed the amount shown for Non-PPO Providers during a Calendar Year.

The annual Deductible is per Calendar Year and only applies to the Calendar Year in which it occurred. There is no Deductible carryover between Calendar Years.

Coinsurance by Plan

Unless otherwise noted, the Plan will pay the benefit specified below:

PPO Provider:	80% after satisfying the Deductible
Non-PPO Provider:	60% after satisfying the Deductible

Out-of-Pocket Limit

	PPO Providers	*Non-PPO Providers*
Per Covered Person	$2,000	$ 4,000
Per Family (aggregate)	$6,000	$12,000

The Out-of-Pocket limit includes the Calendar Year Deductible and medical Copays, other than drug card Copays.

If a combination of PPO Providers and Non-PPO Providers are used, your combined total Out-of-Pocket limit will not exceed the amount shown for Non-PPO Providers. In other words, the amount of expense you will pay for both PPO Providers and Non-PPO Providers will be combined, and the total will not exceed the amount shown for Non-PPO Providers during a Calendar Year.

After your Out-of-Pocket expense for your Coinsurance and Deductible equal the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Out-of-Pocket limit for the balance of the Calendar Year.

Note: ***Non-compliance penalties, ineligible charges, charges in excess of Usual and Customary, and drug card Copays do not qualify under the Out-of-Pocket limit provision.***

Premier PPO Plan		
Covered Services	*PPO Providers*	*Non-PPO Providers*
Allergy Injections & Serum	80% after Deductible	60% after Deductible
Ambulance Services	80% after Deductible	60% after Deductible
Chiropractic Services (including X-ray and Laboratory) Limited to a maximum benefit of $5,000 per person per Calendar Year.	100% after $25 Copay, no Deductible	60% after Deductible

Premier PPO Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Diagnostic X-Ray & Lab - Outpatient	80% after Deductible	60% after Deductible
Durable Medical Equipment	80% after Deductible	60% after Deductible
Emergency Services – Hospital Copay is waived if admitted	80% after $150 Copay and Deductible	80% after $150 Copay and PPO Deductible *PPO Out-of-Pocket limit applies*
For purposes of this benefit, “Emergency Services” means treatment given in an emergency department of a Hospital for an Emergency Medical Condition. Such treatment includes a medical screening examination within the capability of the Hospital emergency department, including ancillary services routinely available to evaluate such Emergency Medical Condition and further examination and treatment required to stabilize the patient. An “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or, (ii) serious impairment to bodily functions; or, (iii) serious dysfunction of any bodily organ or part.		
Home Health Care Limited to a maximum of 100 visits per person per Calendar Year.	80% after Deductible	60% after Deductible
Hospice Care	80% after Deductible	60% after Deductible
Hospital - Inpatient/Outpatient Services (other than Emergency Services)	80% after Deductible	60% after Deductible
Infertility – Diagnostic Only Limited to supplies and services for the diagnosis of infertility; treatment of infertility is not covered.		
• **Physician Office Visits and Office Services**	100% after $25 Copay, no Deductible	60% after Deductible
• **All Other Services**	80% after Deductible	60% after Deductible
Obesity (Surgical Treatment) As outlined in the section “Medical Expense Covered Charges”.	80% after Deductible	60% after Deductible
Orthotics	80% after Deductible	60% after Deductible

Premier PPO Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Physician: • **Office Visit and Office Services** Includes all office services, office Surgery and related services, other than allergy testing and allergy injections and serum. • **All Other Physician Services**	100% after $25 Copay, no Deductible 80% after Deductible	60% after Deductible 60% after Deductible
Pregnancy – Employee and Covered Spouse Only (Dependent daughters are not eligible for coverage for any expenses in connection with pregnancy.)		
• **Office Visit and Office Services** • **All Other Physician Services**	100% after $25 Copay, no Deductible 80% after Deductible	60% after Deductible 60% after Deductible
Preventive Services Charges for Preventive Services as outlined in the section "Medical Expense Covered Charges".	100% no Copay or Deductible	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible
Routine Alternative Wellness Care Limited to a maximum benefit of $250 per person per Calendar Year. Covered Charges include massage therapy, chelation therapy, acupuncture, herbal remedies and colonic therapy.	100% no Deductible	100% no Deductible
Skilled Nursing Facility Limited to a maximum of 120 days per person per Calendar Year.	80% after Deductible	60% after Deductible
Surgery	80% after Deductible	60% after Deductible
Therapy – Occupational, Physical and Speech	80% after Deductible	60% after Deductible
Treatment of Mental Health Illness/ Substance Abuse	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Treatment of Temporomandibular Joint Dysfunction (TMJ)	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Urgent/Immediate Care Center	100% after $50 Copay no Deductible	60% after Deductible

Premier Partial PPO Plan

Premier Partial PPO Plan		
Calendar Year Deductible		
	PPO Providers	***Non-PPO Providers***
Per Covered Person	$ 450	$ 900
Per Family (aggregate)	$1,350	$2,700

If a combination of PPO Providers and Non-PPO Providers are used, your combined total Deductible will not exceed the amount shown for Non-PPO Providers during a Calendar Year.

The annual Deductible is per Calendar Year and only applies to the Calendar Year in which it occurred. There is no Deductible carryover between Calendar Years.

Coinsurance by Plan

Unless otherwise noted, the Plan will pay the benefit specified below:

PPO Hospital and Other Providers:	80% after satisfying the Deductible
Non-PPO Hospital:	60% after satisfying the Deductible

Out-of-Pocket Limit

	PPO Hospital and Other Providers	***Non-PPO Hospital***
Per Covered Person	$2,000	$ 4,000
Per Family (aggregate)	$6,000	$12,000

The Out-of-Pocket limit includes the Calendar Year Deductible and medical Copays, other than drug card Copays.

If a combination of PPO Providers and Non-PPO Providers are used, your combined total Out-of-Pocket limit will not exceed the amount shown for Non-PPO Providers. In other words, the amount of expense you will pay for both PPO Providers and Non-PPO Providers will be combined, and the total will not exceed the amount shown for Non-PPO Providers during a Calendar Year.

After your Out-of-Pocket expense for your Coinsurance and Deductible equal the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Out-of-Pocket limit for the balance of the Calendar Year.

Note: Non-compliance penalties, ineligible charges, charges in excess of Usual and Customary, and drug card Copays do not qualify under the Out-of-Pocket limit provision.

Premier Partial PPO Plan		
Covered Services	***PPO Providers***	***Non-PPO Hospital***
Allergy Injections & Serum	80% after Deductible	
Ambulance Services	80% after Deductible	
Chiropractic Services (including X-ray and Laboratory) Limited to a maximum benefit of $5,000 per person per Calendar Year.	80% after Deductible	

<table>
<tr><th colspan="3">Premier Partial PPO Plan</th></tr>
<tr><th>Covered Services</th><th>PPO Providers</th><th>Non-PPO Hospital</th></tr>
<tr><td>Diagnostic X-Ray & Lab - Outpatient</td><td colspan="2">80%
after Deductible</td></tr>
<tr><td>Durable Medical Equipment</td><td colspan="2">80%
after Deductible</td></tr>
<tr><td>Emergency Services – Hospital
Copay is waived if admitted</td><td>80% after $150 Copay
and Deductible</td><td>80% after $150 Copay
and PPO Deductible
(PPO Out-of-Pocket limit applies)</td></tr>
<tr><td colspan="3">For purposes of this benefit, “Emergency Services” means treatment given in an emergency department of a Hospital for an Emergency Medical Condition. Such treatment includes a medical screening examination within the capability of the Hospital emergency department, including ancillary services routinely available to evaluate such Emergency Medical Condition and further examination and treatment required to stabilize the patient. An “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or, (ii) serious impairment to bodily functions; or, (iii) serious dysfunction of any bodily organ or part.</td></tr>
<tr><td>Home Health Care
Limited to a maximum of 100 visits per person per Calendar Year.</td><td colspan="2">80%
after Deductible</td></tr>
<tr><td>Hospice Care</td><td colspan="2">80%
after Deductible</td></tr>
<tr><td>Hospital -
Inpatient/Outpatient Services
(other than Emergency Services)</td><td>80%
after Deductible</td><td>60%
after Deductible
(Non-PPO Hospital
Out-of-Pocket limit applies)</td></tr>
<tr><td>Infertility – Diagnostic Only
Limited to supplies and services for the diagnosis of infertility; treatment of infertility is not covered.</td><td colspan="2">80%
after Deductible</td></tr>
<tr><td>Obesity (Surgical Treatment)
As outlined in the section “Medical Expense Covered Charges”.</td><td colspan="2">80%
after Deductible</td></tr>
<tr><td>Orthotics</td><td colspan="2">80%
after Deductible</td></tr>
<tr><td>Physician:
• Office Visit and Office Services
Includes all office services, office Surgery and related services, other than allergy testing and allergy injections and serum.</td><td colspan="2">80%
after Deductible</td></tr>
<tr><td>• All Other Physician Services</td><td colspan="2">80%
after Deductible</td></tr>
</table>

Premier Partial PPO Plan		
Covered Services	***PPO Providers***	***Non-PPO Hospital***
Pregnancy – Employee and Covered Spouse Only (Dependent daughters are not eligible for coverage for any expenses in connection with pregnancy.)	80% after Deductible	
Preventive Services Charges for Preventive Services as outlined in the section "Medical Expense Covered Charges".	100% no Deductible	80% after Deductible *(PPO Out-of-Pocket limit applies)*
Prosthetics	80% after Deductible	
Routine Alternative Wellness Care Limited to a maximum benefit of $250 per person per Calendar Year. Covered Charges include massage therapy, chelation therapy, acupuncture, herbal remedies and colonic therapy.	100% no Deductible	
Skilled Nursing Facility Limited to a maximum of 120 days per person per Calendar Year.	80% after Deductible	
Surgery	80% after Deductible	
Therapy – Occupational, Physical and Speech	80% after Deductible	
Treatment of Mental Health Illness/ Substance Abuse	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Treatment of Temporomandibular Joint Dysfunction (TMJ)	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Urgent/Immediate Care Center	100% after $50 Copay no Deductible	60% after Deductible

Value PPO Plan

Value PPO Plan		
Calendar Year Deductible		
	PPO Providers	***Non-PPO Providers***
Per Covered Person	$1,250	$2,500
Per Family (aggregate)	$2,500	$5,000

If a combination of PPO Providers and Non-PPO Providers are used, your combined total Deductible will not exceed the amount shown for Non-PPO Providers during a Calendar Year.

The annual Deductible is per Calendar Year and only applies to the Calendar Year in which it occurred. There is no Deductible carryover between Calendar Years.

Coinsurance by Plan

Unless otherwise noted, the Plan will pay the benefit specified below:

PPO Provider:	80% after satisfying the Deductible
Non-PPO Provider:	60% after satisfying the Deductible

Out-of-Pocket Limit

	PPO Providers	***Non-PPO Providers***
Per Covered Person	$4,000	$ 8,000
Per Family (aggregate)	$8,000	$16,000

The Out-of-Pocket limit includes the Calendar Year Deductible and medical Copays, other than drug card Copays.

If a combination of PPO Providers and Non-PPO Providers are used, your combined total Out-of-Pocket limit will not exceed the amount shown for Non-PPO Providers. In other words, the amount of expense you will pay for both PPO Providers and Non-PPO Providers will be combined, and the total will not exceed the amount shown for Non-PPO Providers during a Calendar Year.

After your Out-of-Pocket expense for your Coinsurance and Deductible equal the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Out-of-Pocket limit for the balance of the Calendar Year.

Note: ***Non-compliance penalties, ineligible charges, charges in excess of Usual and Customary, and drug card Copays do not qualify under the Out-of-Pocket limit provision.***

Value PPO Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Allergy Injections & Serum	80% after Deductible	60% after Deductible
Ambulance Services	80% after Deductible	60% after Deductible
Chiropractic Services (including X-ray and Laboratory) Limited to a maximum of 20 visits per person per Calendar Year.	100% after $35 Copay, no Deductible	60% after Deductible
Diagnostic X-Ray & Lab - Outpatient	80% after Deductible	60% after Deductible

Value PPO Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Durable Medical Equipment	80% after Deductible	60% after Deductible
Emergency Services – Hospital Copay is waived if admitted	80% after $150 Copay and Deductible	80% after $150 Copay and PPO Deductible *PPO Out-of-Pocket limit applies*
For purposes of this benefit, "Emergency Services" means treatment given in an emergency department of a Hospital for an Emergency Medical Condition. Such treatment includes a medical screening examination within the capability of the Hospital emergency department, including ancillary services routinely available to evaluate such Emergency Medical Condition and further examination and treatment required to stabilize the patient. An "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or, (ii) serious impairment to bodily functions; or, (iii) serious dysfunction of any bodily organ or part.		
Home Health Care Limited to a maximum of 20 visits per person per Calendar Year.	80% after Deductible	60% after Deductible
Hospice Care	80% after Deductible	60% after Deductible
Hospital - **Inpatient/Outpatient Services** **(other than Emergency Services)**	80% after Deductible	60% after Deductible
Infertility – Diagnostic Only Limited to supplies and services for the diagnosis of infertility; treatment of infertility is not covered.		
• **Physician Office Visits and Office Services**	100% after $35 Copay, no Deductible	60% after Deductible
• **All Other Services**	80% after Deductible	60% after Deductible
Obesity (Surgical Treatment) As outlined in the section "Medical Expense Covered Charges".	80% after Deductible	60% after Deductible
Orthotics	80% after Deductible	60% after Deductible
Physician:		
• **Office Visit and Office Services** Includes all office services, office Surgery and related services, other than allergy testing and allergy injections and serum.	100% after $35 Copay, no Deductible	60% after Deductible
• **All Other Physician Services**	80% after Deductible	60% after Deductible

Value PPO Plan		
Covered Services	***PPO Providers***	***Non-PPO Providers***
Pregnancy – Employee and Covered Spouse Only (Dependent daughters are not eligible for coverage for any expenses in connection with pregnancy.)		
• **Office Visit and Office Services**	100% after $35 Copay, no Deductible	60% after Deductible
• **All Other Physician Services**	80% after Deductible	60% after Deductible
Preventive Services Charges for Preventive Services as outlined in the section "Medical Expense Covered Charges".	100% no Copay or Deductible	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible
Routine Alternative Wellness Care Limited to a maximum benefit of $250 per person per Calendar Year. Covered Charges include massage therapy, chelation therapy, acupuncture, herbal remedies and colonic therapy.	100% no Copay or Deductible	100% no Deductible
Skilled Nursing Facility Limited to a maximum of 60 days per person per Calendar Year.	80% after Deductible	60% after Deductible
Surgery	80% after Deductible	60% after Deductible
Therapy – Occupational, Physical and Speech Limited to a maximum of 20 visits per person per Calendar Year for all therapies combined.	80% after Deductible	60% after Deductible
Treatment of Mental Health Illness/ Substance Abuse	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Treatment of Temporomandibular Joint Dysfunction (TMJ)	Benefits are paid in the same manner as any other Illness. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Urgent/Immediate Care Center	100% after $50 Copay no Deductible	60% after Deductible

Out-of-Area Plan

Out-of-Area Plan
Calendar Year Deductible
Per Covered Person $ 450 Per Family (aggregate) $1,350 The annual Deductible is per Calendar Year and only applies to the Calendar Year in which it occurred. There is no Deductible carryover between Calendar Years.
Coinsurance by Plan
Unless otherwise noted, the Plan will pay the benefit specified below: 80% after satisfying the Deductible
Out-of-Pocket Limit
Per Covered Person $1,000 Per Family (aggregate) $3,000 The Out-of-Pocket limit includes the Calendar Year Deductible and medical Copays, other than drug card Copays. After your Out-of-Pocket expense for your Coinsurance and Deductible equal the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Out-of-Pocket limit for the balance of the Calendar Year. ***Note:*** ***Non-compliance penalties, ineligible charges, charges in excess of Usual and Customary, and drug card Copays do not qualify under the Out-of-Pocket limit provision.***

