

SABINE-NECHES HEALTH & WELFARE FUND

EXTRUDER

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Effective: January 1, 2001

Restated: March 1, 2012

Third Party Administrator:

GreenTree Administrators, LLC

P.O. Box 7306

Beaumont, TX 77726-7306

87 Interstate 10 North, Suite 225

Beaumont, TX 77707

Phone (409) 832-2335 / (800) 825-2117 * Fax (409) 832-2301

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GENERAL PLAN INFORMATION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Sabine-Neches (the "Company" or the "Plan Sponsor") as of January 1, 2012, hereby amends and restates the Sabine-Neches Health and Welfare Fund (the "Plan"), which was originally adopted by the Company, effective January 1, 2001.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, [or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the employees covered by such agreement] (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Date: 02-29-2012

By: [Signature]
Name: Steve Hodes
Title: Chairman Board of Trustees

By: [Signature]
Name: Jodi Fuller
Title: Director of Benefits

By: [Signature]
Name: Mark S. Lee
Title: Trustee

By: [Signature]
Name: Gary W. Thomas
Title: Secretary Board of Trustees

By: [Signature]
Name: Arthur W. Garza
Title: Financial Chair

By: [Signature]
Name: Bill L. Meyer
Title: HR Manager

GENERAL PLAN INFORMATION (Continued)

What is the purpose of the Plan

The *Plan Sponsor* has established the Sabine-Neches Health & Welfare Fund *Plan* (“*Plan*”) for your benefit, on the terms and conditions described herein. The *Plan Sponsor’s* purpose in establishing the *Plan* is to help to offset, for you, the economic effects arising from an *injury* or *illness*. To accomplish this purpose, the *Plan Sponsor* must be cognizant of the necessity of containing healthcare costs through effective *Plan* design, and the *Plan Administrator* must abide by the terms of the *plan document and summary plan description*, to allow the *Plan Sponsor* to allocate the resources available to help those individuals participating in the *Plan* to the maximum feasible extent.

The *Plan* is not a contract of employment between you and your *participating employer* and does not give you the right to be retained in the service of your *participating employer*.

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* which is required by ERISA. This *plan document and summary plan description* amends and replaces any prior statement of the healthcare coverage contained in the *Plan* or any predecessor to the *Plan*.

This *Plan* is maintained pursuant to an agreement between the *participating employers* and USW Local 801, USW Local 825 and IBEW Local 2286 designated collectively as the “Union”.

A copy of the agreement between the *Plan Sponsor* and the *Union* may be obtained upon written request to the *Plan Administrator* and is available for examination at the *Plan Sponsor’s* principal office, and at each establishment of the *Plan Sponsor* in which at least 50 *covered persons* are customarily working