Out-of-Area Plan	
Covered Services	***Coinsurance by Plan***
Allergy Injections & Serum	80% after Deductible
Ambulance Services	80% after Deductible
Chiropractic Services (including X-ray and Laboratory) Limited to a maximum benefit of $5,000 per person per Calendar Year.	80% after Deductible
Diagnostic X-Ray & Lab – Outpatient	80% after Deductible
Durable Medical Equipment	80% after Deductible

Out-of-Area Plan	
Covered Services	***Coinsurance by Plan***
Emergency Services – Hospital Copay is waived if admitted	80% after $150 Copay and Deductible
For purposes of this benefit, "Emergency Services" means treatment given in an emergency department of a Hospital for an Emergency Medical Condition. Such treatment includes a medical screening examination within the capability of the Hospital emergency department, including ancillary services routinely available to evaluate such Emergency Medical Condition and further examination and treatment required to stabilize the patient. An "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or, (ii) serious impairment to bodily functions; or, (iii) serious dysfunction of any bodily organ or part.	
Home Health Care Limited to a maximum of 100 visits per person per Calendar Year.	80% after Deductible
Hospice Care	80% after Deductible
Hospital - Inpatient/Outpatient Services **(other than Emergency Services)**	80% after Deductible
Infertility – Diagnostic Only Limited to supplies and services for the diagnosis of infertility; treatment of infertility is not covered.	80% after Deductible
Obesity (Surgical Treatment) As outlined in the section "Medical Expense Covered Charges".	80% after Deductible
Orthotics	80% after Deductible
Physician: • **Office Visit and Office Services** Includes all office services, office Surgery and related services, other than allergy testing and allergy injections and serum. • **All Other Physician Services**	80% after Deductible 80% after Deductible
Pregnancy – **Employee and Covered Spouse Only** (Dependent daughters are not eligible for coverage for any expenses in connection with pregnancy.)	80% after Deductible
Preventive Services Charges for Preventive Services as outlined in the section "Medical Expense Covered Charges".	100% no Deductible
Prosthetics	80% after Deductible
Routine Alternative Wellness Care Limited to a maximum benefit of $250 per person per Calendar Year. Covered Charges include massage therapy, chelation therapy, acupuncture, herbal remedies and colonic therapy.	100% no Deductible

Out-of-Area Plan	
Covered Services	***Coinsurance by Plan***
Skilled Nursing Facility Limited to a maximum of 120 days per person per Calendar Year.	80% after Deductible
Surgery	80% after Deductible
Therapy – Occupational, Physical and Speech	80% after Deductible
Treatment of Mental Health Illness/ Substance Abuse	Benefits are paid in the same manner as any other Illness.
Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Treatment of Temporomandibular Joint Dysfunction (TMJ)	Benefits are paid in the same manner as any other Illness.
Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Urgent/Immediate Care Center	100% after $50 Copay no Deductible

Coinsurance and Deductible

Upon receipt of written proof of loss (which includes the claim form and information sufficient to enable proper consideration of the claim), the Plan will pay the benefits outlined in the Schedule of Medical Benefits for Eligible Expenses Incurred in each Calendar Year unless otherwise stated in the Plan. All Eligible Expenses Incurred in the benefit period in excess of the Out-of-Pocket limit will be paid at 100%, as outlined on the Schedule of Medical Benefits. The amount payable in no event will exceed any maximum limitation stated in the Schedule of Medical Benefits or in the section entitled “General Exclusions and Limitations.” The Out-of-Pocket limit may not apply to all benefits.

The Deductible applies to the Eligible Charges for each Calendar Year, but it applies only once for each Covered Person within a Calendar Year. However, if members of a Family have Incurred Eligible Charges subject to the Family Deductible limit during the same Calendar Year and the Family Deductible limit is then satisfied, no further Deductible applies to any member of that Family during the remainder of that Calendar Year.

The annual Deductible is per Calendar Year and only applies to the Calendar Year in which it occurred. There is no Deductible carryover between Calendar Years.

If two or more members of a covered Family unit are Injured in the same Accident, only one Deductible will be applied to Covered Expenses Incurred as a result of that Accident during the Calendar Year in which the Accident occurred. This will be done only to determine the amount of benefits to be paid for Injuries sustained in that specific Accident.

Allocation and Apportionment of Benefits

The Plan reserves the right to allocate the Deductible amount to any Eligible Charge and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment will be conclusive and binding upon the Covered Person and all assignees.

During the year this Plan is established, charges which were used toward satisfying the Deductible or Out-of-Pocket limit under the prior plan or insurance coverage for that year will be accepted by the Plan Administrator toward satisfying the Deductible or Out-of-Pocket limit of this Plan, upon receipt of documented proof of such full or partial satisfaction.

Medical Expense Covered Charges

To be eligible for benefits under this provision, expenses actually Incurred by a Covered Person must meet the following requirements:

1. They are administered or ordered by a Physician; and
2. They are Medically Necessary, unless otherwise stated; and
3. They are considered Covered Charges under the Plan; and
4. They are Usual and Customary charges.

Covered Expenses are limited to:

1. **Ambulance.** Charges for local professional ground ambulance service to the nearest facility where Emergency Medical Care or treatment is rendered, or the Medically Necessary transfer from one facility to another.

   Charges for Medically Necessary air ambulance service to the appropriate facility for Emergency Medical Care or treatment if the patient's Condition is life threatening.

   The "nearest facility" is defined as one that is specialized and equipped to care for the person's Condition.

2. **Ambulatory Surgical Center.** Charges made by an Ambulatory Surgical Center or minor emergency medical clinic.

3. **Anesthesia.** Charges for the cost and administration of an anesthetic.

4. **Autism Spectrum Disorder**. Charges Incurred by a Covered Dependent for:
   a. The diagnosis of autism spectrum disorder; and,
   b. The following services prescribed by a Physician and rendered by a licensed provider when such treatment is Medically Necessary and result in improved clinical status:
      (1) Psychiatric care;
      (2) Psychological care;
      (3) Habilitative or rehabilitative care (i.e. counseling and treatment programs intended to develop, maintain, and restore the function of an individual);
      (4) Therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas: self-care and feeding; pragmatic, receptive, and expressive language; cognitive functioning; applied behavioral analysis, intervention, and modification; motor planning; and, sensory processing.

   Covered Charges do not include habilitative services that are solely educational in nature or otherwise paid under State or Federal law or which are Experimental or Investigational.

5. **Blood.** Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood components if replaced by donation; charges for storage of the Covered Person's own blood within 30 days of Surgery.

6. **Cardiac Rehabilitation**. Charges for cardiac rehabilitation program services when ordered by a Physician as part of the treatment program for a Covered Person's Illness. However, Covered Charges do not include Phase III of such programs.

7. **Chemotherapy Services.** Charges for administration of chemotherapy treatment, including drugs and supplies used during the treatment.

8. **Chiropractic.** Charges for chiropractor services unless otherwise stated.

9. **Clinical Trials.** The Plan will not:

   a. Deny any Covered Person the right to participate in a clinical trial for which he or she is eligible according to the trial protocol;

   b. Deny, limit or impose additional conditions on the coverage of Routine Patient Costs for items and services furnished in connection with participation in the clinical trial; or

   c. Discriminate against any Covered Person who participates in a clinical trial.

   For the purpose of this provision, "Routine Patient Costs" is defined to mean items and services typically provided under the Plan for an individual not enrolled in a clinical trial. However, such items and services do not include:

   a. The investigational item, device or service itself;

   b. Items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or,

   c. A service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

10. **Cochlear Implants.** Charges for placement of cochlear implant devices. Benefits will also include charges for repair and maintenance. Replacement of cochlear implant devices are covered when the device cannot be repaired or when the current device has become non-functional due to a change in a patient's status and an improved functional status is expected to be achieved with a replacement unit. Covered Charges do not include expenses Incurred for replacement batteries.

11. **Contraceptives – A Preventive Service.** Charges for prescription contraception dispensed by the prescribing Physician during an office visit such as implantable contraceptives, intrauterine devices (IUD) and diaphragms, to the extent such expense is not covered under the Outpatient Prescription Drug Card Benefit. Covered Charges also include the initial visit to the prescribing Physician and any follow-up visits.

12. **Diabetic Supplies/Self-Management Programs.** Charges for the following services and supplies provided for a Covered Person with diagnosed gestational, Type I or Type II diabetes:

   a. All Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes. Diabetic supplies will be eligible for medical benefits only if the expense is not covered under the Outpatient Prescription Drug Card Benefit.

   b. Diabetes Outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.

13. **Diagnostic Tests.** Charges for X-rays, laboratory and pathology tests, neuropsychological testing or similar well established diagnostic tests generally approved by Physicians throughout the United States, for the diagnosis of the Illness or Injury.

14. **Dialysis. – A Specialty Care Benefit.**

   An individual receiving Outpatient dialysis treatment and related services may or may not be eligible for Medicare coverage. Benefits provided under this Plan for treatment received in connection with Outpatient dialysis and related services are subject to the following provisions.

   Although a Covered Person may not be eligible or obligated to apply for Medicare Part A and/or Part B, the Plan will provide benefits for charges Incurred with Non-PPO providers as described below regardless of whether or not the Covered Person is eligible or has enrolled for Medicare coverage:

   - During the period of time that Medicare would otherwise have become, or is eligible to become, the secondary payer for Outpatient dialysis treatment and related services, the Plan will pay these services at 125% of the then current Medicare allowable expense.

- During the period of time that Medicare would otherwise have become, or is eligible to become, the primary payer for Outpatient dialysis treatment and related services, the Plan will pay these claims at 100% of the then current Medicare allowable expense.

Charges Incurred with a PPO provider will not be subject to the above provision. The Plan will provide benefits for charges Incurred with a PPO provider based on the charge negotiated between that provider and the PPO.

The Plan cannot enroll you in Medicare; it is your decision and your responsibility to enroll in Medicare. If you or your Dependent obtains Medicare Part B coverage upon qualifying for Medicare coverage due to a Condition requiring dialysis and/or a need for dialysis, the Plan will reimburse you or your Dependent for the cost of the applicable Medicare Part B coverage throughout the period of time the Plan is the primary payer of benefits. Requests for reimbursement must be submitted to the Plan Administrator per the Plan Administrator's policies and procedures as described below.

In order to ensure the correct coordination of claims payments between the Plan and Medicare, members are required to take the following steps:

a. Notify the Plan Administrator when you are diagnosed with a condition requiring Outpatient dialysis treatment;

b. Notify the Plan Administrator if or when you begin to receive dialysis treatment;

c. Give the Plan Administrator a copy of your Medicare card, showing the effective date of the Part A and Part B coverage.

15. **Domestic Violence.** With respect to any Injury which is otherwise covered by the Plan, the Plan will provide benefits for treatment of an Injury for victims of Domestic Violence or if the Injury results from a medical Condition (including both physical and mental health Conditions).

16. **Durable Medical Equipment.** Charges for rental up to the purchase price of a wheelchair to accommodate basic needs, Hospital bed or other Durable Medical Equipment required for therapeutic use, or the purchase of this equipment if economically justified, whichever is less.

    Benefits will also include adjustments or repairs of the equipment to restore useful function or replacement when required because of wear or when the current device has become non-functional due to a change in a patient's status and an improved functional status is expected to be achieved with the replacement.

17. **Elective Abortions.** Charges for elective abortions for you or your covered spouse. Dependent children are not eligible for coverage for any expenses in connection with pregnancy.

18. **Feet.** Charges for treatment of medical Conditions of the feet. Covered Charges include custom molded orthotics.

19. **Fertility.** Charges for supplies and services for the diagnosis of infertility; treatment of infertility is not a Covered Expense.

20. **Genetic Testing.** Charges for genetic testing when required:

    a. To diagnose a specific disease process when the Covered Person is symptomatic of the disease and to determine whether treatment will be effective; or,

    b. In prenatal testing when the pregnancy is categorized as high-risk, including cases where the mother is age 35 and over, or if the mother or father are at high risk as carriers for a hereditary genetic disease/disorder that may be passed on to the fetus.

21. **Home Health Care.** Charges made by a Home Health Care Agency for Medically Necessary care, up to any maximum benefit specified under the Schedule of Medical Benefits. A Home Health Care

visit will be considered a periodic visit by either a Nurse or therapist, as the case may be, or four hours of home health aide services. Covered Expenses may include, but are not limited to:

a. Part-time or intermittent nursing care by a Nurse.

b. Home health aides.

c. Medical supplies, drugs or other Medically Necessary services prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

TRANSPORTATION SERVICE, DOMESTIC SERVICE, CUSTODIAL CARE AND NON-MEDICAL SUPPLIES ARE NOT COVERED.

22. **Hospice Care.** Charges made by a Hospice care program for services, supplies and treatment which are ordered by a Physician for the care of a terminally ill person. Charges include bereavement counseling for the patient's immediate family members covered by the Plan.

23. **Hospital.** Charges made by a Hospital for:

a. **Room and Board.** Daily Room and Board and general nursing services, or confinement in an intensive care unit, not to exceed the applicable maximum limits shown:

Hospital Room and Board Charges	Average Semi-Private
Private Room Charges	Average Semi-Private
Intensive Care Units	Full Usual and Customary Charge
Medically Necessary Isolation Room	Full Usual and Customary Charge
Single Bed/Private Room Only Charges	Full Usual and Customary Charge
Birthing Room	Full Usual and Customary Charge

b. **Hospital Miscellaneous Expenses.** Hospital Miscellaneous Expenses, and incremental nursing charges, furnished by the Hospital during an Inpatient confinement.

c. **Outpatient Treatments.** Medically Necessary services and supplies for Outpatient Hospital treatments.

24. **Jaw.**

a. **Non-surgical.** Non-surgical, reversible treatment designed to relieve or treat acute pain of the Temporomandibular Joint or TMJ Dysfunction and acute pain or dysfunction associated with any other Craniomandibular Disorder, when Medically Necessary. Examples of Medical Necessity include, but are not limited to, chronic dislocation of the jaw joint, severe restriction of jaw opening, locking of the jaw, or acute pain upon opening the jaw. Examples of covered treatments would include, but are not limited to, injection of local anesthetic and reduction of a dislocation, necessary and appropriate physical therapy when ordered by a Physician or bite plane therapy utilizing an appliance that does not reposition the teeth or change bite. Charges for irreversible treatment including, but not limited to, fixed or removable appliances which reposition the teeth, orthodontic care, bridges, partials and full dentures are specifically excluded.

b. **Surgical.** Surgical treatment of the Temporomandibular Joint will be covered only when it follows a course of reversible, non-surgical therapy or if there is adequate documentation that non-surgical therapy is inappropriate as determined through a mandatory second surgical opinion. This mandatory second opinion must be by a Physician qualified to render such a service either through experience, specialized training, education or such similar criteria and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

25. **Mastectomy.** Charges for reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce symmetrical appearance; and coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient. Such coverage may be subject to the annual Deductibles and Coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan.

26. **Medical Supplies.** Charges for dressings, sutures, casts, splints, trusses, crutches, braces, cervical collar, colostomy bags or supplies, ileostomy supplies, catheters or other Medically Necessary medical supplies. Charges for blood pressure kits and blood testing kits are eligible only if the Condition is severe enough to require self-home testing as prescribed by a Physician. Covered Charges do not include dental braces (fixed or removable appliances that move or reposition teeth) or corrective shoes unless required due to the use of a Medically Necessary brace.

27. **Mental Health Illness/Substance Abuse.** Charges for services rendered for Psychiatric Care and/or Substance Abuse Treatment. Treatment may be rendered as an Inpatient, Outpatient or through an Intensive Outpatient Plan. Covered Charges include treatment provided at a Residential Treatment Facility. When treatment is provided on an Inpatient basis, the confinement is subject to utilization management review. Please refer to the section "Utilization Management Service" for Plan requirements. Coverage does not include treatment that is considered custodial. Professional services are limited to only those providers listed as covered Physicians or Mental Health/Substance Abuse Providers under the "Definitions" section.

28. **Multiple Surgical Procedures**. Subject to other Plan provisions, charges for multiple surgical procedures will be eligible as follows:

    a. For related operations or procedures performed through the same incision or in the same operative field, Covered Expenses will include the surgical allowance for the highest paying procedure, plus 50% of the surgical allowance for each additional procedure.

    b. When two or more unrelated operations or procedures are performed at the same operative session, Covered Expenses will include the surgical allowance for the highest paying procedure, plus 50% of the surgical allowance for each additional procedure.

29. **Nursing.** Charges for the services of a Nurse, acting within the scope of his or her license.

30. **Obesity.** (Pre-authorization is strongly recommended.) Charges for surgical treatment of morbid obesity to the extent the surgical procedure is Medically Necessary and not Experimental or Investigational when the below listed criteria are met:

    Criteria

    In order for morbid obesity Surgery or related expenses to be a Covered Expense, the Covered Person must satisfy all of the following requirements:

    a. The Covered Person must have completed adult growth (i.e. 18 years of age or documentation of completion of bone growth).

    b. The Covered Person must have one of the following:

        (1) A body mass index ("BMI") of 40 or greater; or,

        (2) A BMI of 35 or greater and a serious condition related to obesity such as Type II diabetes, life threatening cardiac or pulmonary conditions (i.e. coronary artery disease, severe sleep apnea not responding to CPAP) or debilitating joint disease in weight bearing joints.

    c. The Covered Person must supply documentation to support previous Physician-supervised weight loss attempts. This includes a complete history and physical, weight loss record, diet(s), nutritional counseling/programs, exercise programs/regime, and contemporaneous progress notes indicating adherence to at least 2-3 weight loss programs for a duration of 6 consecutive months or greater with each attempt.

    d. The Covered Person must have no medical contraindications to Surgery (e.g. significant heart, lung, liver or kidney disease; or a history of cancer other than skin cancer).

    e. The Covered Person must have no untreated physiological Condition that may contribute to the morbidly obese Condition (i.e. hypothyroidism).

    f. Current substance abuse has not been identified.

g. The Covered Person has demonstrated reliable participation in a pre-operative weight-loss program that is multidisciplinary (i.e. low-calorie diet, supervised exercise and behavior modification).

h. The Covered Persons has received clearance for Surgery following a psychological evaluation to assess motivation and the ability to consent to Surgery and the ability to comply with postoperative instructions and lifestyle.

Covered Charges do not include repeat bariatric Surgery regardless of whether the above criteria are met.

31. **Organ and Tissue Transplants.** Charges for the replacement of organs or tissues to the extent that they are Medically Necessary and are NOT Experimental or Investigational.

It is IMPORTANT that you contact the Utilization Review Manager and PBA (the Claims Administrator) as soon as you are told that you or a covered Dependent is a candidate for a covered organ transplant. These companies will work with you and your Physicians to make sure that the most appropriate treatment program is developed.

a. **Mandatory Second Opinion.** A second opinion (record review or physical exam) **must** be obtained prior to undergoing any transplant procedure. This mandatory second opinion must be by a Physician qualified to render such a service either through experience, specialized training, education or such similar criteria, and who is not affiliated in any way with the Physician who will be performing the actual Surgery.

b. **Donor Expenses.** Eligible Expenses Incurred by the donor will be considered for benefits only if the recipient is covered by this Plan. Charges for the donor are considered as part of the recipient's claim and not the donor's.

c. **Other Charges.**

(1) **Acquisition, Storage and Transportation.** The Usual and Customary costs of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and the Hospital's charge for storage or transportation of the organ, will be considered an Eligible Expense.

(2) **Transportation - Recipient.** Transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the case of a minor, two other individuals, and all reasonable and necessary lodging expenses Incurred, up to a maximum of $10,000.

32. **Oxygen.** Charges for oxygen and rental of equipment for its use.

33. **Physician.** Charges for the services of a Physician for medical care and/or surgical treatments including, but not limited to, office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care and consultations, including telephone and online consultations.

34. **Pregnancy.** Charges for treatment of pregnancy for you or your covered spouse. Dependent children are not eligible for coverage for any expenses in connection with pregnancy, except as otherwise required by the Affordable Care Act for Preventive Services.

a. **Maternity Stays.** Coverage for a Hospital stay following a normal vaginal delivery will be 48 hours for both the mother (if a Covered Person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Coverage for a Hospital stay in connection with childbirth following a Cesarean section will be 96 hours for both the mother (if a Covered Person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician.

b. **Birthing Center.** Charges made by a Birthing Center when such facility is used in lieu of childbirth in a Hospital.

c. **Pre-natal Care.** Obstetrical care services rendered by a Physician, including pre-natal standard tests and two routine ultrasounds.

d. **Newborn Care.** Newborn Well Baby Care for Hospital nursery charges, in-Hospital doctor visits and circumcision. Newborn Covered Expenses will also include neo-natal intensive care Room and Board and necessary ancillary expenses for treatment of an Illness. However, newborn charges will be considered eligible only if the newborn is an eligible Dependent and has been properly enrolled as required by the Plan.

35. **Prescription Drugs.** Charges for drugs requiring the written prescription of a Physician, to the extent that the drugs are not covered under the Outpatient Prescription Drug Card Benefit; such drugs must be FDA approved for the treatment of the Illness or Injury. Purchase is limited to a 90-day supply.

36. **Preventive Services ("Routine Alternative Wellness Care is a separate benefit.)** Charges Incurred for Preventive Services including, but not limited to, routine physical exams and screenings, Well Child Care, routine x-ray and lab, mammograms, pap smears, PSA tests, immunizations, and colonoscopies, at the age and frequency recommended under federal guidelines or by current American Cancer Society guidelines.

    Federal guidelines fall under four broad categories as shown below:

    a. Evidence-based items or services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:

        (1) Breast cancer;
        (2) Cervical cancer;
        (3) Colorectal cancer;
        (4) High Blood Pressure;
        (5) Type 2 Diabetes Mellitus;
        (6) Cholesterol;
        (7) Child and Adult Obesity.

    b. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

    c. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

    d. With respect to women, additional preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

        (1) FDA approved women's contraceptives and counseling, including sterilization procedures. Prescription drugs will be covered under the Outpatient Prescription Drug Card benefit.

        (2) Breastfeeding support, supplies, and counseling.

        (3) Gestational diabetes screening.

    Additional information about Preventive Services required under the Affordable Care Act (ACA) is available at the following government websites:

    https://www.healthcare.gov/coverage/preventive-care-benefits/

    https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations
    http://www.hrsa.gov/womens-guidelines

    Any exclusion contained in the Plan for an exam, screening, service, supply, drug or device that is considered a required *Preventive Service* does not apply.

37. **Prosthetics**. Charges for placement of the original prosthetic devices, special appliances and surgical implants (not to include dental or penile implants) required as a result of an Illness or Injury. Benefits will also include adjustments, repairs and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or when the current device has become non-functional due to a change in a patient's status and an improved functional status is expected to be achieved with the replacement.

38. **Radiation Therapy.** Charges for treatment by x-ray, radium, external radiation, or radioactive isotopes, including the fee for materials.

39. **Respiratory/Inhalation Therapy.** Charges for respiratory and inhalation therapy.

40. **Routine Alternative Wellness Care**. Charges for the following services, up to any maximum benefit specified under the "Schedule of Medical Benefits":

    a. Massage Therapy. Massage and Body Work Therapy is defined as manipulation, methodical pressure, friction, and kneading of the body. Therapy must be prescribed by a licensed, certified, or recognized technician.

    b. Chelation Therapy. Chelation Therapy is the removal of heavy metals from the bloodstream by means of a chelate. It must be prescribed by a licensed Physician.

    c. Acupuncture. Acupuncture is a technique for treating certain painful Conditions and for producing regional anesthesia by passing long, thin needles through the skin to specific points. It is not used for the treatment of internal disorders not related to pain/physical medicine.

    d. Herbal Remedies. Herbal Remedies are medicines derived from plant extracts. They are generally concentrated in form and contain measurable amounts of physiologically active substances. Herbal Remedies include dried medicinal and/or herbals that do not contain vitamins, minerals, and/or supplements.

    e. Colonic Therapy. Colon Therapy is any treatment designed for the purpose of cleansing the colon. It must be prescribed by a licensed Physician.

41. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility for services and supplies furnished by the facility in connection with convalescence from the Illness or Injury. These expenses include:

    a. **Room and Board.** Room and Board, including general nursing services. If private room accommodations are used, the Room and Board charge allowed will not exceed the facility's average semi-private rate. However, this limitation will not apply if the facility offers only private rooms.

    b. **Other Services.** Medical services customarily provided by the facility, with the exception of private duty or special nursing services and Physician's fees.

42. **Sterilization.** Charges for elective sterilization for you or your covered spouse. Sterilizations for women are covered under the Preventive Services benefit as required under the Affordable Care Act (ACA).

43. **Surgical Assistants.**

    a. **Assistant Surgeons.** Charges for services by a licensed Physician who actively assists the operating surgeon in the performance of surgical procedures when the Condition of the patient and complexity of the Surgery warrant such assistance. Covered Charges will be limited to 20% of the contract rate or Usual and Customary charges, as applicable, for the total procedure.

    b. **Certified Surgical Assistants.** Covered Charges include these services when rendered by a licensed/certified surgical assistant; such charges will be limited to 15% of the contract rate or Usual and Customary charges, as applicable, for the total procedure.

    c. **Physician Assistants.** Benefits are also provided for these services when rendered by a licensed physician assistant; Covered Charges will be limited to 15% of the contract rate or Usual and Customary charges, as applicable, for the total procedure.

44. **Therapy: Physical - Occupational – Speech.** Charges Incurred for the following services up to any maximum benefit specified under the Schedule of Medical Benefits:

    a. **Physical Therapy.** Treatment or services rendered by a licensed physical therapist. The therapy must be in accord with an M.D. or D.O.'s exact orders as to type, frequency and

duration and for Conditions which are subject to significant improvement through short-term therapy.

b. **Occupational Therapy.** Treatment or services rendered by a licensed occupational therapist. Therapy must be ordered by an M.D. or D.O, result from an Illness or Injury and improve a body function. Covered Charges do not include recreational programs or supplies used in occupational therapy.

c. **Speech Therapy.** Fees of a Physician or licensed speech therapist. Therapy must be ordered by an M.D. or D.O. and follow either:

   (1) An Injury;

   (2) An Illness that is other than a mental disorder or a learning disorder; or,

   (3) A congenital defect, disease, trauma, congenital anomalies or previous therapeutic processes.

Covered Expenses do not include therapy services (i.e., physical therapy, occupational therapy or speech therapy) determined to be for maintenance treatment. Maintenance treatment is considered to be therapy rendered after the patient has reached his or her optimal level of functioning, or when no measurable improvement is shown from continuous ongoing care.

OUTPATIENT PRESCRIPTION DRUG CARD BENEFIT

A list of “Participating Pharmacies” or information regarding the “Mail Order Pharmacy” can be obtained directly from the prescription drug card vendor listed on your Plan I.D. card.

When you are being treated for an Illness or Accident, your Physician may prescribe certain drugs or medicine as part of your treatment. Your coverage includes benefits for drugs, and this section explains which drugs are covered and the benefits that are available for them. Benefits will be provided only if such drugs are Medically Necessary.

Benefits for prescription drugs covered under this Outpatient Prescription Drug Card Benefit will not be provided under any other section of this Plan.

Covered Services

The drugs for which benefits are available under this section are:

1. Drugs that require, by Federal law, a written prescription;
2. Injectable insulin, including syringes and needles purchased by prescription, and diabetic supplies; and
3. Any drug or device that is considered a Preventive Service under the Affordable Care Act including, but not limited to, FDA approved women’s contraceptives, provided the Covered Person has a valid prescription for such drug or device.

Benefits for these drugs will then be provided when you have been given a written prescription for them by your Physician. However, certain drugs may be subject to Clinical Prior Authorization requirements.

Not all drugs are covered by this Plan. Please contact the prescription drug card vendor listed on your Plan I.D. card if you have any questions concerning which drugs or devices qualify for benefits under this Plan.

Benefits will not be provided for refills if the prescription is more than one year old.

Preventive Services

Covered Charges include any drug or device that is considered a Preventive Service under the Affordable Care Act (“ACA”), provided the Covered Person has a valid prescription for such drug or device and it is purchased from a participating retail pharmacy or, if applicable, the mail order program. Preventive Services may include some items that are available “over-the-counter” (provided the item is purchased with a valid prescription).

Benefits for Preventive Services will be payable in keeping with the requirements of ACA. Any exclusion contained in the Plan for a drug or device that is considered a required Preventive Service does not apply.

Benefit Payment for Prescription Drugs

Short Term - Acute Drugs – Retail Pharmacy

When you obtain drugs from a Participating Pharmacy, your Copay for each prescription is:

Pharmacy Option	Premier Rx and Out-of-Area Plan	Value PPO Plan
Preventive Services under the Affordable Care Act	$0	$0
Generic Drugs	$10	$10 plus 25% (maximum $ 25)
Formulary Brand-Name Drugs	$35	$35 plus 25% (maximum $ 70)
Non-Formulary Brand-Name Drugs	$50	$50 plus 25% (maximum $100)

Benefits will be provided for the remaining eligible charge. One prescription means up to a 30-consecutive day supply of a drug.

If a drug is purchased from a non-participating pharmacy, 75% of the eligible change will be payable less the applicable Copayment/Coinsurance shown above.

If you request a Brand-Name Drug when there is an approved Generic equivalent available, the pharmacist will require you to pay the difference between the Generic Drug and Brand-Name cost, in addition to the higher Copay/Coinsurance. If your Physician does not want a Generic substitute, he must indicate this on the prescription.

Long Term - Maintenance Drugs - Mail Order

When you obtain drugs from the Mail Order Pharmacy, your Copay for each prescription is:

Pharmacy Option	Premier Rx, and Out-of-Area Plan	Value PPO Plan
Preventive Services under the Affordable Care Act	$0	$0
Generic Drugs	$20	$20
Formulary Brand-Name Drugs	$70	$70
Non-Formulary Brand-Name Drugs	$100	$100

Maintenance drug prescription means up to a 90-day supply of a drug.

Overall Copay Limit

Maximum per Covered Person per Calendar Year $1,000
Maximum per Family (aggregate) per Calendar Year $2,000

After your Outpatient prescription drug card Copays equal the above stated amount per Calendar Year (retail pharmacy and mail order pharmacy combined), the Plan will pay 100% of all eligible Outpatient prescription drug card expenses for the balance of the Calendar Year. This Copay Limit is separate from the medical Coinsurance limit.

DENTAL EXPENSE BENEFITS

Schedule of Dental Benefits

Deductible	
Covered Person per Calendar Year	$50
Coinsurance by Plan	
Preventive Services	100% no Deductible
Restorative Services	80% after Deductible
Major Services	50% after Deductible
Orthodontia Services	50% after Deductible
Maximum Benefit	
Preventive, Restorative and Major Services	$1,500 per person per Calendar Year
Orthodontia Services	$1,000 per person while covered under this Plan
Note: Orthodontic benefits are available only for covered Dependent children under age 19.	

Covered Dental Expenses

The term “Covered Dental Expenses” refers to the items of dental expenses for which dental benefits may be payable. Covered Dental Expenses are charges for the following services and supplies, which are certified by the attending Dentist or Physician to be reasonably necessary for the treatment of a dental Condition, to the extent that the charges do not exceed the usual charge of the Dentist or Physician and the Usual and Customary charges generally made in the same locality under similar conditions. A service or supply will be considered “reasonably necessary” if it is: (1) appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, Injury or Illness; (2) provided for the diagnosis or direct care and treatment of the dental condition, Injury or Illness; (3) within standards of good dental practice within the organized dental community; (4) not primarily for the convenience of the Covered Person, the Covered Person’s Dentist or another provider; and (5) the most appropriate supply or level of service which can safely be provided.

A “Dentist” is an individual holding a D.D.S. or D.M.D. degree, who is licensed to practice dentistry in the jurisdiction where such services are provided.

A charge is considered to have been Incurred as of the date on which the service or supply for which the charge is made is rendered or obtained.

Preventive Services

1. Routine oral examinations and prophylaxis (cleaning and polishing of teeth), but not more than twice during any Calendar Year.

2. Full mouth X-rays, but not more than once in any 36-consecutive month period;

3. Supplementary bitewing X-rays, but not more than twice during any Calendar Year.

4. Topical application of fluoride for Dependent children under age 19, but not more than once during any Calendar Year.

5. Space maintainers for covered Dependent children under age 19 to replace primary teeth.

6. Emergency oral exams and palliative treatment of dental pain.

7. Sealants for Dependent children under age 13.

Restorative Services

1. Dental X-rays not included under Preventive Services.

2. Extractions.

3. Oral Surgery.

4. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth.

5. General anesthesia when Medically Necessary and administered in connection with oral or dental Surgery.

6. Treatment of periodontal or other diseases of the tissues of the mouth.

7. Endodontic treatment, including root canal therapy.

8. Injection of antibiotic drugs by the attending Dentist or Physician.

9. Recementing of crowns, inlays, onlays, or bridgework.

10. Analgesia, including nitrous oxide gas.

11. Dental consultations.

12. Custom occlusal guards.

Major Services

1. Inlays, onlays, gold fillings or crown restorations to restore diseased or fractured teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic porcelain or composite restoration.

2. Initial installation of partial or full removable dentures replacing extracted natural teeth, including any adjustments during the 6-month period following installation and precision attachments.

3. Initial installation of fixed or removable bridgework (including inlays and crowns as abutments) to replace extracted natural teeth.

4. Addition of clasp or rest to existing partial removable dentures.

5. Repair of crowns, bridgework and removable dentures.

6. Relining or rebasing of removable dentures.

7. Replacement of an existing partial or full removable denture or bridgework by a new denture or bridgework, or the addition of teeth to an existing partial removable denture or bridgework, but only if:

   a. The replacement or addition of teeth is required to replace one or more extracted teeth;

   b. The existing denture or bridgework was installed at least 5 years prior to its replacement and the existing denture or bridgework cannot be made serviceable; or

   c. The existing denture is an immediate temporary denture and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture (unless otherwise required by applicable law).

8. Dental implants.

Orthodontic Services

Note: Orthodontic benefits are available only for covered Dependent children under age 19.

Orthodontic diagnostic procedures and treatment consisting of appliance therapy, provided treatment is rendered, while coverage is in effect. The Dentist must submit a complete treatment plan for approval by the Claims Administrator prior to the start of treatment; including the proposed charges, suggested correction procedure, and approximate time period for the entire Orthodontic Treatment.

Deductible Amount

The "Deductible Amount" is the dollar amount of Covered Dental Expenses for which you are responsible. A Deductible will be applied to the Covered Dental Expenses Incurred by each person covered under the Plan once during each Calendar Year as shown in the Schedule of Dental Benefits. There is no Deductible carryover between Calendar Years.

Pre-determination of Benefits

If a course of treatment can reasonably be expected to involve Covered Dental Expenses of $300 or more, a pre-determination or treatment plan should be filed with the Claims Administrator prior to beginning the course of treatment.

You and your Dentist will be notified of the benefits payable based upon the course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services or course of treatment that may be performed for the dental Conditions concerned in order to accomplish the desired results based on accepted standards of dental practice.

If a pre-determination or treatment plan is not submitted in advance, the Plan Administrator reserves the right, at the time claim is filed, to make a determination of benefits, taking into account alternate procedures, services or course of treatment, based on accepted standards of dental practice.

Benefits Payable

When you or a Dependent incur Covered Dental Expenses in excess of the Deductible amount for dental care while covered under the Plan, you will become entitled to benefits for Covered Dental Expenses shown in the Schedule of Dental Benefits.

In no event will benefits payable on any Covered Person exceed the maximum benefit amount shown in the Schedule of Dental Benefits.

Maximum Benefit

The amount of the maximum benefit is shown in the Schedule of Dental Benefits. It applies separately to Covered Dental Expenses Incurred by you or your covered Dependents.

Benefits After Termination

If coverage for you or your Dependent terminates for any reason, no benefits are payable for services rendered beyond the date of termination. There will be no extension of benefits for a treatment plan initiated but not completed, including, but not limited to, root canal therapy, crowns, bridges, inlay/onlays, full/partial dentures and orthodontia treatment.

For services to be considered Eligible Expenses, the work must be started and completed prior to or on the date of termination.

Dental Expense Exclusions and Limitations

The following exclusions and limitations apply to expenses Incurred by all Covered Persons:

1. Services other than those specifically shown as “Covered Dental Expenses”.
2. Charges for treatment by other than a Dentist except for the taking of x-rays, cleaning of teeth and topical application of fluoride which may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the Dentist.
3. Charges for veneers or similar properties of crowns and pontics for Cosmetic purposes.
4. Charges for replacement made within 5 years after the last placement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge. This exclusion is waived if replacement is needed because the appliance, crown, inlay, onlay or bridge, while in the oral cavity, is damaged beyond repair due to injury sustained by the Covered Person or following oral surgery in which one or more teeth are removed. (Damage resulting from biting or chewing is not considered an accidental Injury).
5. Charges for a duplicate prosthetic device or appliance or for the replacement of a lost, missing, or stolen prosthetic device or appliance.
6. Charges for services or supplies, which according to accepted standards of dental practice, are not necessary or which are not recommended or approved by the attending Dentist; or are Experimental in nature.
7. Charges for oral hygiene, dietary instruction or plaque control program.
8. Charges for services or supplies that are Cosmetic in nature or directed toward a Cosmetic end, including charges for personalization or characterization of dentures.
9. Charges for periodontal splinting.
10. Charges for services or supplies that in the absence of this coverage, you would not be required to pay.
11. Charges for appliances, restorations and procedures to alter vertical dimension or restore occlusion.
12. Charges for any dental services if benefits or services for all or any part of the expenses are provided under the medical portion of this Plan.
13. Charges for replacement or repair of an orthodontic appliance.
14. Charges for prescription drugs.
15. Charges for equipment sterilization.
16. Surgery to correct malposition in the bones of the jaw.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses Incurred by all Covered Persons:

1. **Abortion, Dependent Child.** Charges Incurred by a Dependent child for services, supplies, care or treatment in connection with an elective abortion. This exclusion does not apply when the life of the mother is endangered.

2. **Alternative Therapies.** Charges for alternative therapies, other than as specifically included under the Routine Alternative Wellness benefit. Such expenses include but not limited to aromatherapy, light therapy, rolfing, homeopathy, hydrogen peroxide, magnetic, naturopathic or any other treatments that are not conventional or the treatment of choice by mainstream medicine.

3. **Behavior Modification.** Charges for milieu therapy; any confinement in an institution primarily to change or control one's environment; services or treatment of behavioral problems, learning disabilities, developmental delays or dysfunctional relationships, unless otherwise specified.

4. **Close Relative.** Charges for services rendered by a Physician, Nurse, licensed therapist or other covered provider, if such Physician, Nurse, licensed therapist or other covered provider is a Close Relative of the Covered Person, or resides in the same household as the Covered Person.

5. **Complications.** Charges for services or supplies that result from complications arising from a non-covered Illness or Injury, or from a non-covered procedure, unless otherwise specified.

6. **Cosmetic.** Charges Incurred in connection with, including any complications resulting from, the care, treatment or Surgery performed for a Cosmetic Procedure. This exclusion will not apply, as allowed by applicable law, when:
    a. Such treatment is rendered to correct a Condition resulting from an Accidental Injury;
    b. When reconstructive Surgery is performed for the treatment of a disease, but only if the disease is considered a covered Condition under the Plan; or
    c. When rendered to correct a Medically Necessary congenital abnormality other than for psychological reasons.

7. **Counseling.** Charges for counseling for marital difficulties, social maladjustment, pastoral issues, financial issues, behavioral issues, or lack of discipline or other antisocial action, except when specifically required to treat a Mental Health Illness Condition.

8. **Custodial.** Charges Incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use; in connection with Custodial Care, education or training; or actually Incurred by other persons.

9. **Effective Date.** Charges Incurred prior to the effective date of coverage under the Plan, or after coverage is terminated, unless otherwise stated in the Plan.

10. **Equipment.** Charges related to:
    a. Personal comfort or convenience items including, but not limited to, air conditioners, humidifiers and purifiers, exercise therapy equipment, ramps, elevators, TDD/TTY communication devices and personal safety alert systems. This exclusion also applies to expenses Incurred for the modification of homes, vehicles or personal property to accommodate patient convenience.
    b. Purchase or rental of luxury medical equipment when standard equipment is appropriate for the patient's Condition (for example, motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).

11. **Exercise Programs**. Charges Incurred for participation in exercise programs, including Phase III cardiac rehabilitation programs.

12. **Experimental.** No benefits will be paid for Experimental, Investigational or educational treatment. In addition, no benefits will be paid for any treatment, services or supplies that are provided primarily for research. This exclusion will not apply to health care services, items, and drugs that are typically provided in health care and would be covered under this Plan if the Covered Person were not enrolled in a clinical trial, including health care services, items, and drugs provided to a patient during the course of treatment in a cancer clinical trial for a Condition or any of its complications that are consistent with the usual and customary standard of care, including the type and frequency of any diagnostic modality.

13. **Feet.** Charges resulting from the treatment of weak, unstable or flat feet, bunions (unless an open cutting procedure is performed), corns, calluses, toenails (unless part of the nailbed or nail root is removed or for treatment of a metabolic or peripheral vascular disease), orthopedic shoes, modative inlays or inserts.

14. **Felonious Act.** Charges resulting from or occurring during the commission of a Felonious Act or aggravated assault by the Covered Person; or while the Covered Person is engaged in an illegal occupation.

15. **Fertility.**
    a. Charges related to, or in connection with, surrogate parenting, donor eggs, donor sperm and host uterus.
    b. Charges related to, or in connection with, fertility studies, sterility studies, procedures to restore or enhance fertility (including fertility drugs), artificial insemination, in-vitro fertilization, gamete intra-fallopian transfer (G.I.F.T. Program) or similar programs or infertility medication or testing.

16. **Food Supplements.** Charges related to food supplement or augmentation, in any form (unless Medically Necessary to sustain life in a critically ill person).

17. **Government.** Charges Incurred while confined in a Hospital owned or operated by the United States Government or any agency thereof; or charges for service, treatment or supplies furnished by the United States Government or any agency thereof; unless applicable law requires the Plan to pay.

18. **Hearing Aids.** Charges Incurred in connection with hearing aids or such similar aid devices and exams for their fitting. This exclusion will not apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure performed or Traumatic Event.

19. **HMO.** Services rendered to an employee who is covered under a Contributing Employer-sponsored HMO or similar organization.

20. **Legally Obligated.** Charges Incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay, that would be covered by a grant; or for which a charge would not ordinarily be made in the absence of this coverage. Not to be affected by this exclusion is the Plan's liability as outlined in the section entitled "Coordination of Benefits" in connection with another plan that is an HMO.

21. **Medically Necessary.** Charges Incurred in connection with services and supplies which are:
    a. Not Medically Necessary for the treatment of an Injury or Illness; or
    b. Not recommended and approved by a Physician unless specifically shown as a Covered Expense elsewhere in the Plan.

    The fact that a Physician or other provider may prescribe, order, recommend or approve a service or supply, does not, in and of itself, make such service or supply Medically Necessary.

    Charges for services, supplies or treatment not recognized by the Food and Drug Administration, National Institute of Health or the Centers for Medicare and Medicaid Services (CMS) as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury;

or charges for procedures, surgical or otherwise, which are specifically listed by the Food and Drug Administration, National Institute of Health or CMS as having no medical value.

Non-Medically Necessary Hospital Inpatient admissions, extended stays to Inpatient admissions, Hospital Miscellaneous Expenses, diagnostic tests, exams, x-rays or other treatment.

22. **Motor Vehicle.** Charges Incurred as a result of a motor vehicle Accident while the Covered Person was insured or eligible for health benefits or benefits under a valid “no-fault” automobile policy or medical pay benefit, but only to the extent of coverage under the “no-fault” automobile policy or medical pay benefit, unless required by law.

23. **Not Covered.** Charges for services or supplies that are not specifically covered under this Plan.

24. **Obesity.** Charges for treatment of obesity including but not limited to suction lipectomy, weight reduction, dietary consultations, and surgical treatment of obesity or complications thereof, unless otherwise stated in the “Medical Expense Covered Charges” section or as otherwise required by ACA for a Preventive Service. X-ray and laboratory tests performed to determine the cause of obesity are covered.

25. **Occupation/Occupational.**
    a. Charges arising out of or in the course of any occupation for wage or profit that a Covered Person has with another employer. Another employer includes being self-employed when workers’ compensation coverage is available, regardless of whether such coverage is actually in effect. However, self-employed is not intended to include minors with jobs such as a paper route.
    b. Charges for which benefits are available under any workers’ compensation or occupational disease law, or any such similar law which applies to any company the Covered Person works for, whether or not such coverage is actually in effect.
    c. Charges for which benefits are available under any workers’ compensation coverage provided by the Contributing Employer for their employees. However, if benefits are denied under such coverage, expenses may be eligible under the Plan.

26. **Period of Coverage.** Charges Incurred prior to or after any period of coverage under this Plan, except as specifically provided herein.

27. **Physician.** Charges for Physician’s fees for any treatment which is not rendered by or in the physical presence of a Physician, including standby Physician/surgeon, except as otherwise specified.

    Charges for failure to keep a scheduled visit, for completion of a claim form or for preparation of report(s) to other Physicians, or late payment fees assessed by the Physician.

28. **Pregnancy of a Dependent Child**. Charges related to the Pregnancy of a Dependent child, including pre-natal, delivery and post-natal care, treatment of miscarriage, unless required by applicable law.

29. **School.** Charges for services rendered or billed for by a school or half-way house or a member of its staff.

30. **Sex.** Charges for services related to sex transformations, non-organic sexual dysfunctions or inadequacies. Any implants or sexual counseling is excluded regardless of the cause.

31. **Smoking.** Charges for services, supplies, drugs or treatment rendered for the purpose of nicotine addiction, e.g., hypnosis, stop smoking clinics and programs, except as otherwise stated.

32. **Sterilization.** Charges resulting from or in connection with the reversal of sterilization procedures.

33. **Teeth.** Charges Incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes will not be eligible for medical benefits; however, medical benefits will be payable for charges Incurred:

    a. For the removal of impacted teeth (no allowance for other extractions) on an Outpatient basis unless Hospital confinement is Medically Necessary;

    b. For the removal of tumors and cysts of the jaws, cheeks, lips, tongue, floor and roof of the mouth;

    c. For treatment required because of Accidental Injury to sound natural teeth (but not from chewing, excluding dental implants unless dentally necessary), and not for repair or replacement of a denture;

    d. Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;

    e. Excision of benign bony growths of the jaw and hard palate;

    f. External incision and drainage of cellulites;

    g. Incision of sensory sinuses, salivary glands or ducts;

    h. For charges by a Hospital (Inpatient or Outpatient care) or Outpatient facility (including anesthesia) when treatment at the facility is Medically Necessary for the dental treatment.

    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.

    Dentist and oral surgeon's charges for treatment of a dental Condition are not eligible under the medical benefits portion of the Plan unless stated above or under the section entitled "Medical Expense Covered Charges."

    Charges for non-surgical correction of malocclusion or protrusion or recession of the mandible; maxillary hyperplasia, or maxillary hypoplasia. (Malocclusion occurs when teeth do not fit together properly, which is also referred to as a "bite problem;" mandible protrusion or recession; "underbite," or which the chin is excessively large; "overbite," or when the chin is abnormally small; maxillary hyperplasia, or "overbite" due to excess growth of upper jaw; maxillary hypoplasia, or undergrowth of upper jaw). This exclusion will not apply to medical benefits for orthognathic Surgery when Medically Necessary.

34. **Testing.** Charges for any examination or procedure performed for screening, surveys, research or an examination rendered in connection with a physical examination ordered or required for the use of a third party, educational testing or training, including Intelligence Quotient testing, or court-ordered evaluations or programs (unless deemed Medically Necessary).

35. **Travel.** Charges Incurred outside the United States if the Covered Person traveled to such a location for the purpose of obtaining medical services, drugs or supplies. The exclusion does not apply to charges Incurred while outside the United States for the purpose of business, travel or education, so long as the charges meet all other criteria for a Covered Expense.

36. **Ultrasounds.** Charges for ultrasounds or other tests performed solely to determine a fetal age or fetal sex.

37. **Usual and Customary.** Charges which exceed the Usual and Customary allowance as determined by any nationally recognized database which the Claims Administrator utilizes.

38. **Vision.** Charges Incurred in connection with eye refractions, or the purchase or fitting of eyeglasses or contact lenses. This exclusion will not apply to the initial purchase of eyeglasses or contact lenses following cataract Surgery or the necessary replacement due to prescription changes following such Surgery.

Radial keratotomy, keratoplasty, keratomileusis, photorefractive keratectomy (PRK) or any other eye Surgery to improve nearsightedness, farsightedness and/or astigmatism, or to correct, treat or improve any related Conditions or causes of these Conditions.

39. **Vocational Services.** Charges for vocational or training services. However, this exclusion will not apply to education services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be Medically Necessary by the Plan.

40. **War.** Charges Incurred as a result of war or any act of war, whether declared or undeclared, when the Covered Person is an active member of the armed forces of any country or caused during service by a Covered Person in the armed forces of any country. Excluded charges also include treatment of an Illness or Injury sustained due to a Covered Person's participation in any act of aggression or any terrorist activity.

41. **Weekend Admissions.** Charges for weekend admissions, including Friday, unless for Accidents, life-threatening Conditions, maternity or when Surgery is scheduled on that day or before 10:00 a.m. the following day.

42. **While Imprisoned.** Charges Incurred for treatment of an Illness or Injury sustained while a Covered Person was incarcerated, or in the custody of any Federal, State or Local authority.

43. **Wigs.** Charges for wigs.

DEFINITIONS

Certain words and phrases used in this Summary Plan Description are listed below with the definition or explanation of the manner in which the term is used for the purpose of this Plan. **The following definitions are not an indication that charges for particular services or supplies are eligible for payment under the Plan; please refer to the appropriate sections of the Summary Plan Description for that information.**

ACA

"ACA" means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, of 2010.

Accident

"Accident" means an unintentional or unexpected happening which:

1. Causes Injury to the physical structure of the body;
2. Results from an external agent or trauma;
3. Is definite as to time and place; and
4. Happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.

"Accident" does not include a hernia of any kind, harm resulting from a disease, Illness or allergic reactions, with the exception of insect venom reactions.

Active Service

"Active Service" means a Participant is employed by a Contributing Employer for the minimum number of hours per week outlined in the General Eligibility Provisions. Such work may occur either at the usual place of business of the Contributing Employer or at a location to which the business of the Contributing Employer requires the Participant to travel, and for which he receives regular earnings from the Contributing Employer. An employee will be deemed to be in Active Service if he is absent from work due to a health factor.

Ambulatory Surgical Center

"Ambulatory Surgical Center" means an institution or facility, either free standing or as part of a Hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures and in which a patient is admitted and discharged within a 24-hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, will not be considered to be an "Ambulatory Surgical Center."

Birthing Center

"Birthing Center" means an independent, licensed facility which is certified under the statutory requirements of the given state in which it is located, and provides 24-hour nursing services by Registered Nurses and Certified Nurse Midwives. An obstetrician or a Physician qualified to practice obstetrics with hospital admitting privileges must be available for consultation and referral and on call during labor and delivery. A Birthing Center must be equipped, staffed, and operating for the purpose of providing:

1. Family centered obstetrical care for patients during uncomplicated pregnancy, delivery, and immediate postpartum periods;
2. Care for infants born in the center who are either normal or who have abnormalities which do not impair functions or threaten life; and

3. Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

A Birthing Center must have an agreement with an ambulance service and a hospital to accept transfer.

Brand-Name Drug

"Brand-Name Drug" means drugs produced and marketed exclusively by a particular manufacturer. These names are usually registered as trademarks with the Patent Office and confer upon the registrant certain legal rights with respect to their use.

Calendar Year

"Calendar Year" means a period of time commencing on January 1, and ending on December 31, in the same given year.

Claims Administrator

"Claims Administrator" means the firm employed by the Plan Administrator to provide ministerial services in connection with the operation of the Plan and any other function, including the processing and payment of claims.

Close Relative

"Close Relative" means a person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother and stepsister), child (includes legally adopted or stepchild), grandfather or grandmother.

COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance

"Coinsurance" means that portion of Eligible Expenses to be paid by the Plan and the Participant in accordance with the coverage provisions stated in the Plan. It is the basis used to determine the amount of Covered Expenses which are to be paid by the Participant.

Condition

See definitions of "Illness" and "Injury."

Contributing Employer

"Contributing Employer" refers to any eligible agency member of the housing and redevelopment authorities in the Southeast Regional Council (SERC) and Southwest Regional Council (SWRC) of the National Association of Housing and Redevelopment Officials (NAHRO) which is required under the terms of an agreement to make contributions to the Plan on behalf of its employees covered by the agreement and the Plan itself, on behalf of its Eligible Employees.

Copay

"Copay" means that amount shown in any benefit schedule which is the Participant's responsibility for charges Incurred for doctor's office visits, prescription drugs, or other services.

Cosmetic Procedure or Cosmetic

"Cosmetic Procedure" or "Cosmetic" means a procedure or treatment performed solely or primarily for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Charges or Covered Expenses

"Covered Charges" or "Covered Expenses" means the provider's charge for services rendered to the Covered Person for Medically Necessary treatments, services or supplies for an Illness or Injury not caused by the treating provider, which are considered Usual and Customary, are subject to Coinsurance and Deductibles, and are not specifically excluded under the Plan. Any charge that is determined to be inaccurate or excessive as a result of a claim review or audit will not be deemed a Covered Charge under this Plan.

Covered Person

"Covered Person" means any Participant or Dependent. "Covered Person" will be deemed to include, where appropriate, a COBRA continuee or a person who qualifies under other classifications set forth in the General Eligibility Provisions, who meets the eligibility requirements of coverage as specified in this Plan, and is properly enrolled in the Plan.

Craniomandibular Disorder

"Craniomandibular Disorder" means pain, muscular spasm, grinding, clicking, swelling, numbness, stiffness, headache or other pathological Condition which creates a loss or decrease of function, involving chewing muscles of the upper and lower jaws, the postural muscles of the upper and lower jaws and of the neck, and the nerves, muscles, ligaments, glands and bones of the face, skull, neck and spine.

Custodial Care

"Custodial Care" means that type of care or service, whichever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed and supervision over medication which can normally be self-administered.

Deductible

"Deductible" means a specified dollar amount of Covered Expenses which must be Incurred during a Calendar Year (unless otherwise stated in a benefit schedule) before any other Covered Expenses can be considered for payment according to the applicable benefit percentage.

Dependent

"Dependent" is as defined under the section "General Eligibility Provisions – Eligible Dependents".

Dependent Coverage

"Dependent Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of Eligible Expenses Incurred for an Illness or Injury of a Dependent.

Durable Medical Equipment

The term "Durable Medical Equipment" means equipment which is:

1. Able to withstand repeated tests.
2. Primarily and customarily used to serve a medical Illness or Injury.
3. Not generally useful for a person in the absence of Illness or Injury.

Eligible Expenses

See definition of "Covered Charges" or "Covered Expenses."

Emergency Medical Condition

"Emergency Medical Condition" means a medical Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or, (ii) serious impairment to bodily functions; or, (iii) serious dysfunction of any bodily organ or part.

Emergency Services

"Emergency Services" means treatment given in an emergency department of a Hospital for an Emergency Medical Condition. Such treatment includes a medical screening examination within the capability of the Hospital emergency department, including ancillary services routinely available to evaluate such Emergency Medical Condition and further examination and treatment required to stabilize the patient.

ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits

"Essential Health Benefits" means essential health benefits under section 1302(b) of the ACA and applicable regulations. Section 1302(b) of the ACA defines such benefits to include at least the following general categories and the items and services covered within the categories: 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 pediatric oral and vision care.

Experimental, Investigational/Investigative or Unproved

“Experimental”, “Investigational”, “Investigative”, or “Unproved” shall mean a drug, device, medical Treatment or procedure that meets any one of the following:

1. The drug or device cannot be lawfully used or marketed without approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to, the U.S. Federal Drug Administration (FDA). For purposes of this subparagraph, a drug or device being used for an indication or at a dosage that reliable evidence shows is an accepted off-label use will not be considered to be “experimental”, “investigative” or “unproved”.

   Off-label use of drugs will be allowable under the Plan if it meets the following criteria:

   The use of the drugs is supported by one or more citations in The American Hospital Formulary Service Drug Information, Micromedex DrugPoints, Facts and Comparisons, NCCN, Clinical Pharmacology, the Association of Community Cancer Centers or any CMS supported compendia, providing the use is **not** listed as “not indicated” in any one of the listed compendia.

2. The drug, device, medical Treatment or procedure, or the patient informed-consent document utilized with the drug, device, Treatment or procedure, is subject to an ongoing review by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval.

3. Reliable Evidence shows that the drug, device, medical Treatment or procedure is the subject of an ongoing clinical trial, which is research, experimental, a study or investigational arm of an ongoing clinical trial, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of Treatment or diagnosis, or the trial is designed exclusively to test toxicity or disease pathophysiology; or

4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical Treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of Treatment or diagnosis.

“Reliable Evidence” shall mean only consensus findings, opinions or recommendations published in the authoritative medical and scientific literature or peer-reviewed literature; reports of clinical trial committees and other technology assessment bodies; consensus opinions of local and national health care providers in the specialty or subspecialty that would typically manage the sickness or injury for which the drug, device, technology, treatment, supply or procedure is proposed; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical Treatment or procedures; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical Treatment or procedure.

The Plan Administrator will rely on various sources to assist in determining “Experimental, Investigative or Unproved” services. These sources may include, but are not limited to: The DATTA program of the American Medical Association, the Hayes Manual, the National Institute of Health, the U.S. Food and Drug Administration, the National Cancer Institute, Office of Health Technology Assessment and Congressional Office of Technology Assessment.

Extended Care Facility

See definition of “Skilled Nursing Facility.”

Family

“Family” means a Participant and eligible Dependents.

Felonious Act

"Felonious Act" means a crime or offense which carries with it the punishment associated with a felony conviction, as determined by common law or statute within the presiding jurisdiction of law enforcement. An occurrence of driving under the influence of a drug or alcohol is not considered a "Felonious Act" under this Plan.

Generic Drug

"Generic Drug" means drugs not protected by a trademark, usually descriptive of a drug's chemical structure.

Health Breach Notification Rule

"Health Breach Notification Rule" means 16 CFR Part 318.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency

"Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Nurse to govern the services provided, and it must provide for full-time supervision of such services by a Physician or Registered Nurse;
3. It maintains a complete medical record on each individual; and
4. It has a full-time administrator.

Home Health Care Plan

"Home Health Care Plan" means a formal program for care and treatment of the Covered Person established and approved in writing by the Covered Person's attending Physician.

Hospice

"Hospice" means a health care program providing a coordinated set of services rendered at home, in Inpatient settings or in institutional settings for Covered Persons suffering from a Condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (N.H.O.) and applicable state licensing requirements.

Hospice Benefit Period

"Hospice Benefit Period" means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the Covered Person's attending Physician certifies a diagnosis of terminally ill, and the Covered Person is accepted into a Hospice program. The period will end the earliest of six months from this date or at the death of the Covered Person. A new benefit period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof may be required by the Plan Administrator before such a new benefit period can begin.

Hospital

"Hospital" means an institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
2. It is constituted, licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to Hospitals;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical or surgical treatment of an Illness or an Injury, other than specialty Hospitals such as physical therapy and psychiatric Hospitals;
4. Such treatment is provided for compensation by or under the supervision of Physicians with continuous 24-hour nursing services by Nurses;
5. It qualifies as a Hospital, a psychiatric Hospital, physical therapy Hospital or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Hospitals (J.C.A.H. (unless accreditation is limited by the jurisdiction of the J.C.A.H. due to the location of the Hospital or is accredited by the proper authority in the country in which the Hospital is located)); or a Substance Abuse Treatment Facility certified by the Division of Community Services and licensed by the Department of Health; and
6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics or a nursing home.

Hospital Miscellaneous Expenses

"Hospital Miscellaneous Expenses" means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person and which are not otherwise excluded under the Plan. "Hospital Miscellaneous Expenses" do not include charges for Room and Board or for professional services (including intensive nursing care) regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Hours of Service – *Applicable to Housing Authorities with 50 or More Full-Time Equivalents*

"Hours of Service" means each hour for which the employee is paid, or entitled to payment, for performance of duties for the Contributing Employer; and each hour for which the employee is paid, or entitled to payment by the Contributing Employer for a period of time during which no duties are performed due to vacation, holiday, Illness or incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b-2(a)).

Hours of Service do not include:

1. Any hour of service performed as a bona fide volunteer.

2. Any hour of service to the extent those services are performed as part of a federal work-study program as defined under 34 CFR 675 or a substantially similar program of a state or political subdivision thereof.
3. Any hour of service to the extent the compensation for those services constitutes income from sources outside the United States.
4. Any hour of service performed by an individual who is subject to a vow of poverty as a member of that order when the work is in the performance of tasks usually required (and to the extent usually required) of an active member of the order.

The Contributing Employer will establish a Measurement Period for crediting an employee's Hours of Service that is consistent with the method as prescribed by the Shared Responsibility for Employers Regarding Health Coverage rules under section 4980H of the Internal Revenue Code (Code), enacted by the ACA.

Illness

"Illness" means a disorder or disease of the body or mind, or pregnancy as classified in the ICD.10.CM Manuals (or updated version). All Illnesses due to the same cause, or to a related cause, will be deemed to be one "Illness."

Incurred

"Incurred" means the date when a service is performed, a supply is provided or a purchase is made. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury

"Injury" means a Condition caused by an Accident which results in damage to the Covered Person's body.

Inpatient

"Inpatient" refers to the classification of a Covered Person when that person is admitted to a Hospital, Hospice or Convalescent Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment; or when a Covered Person is confined in a Hospital for 24 consecutive hours or more.

Intensive Outpatient Plan or Partial Hospitalization

"Intensive Outpatient Plan" or "Partial Hospitalization" means a distinct and organized intensive ambulatory treatment service, less than 24-hour daily care specifically designed for the diagnosis and active treatment of a Mental Health Illness or Substance Abuse when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

Programs must provide diagnostic services; services of social workers; psychiatric Nurses and staff trained to work with psychiatric patients; individual, group and Family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

The facility providing the Intensive Outpatient Program or Partial Hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a Physician.

Legal Guardianship

"Legal Guardianship" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Maintenance Care

"Maintenance Care" means any service or activity which seeks to prevent disease, prolong life or promote health of an asymptomatic Covered Person who has reached the maximum level of improvement and whose Condition is resolved or stable.

Measurement Period – *Applicable to Housing Authorities with 50 or More Full-Time Equivalents*

"Measurement Period" means the period of time established by the Contributing Employer during which an employee's hours are calculated to determine whether the employee has averaged the number of Hours of Service required to qualify as a full-time eligible employee.

The Contributing Employer will utilize a measurement method prescribed by the Shared Responsibility for Employers Regarding Health Coverage rules under § 4980H of the Internal Revenue Code and may use different methods and Measurement Periods for different categories of employees. Absent anything to the contrary, the Measurement Period will begin on November 1 and end on October 31 of the following year.

Medical Necessity or Medically Necessary

"Medical Necessity" or "Medically Necessary" means services or supplies provided by a Hospital, Physician or other covered provider which are not excluded under this Plan, which are provided to treat or diagnose an Illness or Injury, and which are determined by the Plan Administrator to meet the following criteria:

1. It is consistent with the symptoms or diagnosis and treatment of the Illness or Injury;
2. It is not primarily for the convenience of the Covered Person, Physician or other provider;
3. It does not involve unnecessary or repeated tests;
4. It is not of an Experimental, Investigational or educational nature. Drugs and drug treatment in one or more compendia qualifying for Medicare reimbursement will not be considered Experimental or Investigational;
5. It is furnished by a provider with appropriate training and experience, acting within the scope of his license, and it is provided at the most appropriate level of care needed to treat the particular Condition; and,
6. Meets the following definition of standard of care.

   Standard of care refers to an acceptable level of patient care provided by a medical practitioner. It considers how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.

   Standard of care is sometimes referred to as "standard therapy" or "best practice" and is generally satisfied by any medicine or treatment that experts agree is consistent with generally accepted standards of medical practice, is appropriate, accepted, and widely used for a certain type of patient, illness, or clinical circumstance. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society

recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

The administration of a non-approved experimental drug, procedure or device, or the participation in a clinical trial will not invalidate coverage for treatment that is considered an established standard of care.

The Plan Administrator will analyze whether these requirements have been met based upon:

1. Published reports in authoritative medical and scientific literature;
2. Regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA) and CMS;
3. Listings in the following compendia: The American Hospital Formulary Service Drug Information, Micromedex DrugPoints, Facts and Comparisons, NCCN, Clinical Pharmacology, the Association of Community Cancer Centers or any CMS supported compendia; and
4. Other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Medicare

"Medicare" means the program of health care established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Health Illness

"Mental Health Illness" includes, but is not limited to, schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive Illness), anxiety disorders, somatoform disorders, personality disorders, psychosexual disorders, and bipolar affective disorders or any psychiatric disorder caused by chemical imbalance, as classified in the ICD.10.CM Manual or updated version.

Named Fiduciary

"Named Fiduciary" means the Housing Benefits Plan, which has the authority to control and manage the operation and administration of the Plan.

Nurse

"Nurse" means any of the following:

1. Certified Registered Nurse Anesthetist (C.R.N.A.)
2. Certified Nurse of the Operating Room (C.N.O.R.)
3. Certified Surgical Technologist (C.S.T.)
4. Certified First Assistant (C.F.A.)
5. Licensed Nurse Practitioner (L.N.P.)
6. Licensed Practical Nurse (L.P.N.)
7. Nurse Midwife (N.M.)
8. Registered Nurse (R.N.)

Open Election/Enrollment Period

"Open Election/Enrollment Period" means the time period set forth in the General Eligibility Provisions.

Orthotic Appliance

"Orthotic Appliance" means an external device intended to correct any defect in form or function of the human body.

Outpatient

"Outpatient" refers to the classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office or a Hospital, if not a registered bedpatient at that Hospital, an Outpatient Psychiatric Facility or an Outpatient Alcoholism Treatment Facility.

Outpatient Alcoholism Treatment Facility

"Outpatient Alcoholism Treatment Facility" means an institution which provides a program for diagnosis, evaluation and effective treatment of alcoholism; provides detoxification services needed with its effective treatment program; provides infirmary level medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed Nurses who are directed by a full-time Nurse; prepares and maintains a written plan of treatment for each patient based upon medical, psychological and social needs which is supervised by a Physician; and meets applicable licensing standards.

Outpatient Psychiatric Facility

"Outpatient Psychiatric Facility" means an administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

Participant

"Participant" means a person directly employed in the regular business of, and compensated for services by, the Contributing Employer, who is eligible for, has elected and has enrolled for Participant Coverage.

Participant Coverage

"Participant Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of an Injury or Illness of a Participant.

Physician

"Physician" will include the following health care providers:

1. **Physician.** "Physician" means a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, optometrist, Physician assistant, physical therapist, speech therapist, occupational therapist, audiologist, speech language pathologist, certified consulting psychiatrist, psychologist or licensed or certified mental health/Substance Abuse provider to the extent they, within the scope of their license, are permitted to perform the services provided in this Plan.
2. **Mental Health/Substance Abuse Provider.** "Mental Health/Substance Abuse Provider" means a legally licensed psychiatrist, psychologist, licensed or certified social worker, clinical psychiatric counselor or psychiatric Nurse clinician, or other licensed mental health practitioners. In states

where licensing and certification are not available, this Plan will recognize a provider that holds a Masters level degree in the field of mental health or Substance Abuse.

3. **Nurses.** Nurses, as defined herein.

Plan

"Plan" means the Housing Benefits Plan which is an employee welfare benefit plan that is described in this Summary Plan Description.

Plan Administrator

"Plan Administrator" means the Housing Benefits Plan.

Pre-admission Testing

"Pre-admission Testing" means the tests performed in a Hospital or other facility prior to confinement as a resident Inpatient, provided such tests are related to a scheduled Hospital confinement.

Pre-existing Condition

This Plan does not limit or exclude benefits for charges Incurred for a Pre-existing Condition.

Preventive Service

"Preventive Service" means a screening, immunization or service listed in the following recommendations and guidelines issued on or before September 23, 2009:

1. Evidence-based preventive services: Preventive services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved.
2. Routine immunizations: Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
3. Prevention for children: Preventive care for infants, children, and adolescents recommended under the "Bright Futures" guidelines developed by the Health Resources and Services Administration with the American Academy of Pediatrics.
4. Prevention for women: Preventive care and screening provided for in comprehensive guidelines supported by Health Resources and Services Administration (not otherwise addressed by the recommendations of the Task Force).

A recommendation or guideline adopted after September 23, 2009 will be covered beginning on the first day of the Plan Year that is one year after the date the recommendation or guideline is issued.

Psychiatric Care

"Psychiatric Care," also known as psychoanalytic care, means treatment for a mental Illness or disorder, a functional nervous disorder, alcoholism or drug addiction; with the type of care consisting of psychotherapy, group therapy, psychological testing or Family interviews designed to obtain information and to assist in treating the patient.

As used in this Plan, "Psychotherapy" means treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic

communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. Psychotherapy is performed after a complete psychological/psychiatric evaluation of the patient is completed. Psychotherapy consists of talking to help the patient evaluate, understand, respond to, and cope with his/her mental illness.

QMCSO

The term “QMCSO” means a Qualified Medical Child Support Order. This is a medical child support order or national medical support notice which meets all of the requirements of applicable law.

Residential Treatment Facility

“Residential Treatment Facility” means a facility which provides a program of effective treatment for a Mental Health Illness or Substance Abuse and which meets all of the following requirements:

1. It is licensed by the state in which it operates and is operated in accordance with applicable state law for residential treatment programs.
2. It provides a program of treatment under the active participation and direction of a Physician.
3. It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
4. It provides all of the following basic services 24-hours per day:
    a. Room and board.
    b. On-site nursing services.
    c. Evaluation and diagnosis.
    d. Counseling.
    e. Referral and orientation to specialized community resources.
5. It is accredited by one of the following: Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities, or Accreditation Association for Ambulatory Health Care.

A Residential Treatment Facility does not include half-way houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities.

Room and Board

“Room and Board” refers to all charges by whatever name called which are made by a Hospital, Hospice or Convalescent Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

Skilled Nursing Facility

“Skilled Nursing Facility” means an institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Nurse under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;
2. Its services are provided for compensation from its patients and under full-time supervision of a Physician or Registered Nurse;
3. It provides 24-hour-per-day nursing service 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 retarded persons, Custodial Care, educational care or care of mental disorders; and
7. It is approved by Medicare and licensed by the state in which it is located.

This term will also apply to expenses Incurred in an institution referring to itself as a "Skilled Nursing Facility," "Extended Care Facility," "Convalescent Nursing Home" or any such other similar nomenclature.

Stability Period – *Applicable to Housing Authorities with 50 or More Full-Time Equivalents*

"Stability Period" means the period of time established by the Contributing Employer during which an employee's status for coverage, as determined during the associated Measurement Period, is locked provided the employee does not terminate employment with the Contributing Employer or as otherwise outlined in the regulations relating to Code Section 4980H of the Internal Revenue Code. A Stability Period applies only if the Contributing Employer is using the look back measurement method.

A Stability Period begins at the end of the associated Measurement Period and includes any applicable administrative period established by the Contributing Employer during which administrative and enrollment functions are performed.

The Contributing Employer may use different Stability Periods for different categories of employees in a manner that is consistent with the Shared Responsibility for Employers Regarding Health Coverage rules under section 4980H of the Internal Revenue Code (Code), enacted by the Affordable Care Act.

Substance Abuse

"Substance Abuse" means the uncontrollable or inappropriate use of addictive substances or the intentional inhalation of toxic fumes, gases or substances and the resultant physiological or psychological dependency which develops with continued use, requiring medical care as determined by a Physician or psychologist. Addictive substances include but are not limited to: alcohol, morphine, marijuana, cocaine, opium and other barbiturates and amphetamines.

Substance Abuse Treatment

"Substance Abuse Treatment" means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician or psychologist, court-ordered evaluations, programs which are primarily for diagnostic evaluations, care in lieu of detention or correctional placement or Family retreats.

Substance Abuse Treatment Facility

"Substance Abuse Treatment Facility" means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and which is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

Summary Plan Description

"Summary Plan Description" means this Plan Document and Summary Plan Description, as required by ERISA.

Surgery

"Surgery" means only the following:

1. A cutting operation;
2. Suturing of a wound;
3. Treatment of a fracture;
4. Reduction of a dislocation;
5. Radiotherapy, if used in lieu of a cutting operation;
6. *Electrocauterization;
7. *Injection treatment of hemorrhoids and varicose veins;
8. Any procedure defined as a surgical procedure by the American Medical Association; or
9. *Diagnostic and therapeutic endoscopic procedures.

* **For the purpose of complying with the Plan's utilization review requirement, these procedures will not be considered "Surgery."**

TMJ Dysfunction

"TMJ Dysfunction" means pain, swelling, clicking, grinding, popping, dislocation, locking, malposition, bite discrepancies or other pathological Conditions which create a loss or decrease of function in, around or caused by one or both of the jaw joints.

Totally Disabled

"Totally Disabled" means a physical or mental state of a Covered Person resulting from Illness or Injury which prevents a Participant from performing the normal duties of his occupation, or a Dependent from performing the activities of a person of like age and sex.

Traumatic Event

"Traumatic Event" means a sudden, unexpected, violent happening which causes Injury to the body.

Urgent Care

"Urgent Care" means any claim for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical Condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Usual and Customary

"Usual and Customary" means:

In the case of a provider who is a member of a Preferred Provider Organization ("PPO"), the Usual and Customary means the charge negotiated between that provider and the PPO.

In all other cases, the Usual and Customary means the PPO's non-network allowed charge, or the designation of a charge, as determined by any nationally recognized database or any other research firm which the Claims Administrator utilizes, as being the Usual charge made by a Physician or other provider of services, supplies, medications or equipment that does not exceed the general level of charges made by other providers furnishing such care or treatment within the same area, or using normative data such as,

but not limited to, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature or severity of the Condition being treated and any medical complication or unusual circumstances which require additional time, skill or expertise.

The term "Usual" refers to the amount of a charge made 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 is 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 the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, pharmacist or other provider. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Waiting Period

"Waiting Period" means the amount of time that must pass before an individual is eligible to be covered for benefits under the terms of the Plan.

Well Baby Care

"Well Baby Care" means medical treatment, services or supplies rendered to a newborn child solely for the purpose of health maintenance and NOT for the treatment of an Illness or Injury prior to its discharge from the Hospital following birth.

Well Child Care

"Well Child Care" means medical treatment, services or supplies rendered solely for the purpose of health maintenance and NOT for the treatment of an Illness or Injury.

COORDINATION OF BENEFITS PROVISION

The coordination of benefits provision is intended to prevent payments of benefits which exceed expenses. It applies when a Covered Person is **also covered** by any **Other Plan or Plans**. When more than one coverage exists, one plan normally pays its benefits in full and the Other Plans pay a reduced benefit. Only the amount paid by this Plan will be charged against the Plan maximums.

This Plan coordinates benefits in the **traditional method** defined as follows: this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the Other Plan or Plans, will not exceed 100% of Allowable Expenses.

The coordination of benefits provision applies whether or not a claim is filed under the Other Plan or Plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the Other Plan or Plans, or to recover overpayment. All benefits under this Plan are subject to this provision.

There is no coordination of benefits within this Plan. Coordination of benefits is applicable only with OTHER PLANS.

Definitions

The term **"Plan"** as used herein will mean any plan providing benefits or services for or by reason of medical or dental treatment, whose benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis, including but not limited to:
    a. Hospital indemnity benefits; and
    b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity benefits at the time of claims;
2. Hospital or medical service organizations on a group basis, group practice, and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A licensed Health Maintenance Organization (H.M.O.);
5. Any coverage under a governmental program, and any coverage required or provided by any statute;
6. Group motor vehicle insurance including, without limitation, medical reimbursement coverages;
7. Individual motor vehicle insurance coverage on a motor vehicle leased or owned by the Contributing Employer;
8. Individual motor vehicle insurance under "no-fault" coverage, personal Injury protection coverage, medical payments or reimbursement coverage, financial responsibility coverage, "no-fault" medical payments coverage, underinsured coverage, uninsured coverage and any other medical payment coverage;
9. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefits organization plans, and similar medical payable coverage;
10. Medical reimbursement coverage available under homeowners' insurance, or any other type of Insurance policy;
11. "School" or team insurance or any coverage for students which is sponsored by or provided through a school or other educational institution.

The term “Other Plan” will be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

The term “Allowable Expenses” means any Covered Expense under this Plan. Any expense excluded under this Plan in the absence of coordination of benefits will also be excluded under this Plan in the presence of coordination of benefits, regardless of whether or not the expense is covered by any Other Plan. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of these services rendered will be deemed to be both an Allowable Expense and a benefit paid. In the case of an HMO (Health Maintenance Organization) plan, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

The term “Claim Determination Period” means a Calendar Year or that portion of a Calendar Year during which the Covered Person for whom a claim is made has been covered under this Plan.

Coordination Procedure

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits payable under all plans will not exceed:

Under the **traditional method** – the total of Allowable Expenses Incurred during any Claim Determination Period.

Payments

Each Plan makes its claim payment according to the following order if Medicare is not involved:

1. If a plan contains no provision for coordination of benefits, it pays before all other plans.
2. If a person is a covered employee under one plan, and a covered dependent under another plan, the plan that covers the person as an employee is the primary plan.
3. If a child is covered under more than one plan and the parents are not legally separated or divorced, the primary plan is:
    a. The plan of the parent whose birthday falls earlier in the calendar year will be the primary plan; or,
    b. If both parents have the same birthday, the plan which has covered the parent the longest will be the primary plan.

    If the other plan does not have this rule but instead has a rule based upon the gender of the parent, the rule in this plan will override the rules of the other plan in determining the order of benefits.
4. If a child is covered under more than one plan and the parents are legally separated or divorced, the primary plan is determined as follows:
    a. The plan of the natural parent having responsibility for the child’s health care expenses by court decree pays first. If the court decree splits the responsibility equally between the divorced parents or if the specific terms of the court decree state that the parents share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the primary plan is the plan of the parent whose birthday, excluding year of birth, falls earlier in the calendar year. If both parents have the same birthday, then the plan which has covered the child the longest will be the primary plan;
    b. In the absence of a court decree, -
        (1) The plan of the natural parent having legal custody pays; then,
        (2) The plan of the spouse (if any) of the natural parent with legal custody pays; then,

(3) The plan of the natural parent without legal custody pays last.

c. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

5. If an adult child is employed and/or married, the plan covering the child as an employee is the primary plan, the plan covering the child as a spouse is secondary, and the plan covering the child as a dependent child will pay third. A plan that pays third will only pay benefits if there are unpaid allowable expenses after the first and second plans have paid.
6. If a person is a covered active employee under one plan and a covered retired or laid off employee under another plan, the plan that covers the person as an active employee or a dependent of an active employee is the primary plan.
7. If a person covered under a right of continuation pursuant to federal or state law is also covered under another plan, the plan that covers the person as an employee, member or subscriber is the primary plan and the plan providing continuation coverage is secondary.
8. 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.
9. If the order described above fails to establish the order of payment, then the plan which the person has been covered for the longest period of time is the primary plan.
10. In the event that you or your Dependent is covered by another group medical plan which, by its terms:
    a. The plans cannot agree on the primary versus secondary order; or
    b. Provides that it is secondary to other health plans, and the provisions of this Plan would make coverage under this Plan secondary to other applicable health plan coverage;

    Then the payments by this Plan will automatically be reduced by 50% and will be paid to the health provider or the employee as applicable and this Plan will have no further obligations with respect to such medical expenses.

Regardless of the order outlined above, in the event a Covered Person is injured in any way due to an Accident, and any no-fault, personal injury protection ("PIP") and/or medical payments coverage(s) are found to be available, these First Party coverages are primary and must be paid out (exhausted) in their entirety before a payment under this Plan is to be considered eligible.

The Plan Administrator has the right:

1. To obtain or share information with an insurance company, Plan Administrator or other organization regarding coordination of benefits without the claimants consent;
2. To require that the claimant provide the Plan Administrator with information on such Other Plans so that this provision may be implemented; and
3. To refund the amount due under this Plan to an insurer, plan or other organization if this is necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

Accumulation of Benefit Savings

This Plan does not accumulate benefit savings in a secondary payer capacity to be used to cover the cost of previous Deductibles, Coinsurance and ineligible expenses.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid

will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan will be fully discharged from liability.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in absence of this provision.

Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Plan will have the right to recover such payments, to the extent of such excess, in accordance with the provisions of this Plan.

COORDINATION WITH MEDICARE

If You or Your Dependent are Eligible for Medicare:

Coordination of Benefits with Medicare will conform with Federal Statutes and Regulations. As such, eligibility for Medicare Part A and Part B will not affect Plan benefits for:

1. A Covered Person eligible for Medicare due to End Stage Renal Disease during the period defined by Federal regulations in effect at the time the claim is incurred.
2. An active employee or spouse of an active employee age 65 provided you are not employed by a small Contributing Employer.

   Note: *If you are employed by a Contributing Employer who employs fewer than 20 employees, please refer to the section "Active Employees Age 65 or Over Who Are Employed by a Small Contributing Employer" for information concerning your benefits.*
3. An employee or his covered Dependent who is less than age 65 and covered under the Plan by virtue of his current employment status (as defined by Medicare) and eligible for Medicare by reason of a disability condition other than End Stage Renal Disease.

   Note: *This provision does not apply when the Contributing Employer has less than 100 employees.*

For all other Covered Persons who become eligible for Medicare Part A and Part B, Plan benefits will be coordinated with Medicare in the **traditional method** as described herein. The benefits of Medicare and this Plan are combined to cover and pay for your medical expenses up to, and not exceeding, 100% of the allowable expenses Incurred. When Medicare is the primary payer of benefits, the allowable expense is limited to the Usual and Customary charge approved by Medicare when the provider accepts Medicare assignment. This limitation will not apply if the service provider does not accept Medicare assignment. This coordination of benefits will apply regardless of whether or not the Covered Person has enrolled for Medicare coverage.

Active Employees Age 65 and Over Who Are *Not* Employed by a Small Contributing Employer

If you will soon be age 65, check your eligibility for Medicare prior to your 65th birthday. As long as you are an employee in Active Service past the age of 65 and are not employed by a small Contributing Employer, you will be eligible for the same health benefits as employees under age 65 in Active Service.

If your spouse is also enrolled in this Plan, this provision would apply to your spouse during the period of time your spouse is age 65 or over, regardless of your age.

If you are an employee in Active Service, over age 65 or soon to be age 65, it is extremely important that you sign up for both Medicare Part A and Medicare Part B in advance of losing coverage under this Plan. Unless you sign up for coverage under Medicare, and meet all of the other requirements of Medicare, you will not receive Medicare coverage.

Federal law prohibits a Contributing Employer with more than 20 employees to offer group health coverage that is supplemental to Medicare. Therefore, while you are in Active Service, this Plan will be the primary payer and Medicare the secondary payer of benefits. You (or your spouse) are free to reject this Plan coverage. However, if such an election is made, you (or your spouse) will no longer be eligible for medical coverage under the Plan.

This provision does not apply to employees or spouses entitled to Medicare because of total disability (when the Contributing Employer has less than 100 employees), or end stage renal disease after the initial treatment period.

Active Employees Age 65 or Over Who Are Employed by a Small Contributing Employer

If you are:

1. An active employee age 65; and,
2. Employed by a Contributing Employer who employs fewer than 20 employees; and,
3. Your employer has applied for and been approved by Medicare for an exemption from Medicare Secondary Payer (MSP) requirements,

Medicare will be the primary payer of benefits, and this Plan the secondary payer, on all charges Incurred from the effective date of Medicare's approval. Medicare will also be the primary payer, and this Plan the secondary payer, for your spouse if he or she is age 65 or over while you are actively employed by such Contributing Employer.

Plan benefits will be coordinated with Medicare, Part A and Part B, in the **traditional method**. The benefits of Medicare and this Plan are combined to cover and pay for your medical expenses up to, and not exceeding, 100% of the allowable expenses Incurred. The allowable expense is limited to the Usual and Customary charge approved by Medicare when the provider accepts Medicare assignment. This limitation will not apply if the service provider does not accept Medicare assignment.

Plan benefits will be coordinated with Medicare, as described above, regardless of whether or not you or your spouse has enrolled for Medicare coverage.

This provision does not apply to the Outpatient Prescription Drug Card Benefit.

This provision also does not apply to a Covered Person eligible for Medicare due to End Stage Renal Disease during the period defined by Federal regulations in effect at the time the claim in incurred, or any Covered Person not otherwise eligible per Medicare.

FIRST AND/OR THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Benefits Subject to This Provision

This provision will apply to all benefits provided under any section of this Plan.

When This Provision Applies

A Covered Person may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges Incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement if benefits are paid under the Plan. In addition, the Plan will have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses Incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. If the Plan pays any medical or other benefits for the Injuries or Illness before these papers are signed and services are rendered, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

If requested, the Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;

2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses Incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;

3. Immediately reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) Incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses Incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

"Another Party"

"Another Party" will mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illness.

"Another Party" will include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery"

"Recovery" will mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery will be deemed to apply, first, for Reimbursement.

"Subrogation"

"Subrogation" will mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

Right of Reimbursement

A Covered Person will reimburse this Plan from any recovery received from the Covered Person's insurer, any first and/or third party, and including but not limited to Underinsured/Uninsured, Medical Payments and No-fault coverages that are found to be applicable. The amount of reimbursement will be up to and equal to the amount of benefits paid under the Plan. The right of recovery and reimbursement is binding upon the Covered Person whether the recovery is from a legal judgment, arbitration award, compromise settlement or any other arrangement, even if the recovery to the Covered Person does not include medical expenses. The Plan's right to recover precludes the operation of "common funds" and the Plan's equitable lien supersedes any other common law, statutory rules or state law. Further, the obligation to reimburse exists regardless of how the judgment and/or settlement is classified and whether or not the judgment or settlement specifically designates the recovery.

"Reimbursement"

"Reimbursement" will mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses Incurred by the Plan in collecting this benefit amount.

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased

These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

In the case of a Covered Person's wrongful death or survival claim, the subrogation and related recovery provisions apply to the Covered Person's estate, the personal representative of the estate and the Covered Person's heirs or beneficiaries.

No allocation of damages, settlement funds or any other recovery, by the Covered Person, the Covered Person's estate, the personal representative of the estate, the Covered Person's heirs or beneficiaries, or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest, unless the Plan provides written consent to the allocation.

When a Covered Person Does Not Comply

When a Covered Person does not comply with the provisions of this section, the Plan Administrator will have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

PRIVACY STANDARDS

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

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

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(1) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, will be given access to the PHI to be disclosed:

Human Resources Manager
Staff designated by Human Resources Manager
Chief Financial Officer
Plan Auditor
Privacy Officer
Any other individual named in the Plan Sponsor's HIPAA Compliance documents

(2) The access to and use of PHI by the individuals described in subsection (1) above will be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(3) In the event any of the individuals described in subsection (1) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

k. Notify participants of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).

l. Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Professional Benefit Administrators, Inc., to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures will be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan will comply with the Privacy Standards.

SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions.

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical Safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI;

4. Report to the Plan any security incident of which it becomes aware;

5. Notify participants of any PHI security incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18); and

6. Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).

Any terms not otherwise defined in this section will have the meanings set forth in the Security Standards.

CLAIM PROCEDURES

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan.

Claims

All claims are to be filed as shown on your Plan ID card. All questions regarding claims should be directed to Professional Benefit Administrators, Inc. (PBA). The Plan Administrator will be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to Professional Benefit Administrators, Inc. (PBA); provided, however, that Professional Benefit Administrators, Inc. (PBA) is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan will be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit or disability is covered under the Plan. If the Plan Administrator in its sole discretion determine that the claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant fails to furnish such proof as is requested, no benefits or further benefits will be payable under the Plan.

Under the Plan, there are four types of health claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical Condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   It is important to remember that, if a claimant needs medical care for a Condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

   Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a. The Plan determines that the course of treatment should be reduced or terminated; or

   b. The claimant requests extension of the course of treatment beyond that which the Plan has approved.

   If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed

Claims must be filed within one year of the date charges for the service were Incurred. **Claims filed later than that date will be denied.** However, this one-year period will not apply when the person is not legally capable of submitting the claim.

Should the Plan be terminated, claims must be filed within 90 days following the date of termination. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided.

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by Professional Benefit Administrators, Inc. (PBA) in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by Professional Benefit Administrators, Inc. (PBA), together with a properly completed standard medical billing statement (such as Form HCFA, Form UB92, or UB04) or ADA Dental Claim Form:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges and repricing information;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Upon receipt of the appropriate information, the claim will be deemed to be filed with the Plan.

PBA will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by PBA within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator will notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims.
    a. If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        (1) The Plan's receipt of the specified information; or
        (2) The end of the period afforded the claimant to provide the information.

2. Pre-service Non-urgent Care Claims.

   a. If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

   b. If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the claimant (if additional information was requested during the extension period).

3. Concurrent Claims.

   a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

   b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

   c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

4. Post-service Claims

   a. If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

   b. If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

5. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

6. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

7. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

8. Calculating Time Periods. The period of time within which a benefit determination is required to be made will begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator will provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate Named Fiduciary of the Plan, who will be neither the individual who

made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
7. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the Plan Administrator or Professional Benefit Administrators, Inc. (PBA); information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and
8. In an Urgent Care Claim, for an expedited review process pursuant to which:
   a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
   b. All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

First Appeal Level

Requirements for First Appeal

The claimant must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, claimant may telephone:

Professional Benefit Administrators, Inc. (PBA) at 630-655-3755

To file an appeal in writing, the claimant's appeal must be addressed as follows:

Professional Benefit Administrators, Inc. (PBA)
900 Jorie Boulevard, Suite 250
Oak Brook, IL 60523-3827
Attn: Claim Appeals

Upon receipt, an appeal will be deemed to be filed with the Plan provided all of the information listed below is included.

It is the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the employee/claimant;
2. The employee/claimant's individual identification number printed on the Plan I.D. Card;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose**

the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;

5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that, in the case of a health claim, the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Plan Administrator will notify the claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
3. Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made will begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan Administrator will provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document and Summary Plan Description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures;

9. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims;
10. A statement of the claimant's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator will provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the denial of benefits. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal

The Plan Administrator will notify the claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.
2. Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.
3. Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made will begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for:

1. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed;
2. A description of the Plan's review procedures and the time limits applicable to the procedures; and
3. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claim.

See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator will provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate Named Fiduciary of the Plan on review will be final, binding and conclusive unless such claimant has a right to an external review. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

External Review

When a claimant has exhausted the internal appeals process, the claimant has a right to have that decision reviewed by independent health care professionals who have no association with the Plan, the Plan Sponsor, or the Plan Administrator if:

1. The adverse benefit determination involved making a medical judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment requested; or,
2. The adverse benefit determination is based on a determination that the service or treatment is Experimental or Investigational.

The claimant may submit a request for external review within 4 months after receipt of a denial of benefits to:

Professional Benefit Administrators, Inc. (PBA)
900 Jorie Boulevard, Suite 250
Oak Brook, IL 60523-3827
Attn: Claim Appeals

PBA will forward the claimant's request for external review to an independent review organization as required by law. For standard external review, a decision will be made within 45 days of receiving the claimant's request. If the claimant has a medical condition that would seriously jeopardize his or her life or health or would jeopardize the claimant's ability to regain maximum function if treatment is delayed, the claimant may be entitled to request an expedited external review of the denial. The decision of the independent review organization will be final, binding and conclusive.

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from Professional Benefit Administrators, Inc. (PBA). However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the claimant's medical Condition to act as the claimant's authorized representative without completion of this form. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if you or your Dependents fail to make timely payment of premiums. You should check with your employer to see if COBRA applies to you and your Dependents.

Any questions regarding COBRA Continuation Coverage should be addressed to the Plan Administrator. The Plan Administrator of this Plan is:

Housing Benefits Plan
8610 King George Drive
Dallas, TX 75235
1-800-288-7623

Note: You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your employer's plan) are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
   Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.
5. You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-Covered Employee dies;
2. The parent-Covered Employee's hours of employment are reduced;
3. The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
   Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan. If this Plan does not provide for retiree coverage this paragraph does not apply.

The employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the Qualifying Event.

You must give notice of some Qualifying Events

Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided, has subsequently been determined by the SSA to no longer be disabled.

NOTE: A "Notice of Change" form is available, free of charge, from the Plan Administrator and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual will satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

1. Name and address of the Covered Employee or former employee;
2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;

5. In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age or other);
7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. **If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.**

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

If the Qualified Beneficiary is totally incapacitated and is not legally competent to make an election for COBRA continuation coverage, the 60 day election period is tolled until such time as the Qualified Beneficiary is able to make an election or a guardian or legal representative is appointed who is able to make the election on behalf of the Qualified Beneficiary.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than

36 months beyond the date of the original Qualifying Event; however, if the first Qualifying Event is the Covered Employee's entitlement to Medicare benefits, followed by termination or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of (i) 36 months after the date the Covered Employee became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any dependent children receiving COBRA Continuation Coverage if the Covered Employee or former employee dies, or gets divorced or legally separated, if the dependent child stops being eligible under the Plan as a dependent child, or becomes entitled to Medicare benefits (under Part A, Part B, or both), **but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.**

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date your employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); or

4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation Coverage. You can learn more about many of these options at www.healthcare.gov .

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator will make a charge of $.25 for each page.

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including your Contributing Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

GENERAL PLAN INFORMATION

Name of Plan

The name of the Plan is the Housing Benefits Plan.

Plan Sponsor

The Plan Sponsor is the Board of Directors of Housing Benefits Plan. The Plan Sponsor will have the authority to amend and terminate the Plan, determine its policies, appoint and remove other supervisors, fix their compensation and exercise general administrative authority over them.

Plan Sponsor's Employer Identification Number

The Plan Sponsor's Employer Identification Number (EIN) is 62-1217327.

Named Fiduciary, Plan Administrator

The Named Fiduciary and Plan Administrator is the Housing Benefits Plan. The Plan Administrator may delegate certain ministerial functions which do not require the use of discretionary authority to the Claims Administrator.

Plan Year

January 1 through December 31

Plan Number

501

Plan Type

Medical and Dental

Contributions to the Plan

Contributions are to be made on the following basis:

The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed (if any) by each Participant, in its sole discretion. Any employee contributions are used by the Plan for the payment of claims.

In the event that the Plan Sponsor terminates the Plan, then as of the effective date of termination, the Plan Sponsor and Participants will have no further obligation to make additional contributions to the Plan for claims Incurred after the date of termination.

Plan contributions for PARTICIPANT and DEPENDENT Coverage are shared by the Contributing Employer and employee.

Contributions and Benefits

The tax treatment of contributions and/or benefits under this Plan is governed by Section 105(b) and Section 152 of the Internal Revenue Code and is the sole responsibility of the Participant.

Effective Date

The effective date of the Plan is October 1, 2001.

Claims Administrator

The Claims Administrator of the Plan is Professional Benefit Administrators, Inc. (“PBA”), 900 Jorie Boulevard, Suite 250, Oak Brook, Illinois 60523-3827.

The Plan Sponsor, Plan Administrator and Agent for Service of Process

The agent for service of process is: Plan Administrator
Housing Benefits Plan
8610 King George Drive
Dallas, TX 75235
1-800-288-7623

The Plan is a distinct legal entity. As such, legal notice may be filed with, and legal process served upon, the Plan Administrator.

Plan Construction, Type of Administration and Funding

This Summary Plan Description will be construed in accordance with ERISA and, where not preempted, the laws of the state in which the Plan Sponsor is located.

This is a self-funded Plan with a Claims Administrator. The Plan Administrator is responsible for all claims decisions, and the Plan Sponsor is responsible for providing funds for the payment of the claims out of its general assets.

All Plan terms will be applied on a gender neutral basis. Masculine pronouns used in this Summary Plan Description will include masculine or feminine gender unless the context indicates otherwise.

Wherever any words are used herein in the singular or plural, they will be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Purpose

The purpose of this Summary Plan Description is to set forth the provisions of the Plan which provide for the payment or reimbursement of a portion of the eligible medical expenses. The Plan Sponsor’s purpose in establishing the Plan is to help to offset, for Eligible Employees, the economic effects arising from a non-occupational Injury or Illness. To accomplish this purpose, the Plan Sponsor and the Plan Administrator must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Summary Plan Description, to allow for allocation of the resources available to help those individuals participating in the Plan to the maximum feasible extent.

GENERAL PROVISIONS

Amendments or Changes

The terms of this Plan will not be amended or changed except as provided below under the section entitled "Amending and Terminating the Plan."

Plan Is Not A Contract

This Plan will not be deemed to constitute a contract of employment, give any Participant the right to be retained in the service of a Contributing Employer or interfere with the right of a Contributing Employer to discharge or otherwise terminate the employment of any Participant.

Protection Against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or to become due to any Participant (or former Participant), the Plan Administrator, in its sole discretion, may terminate the interest of such person. In such case, the Plan Administrator will determine how to apply the payment to the benefit of the Participant (or former Participant) or his/her estate. Any such application shall be complete discharge of all liability with respect to such benefit payment.

Free Choice of Physician and Treatment

The Covered Person has free choice of any Physician or surgeon, and the Physician-patient relationship will be maintained. The Covered Person, together with his Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of such care. Providers who are members of any network used by the Plan are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any provider. The Plan will not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any officer or employee or on the part of any Physician in the course of performing services for Covered Persons.

Alternate Care and Treatment

Alternate forms of care and treatment, which can be provided without impairing the quality of care, if recommended by utilization management, and if approved by the Plan Administrator can be considered a Covered Charge. Alternate treatment or care which is not included in the Plan, is included in the Plan but is limited, or is included in the Plan but on a basis that differs from the care and treatment now recommended, will be payable under the Plan on the same basis as the care and treatment for which they are substituted if it can be shown to be cost effective. This is subject to the approval of the Plan Administrator, Covered Person, the Covered Person's Family, and the Attending Physician.

This provision is not intended to override the Experimental or Investigational treatment exclusion or any lifetime maximum contained in the Plan.

Workers' Compensation Not Affected

This Plan is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that the Participant received or is eligible to receive workers' compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it

has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement the Participant receives from workers' compensation. The Plan will exercise its right to recover against the Participant.

A Participant is required to notify the Plan Administrator immediately when a claim for coverage under workers' compensation is filed if a claim for the same Injury or Illness is or has been filed with this Plan.

Personnel Policies

The Plan is intended to automatically comply with the Contributing Employer's current established written personnel policies regarding waiting periods, continuation of coverage or reinstatement of coverage during the following situations regardless of whether or not the Plan has been specifically amended or modified: Employer certified disability, an approved leave of absence, layoff, reinstatement, hire or rehire. The Plan will at all times comply with the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Rights in Recovery

Whenever payments have been made by the Plan Administrator with respect to allowable expenses in excess of the amount of payment necessary to satisfy the intent of this Plan, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to recover such excess payments. Further, the Plan Administrator reserves the right to deduct the amount of any excess payment from future benefits to which a Participant or any of his covered Dependents may become entitled. This right of recovery also applies when a Covered Person, or any plan that pays benefits for which benefits are also paid by the Plan, receives duplicate payments under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

Physical Examination/Consultation/Peer Review

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

The Plan Administrator also has the right to seek and utilize the professional opinion of consultants, peer review and other such entities for the purpose of determining the eligibility of both individuals and claims under this Plan. The expenses related to these services will be considered an eligible expense under this Plan, but only for a Covered Person.

Legal Proceedings

No action at law or in equity shall be brought to recover from the Plan prior to the expiration of 90 days after all administrative remedies under the Plan have been exhausted, nor will such action be brought at all unless brought within one year from the time all administrative remedies under the Plan have been exhausted.

Conformity With Law

This Plan will be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Summary Plan Description. It is intended that the Plan will conform to the requirements of Federal civil rights laws, ERISA and ACA, as it applies to group health plans, as well as any other applicable law.

GINA

"GINA" means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

The term "Genetic Information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term Genetic Information includes participating in clinical research involving genetic services.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes.

This Plan will not discriminate in any manner with its participants on the basis of such Genetic Information.

Rescission

The Plan may rescind coverage for a Covered Person if the individual (or a person seeking coverage on behalf of the individual):

1. Performs an act, practice or omission that constitutes fraud; or
2. Makes an intentional misrepresentation of a material fact.

Both such items are prohibited by the terms of this Plan. The Plan Administrator will determine whether an action or inaction constitutes fraud or an intentional misrepresentation of a material fact.

The Plan will provide 30 days advance written notice of any rescission. The rescission can affect the Covered Person's entire family, even if only one individual committed the fraud or misrepresentation.

Examples of fraud include, but are not limited to, the following:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

In the event of any rescission, the Plan's notice of rescission of coverage is considered to be an adverse benefit determination under the law. Claimants have the right to appeal an adverse benefit determination. A description of how to file an appeal is outlined under the "First Appeal Level" and "Second Appeal Level" of the "Claim Procedures" section. The first appeal must be filed within 180 days following receipt of the Plan's notice of rescission of coverage. After the claimant has exhausted the internal appeals process, the claimant has a right to submit a request for external review.

Plan Administration

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of Professional Benefit Administrators, Inc. to provide certain claims processing and other technical services.

The Plan is administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

When the Plan Sponsor acquires a new unit, whether through acquisition, merger or any other transaction, the employees of the new unit may become eligible under this Plan, waiving any and all Waiting Periods. The Plan Sponsor maintains the right to make the election to do this on an acquisition, merger or transaction basis, as business needs dictate.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. If this Plan is subject to, in whole or in part, one or more collective bargaining agreements, the Plan is intended to automatically comply with any such agreement that has valid bearing on this Plan, whether or not the Plan has been specifically amended or modified. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. In the event of administrative error or oversight, the Plan Administrator has the right to determine the effective date or termination date of coverage. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, will receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

The Plan Sponsor may make special eligibility arrangements for new or separating employees when necessary to serve a valid business purpose.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Right to Audit or Review

Once a written claim for benefits is received, the Claims Administrator, acting on the authority and discretion of the Plan Administrator, may elect to have such claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but not be limited to, identifying:

1. Charges for items/services that may not be covered or may not have been delivered or performed,
2. Duplicate charges or billing mistakes,
3. Charges beyond the Usual and Customary guidelines as determined by the Plan,

4. Charges that have been unbundled, up-coded or otherwise coded inappropriately based on industry accepted practices or guidelines; and,
5. Charges for items/services that are determined to be excessive or beyond that which is generally accepted as being Medically Necessary to treat or diagnose an Illness or Injury.

When an audit or review determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine Covered Charges according to the review and/or audit results.

Any charge that is determined to be inaccurate or excessive by the Plan Administrator as a result of a claim review or audit will not be deemed a Covered Charge under this Plan.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which will be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. Notice will be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination will be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action will be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan will become effective as of a date established by the Plan Sponsor. Contributions by the Plan Sponsor will continue to be issued for the purpose of paying benefits under this Plan with respect to claims arising before such termination.

Indemnification of Employees

Except as otherwise provided by ERISA, no director, officer or employee of the Plan Sponsor or the Claims Administrator will incur any personal liability for the breach of any responsibility, obligation or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan; and each such director, officer and employee will be indemnified and held harmless by the Plan Sponsor from and against any such liability, including all expenses reasonably Incurred in their defense if the Plan Sponsor fails to provide such defense.

Assignment of Benefits

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the provider; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant and the assignee, has been received before the proof of loss is submitted.

Clerical Error

Clerical error on the part of the Plan Administrator or Claims Administrator in keeping the records in connection with a Participant's coverage will not invalidate coverage otherwise in force, nor continue coverage otherwise terminated.

Manuals

Manuals and reference material used by the Plan in order to determine the appropriate administrative procedures, appropriate diagnosis, Usual and Customary allowances and Medical Necessity of claims submitted in compliance with this Summary Plan Description include, but are not limited to, the following:

1. ICD.10.CM (or updated version)
2. Usual and Customary Data Bases, Fee Schedules and Claims Edit Programs
3. 1964 California Relative Value Study (C.R.V.S.)
4. CPT 4 (or updated version)
5. Physician's Desk Reference
6. Merck Manual
7. Taber's Cyclopedic Medical Dictionary
8. The Kennedy Series Medical/Disability and Dentistry Handbooks
9. The Medical Disability Advisor
10. The Hayes Manuals
11. The Trilogy Consulting Group Manuals (as modified by PBA administrative memos)
12. Others as developed or needed
13. Red Book or other NDC References.

Provision Enforcement

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect the right to enforce any other provision of this Plan.

Severability

If any provision within the Plan Document is found to be invalid or illegal, that finding only applies to those such provisions and such a finding will not have any affect or change the obligations of the parties as to the remaining sections and be severable.

Section Titles

Section titles are for convenience of reference only, and are not to be considered in interpreting this Plan.

Active Military Duty

Reservists who are covered under the Plan and who are called to active military duty will be eligible for coverage as outlined in the USERRA Act of 1994 according to the following:

1. Employees - who return under the parameters of the USERRA Act of 1994.
2. Employees - on the day they return to full-time Active Service with the Contributing Employer.
3. Dependents - on the day the Dependent meets the definition of an eligible Dependent under the Plan.

Credit will be given toward satisfaction of any required Waiting Period and reinstatement of coverage will comply with HIPAA.

Quality of Care Provision

This provision allows the Plan Administrator, based upon a case management recommendation, to approve as an Eligible Expense, a treatment technique not addressed by this Plan. If the Plan utilizes a Preferred Provider Organization ("PPO"), the Plan Administrator may recommend and approve a non-PPO Physician or Hospital that is recognized, in its opinion, to be significantly superior in the treatment of the applicable

diagnosis to warrant this special consideration, and to pay this Physician and facility as if they were PPO providers.

Foreign Claims

In the event a Covered Person incurs a Covered Expense in a foreign country due to an unexpected Illness or Injury, the Covered Person will be responsible for providing the following information to the Claims Administrator before reimbursement of any benefits due are payable.

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. Proof that the bills have been paid. Benefits cannot be assigned to a non-U.S. provider.

A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must also be submitted with the claim.

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.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

Unclaimed Payments

Any benefit payment issued under the Plan that is not cashed by the payee within the 12-month period immediately following its date of issue will be considered void and will only become a Plan liability upon receipt of the employee's written request for re-issuance. Such request must be made within the 24-month period immediately following the date the benefit payment was issued. Any request that is filed later will be denied.

YOUR RIGHTS UNDER FEDERAL LAW

Newborns' and Mothers' Health Protection Act of 1996 (The Newborn's Act)

According to The Newborn's Act, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours) or provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under The Newborn's Act.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

WHCRA requires that group health plans provide the following services to any person receiving Plan benefits in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

If you receive benefits from the Plan for a mastectomy and you then elect to have reconstructive surgery, the Plan must provide coverage in a manner determined by consulting with your attending physician and you. The Plan's benefits for breast reconstruction and related services will be the same as the benefits that apply to other services covered by this Plan (i.e., coverage may be subject to annual deductibles and coinsurance).

It is important to note that the Plan covers these expenses. However, the law requires that we provide this notice each year. A group health plan may not deny eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely to avoid the WHCRA requirements.

Family and Medical Leave Act (FMLA)

Under federal law, FMLA provides unpaid leaves of absence for up to 12 weeks during any 12-month period if you experience one of these events:

- The birth or adoption of a child or the placement of a foster child in your home.
- A serious health condition affecting your child, spouse, or parent (parents-in-law are not included).
- A serious health condition that makes you unable to perform your job. A serious health condition is defined as an illness, injury, impairment, or physical or mental condition which involves (1) inpatient care in a hospital, hospice, or residential treatment facility or (2) continuing treatment by a health care provider.
- An urgent need on behalf of the employee due to your child or parent being covered on active duty (or notified of an impending call or order to covered active duty) in the Armed Forces.

FMLA Eligibility

You are eligible for FMLA leave if you worked for your Contributing Employer for at least one year and for 1,250 hours or more during the previous 12 months.

If you are eligible, you may take a total of up to 12 weeks of FMLA leave during any Calendar Year. The right to FMLA leave for birth or adoption expires at the end of the 12-month period following the birth or placement of the child.

Scheduling FMLA Leave

If you are basing FMLA leave on a planned medical treatment, you must make a reasonable effort to schedule the medical treatment (subject to approval by your health care provider) in a way that does not unduly disrupt your Contributing Employer’s operations.

If you or an eligible family member have a serious health condition, FMLA leave may be taken intermittently or on a reduced leave schedule when it is medically necessary. In this situation, your Contributing Employer may temporarily transfer you to an alternative job with equivalent pay and benefits if you are qualified for the position and the alternative job offers equivalent pay and will accommodate recurring periods of leave better than your regular job.

Notice of FMLA Leave

If the leave is foreseeable, you must provide your Human Resources Department with at least 30 days’ notice before the date you want to begin FMLA leave. If circumstances require leave to begin in less than 30 days, you must provide notice as soon as possible.

RECEIPT OF SUMMARY PLAN DESCRIPTION

I, ____ ,
(NAME)
acknowledge the receipt of my Summary Plan Description on ______________________________.
(DATE)

I understand that it is important to read the entire Summary Plan Description to fully understand the extent of my coverage under the Plan, and that I must read my Continuation Rights under COBRA.

____
SIGNATURE

____
DATE

RECEIPT OF SUMMARY PLAN DESCRIPTION

I, __________________, acknowledge the receipt of my Summary Plan Description on ____________. I
(NAME) (DATE)
understand that it is important to read the entire Summary Plan Description to fully understand the extent of my coverage under the Plan, and that I must read my Continuation Rights under COBRA.

__________________ __________________
SIGNATURE DATE

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by the Plan Sponsor as of January 1, 2018, hereby sets forth the provisions of the Plan.

Effective Date
The Summary Plan Description is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document and Summary Plan Description
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document and Summary Plan Description as the written description of the Plan. This Plan Document and Summary Plan Description amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan. This Plan Document and Summary Plan Description also represents the "Summary Plan Description" or "SPD" which is required by ERISA.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed.

Housing Benefits Plan

By: Signature on File
Authorized Representative

Date: May 15, 2018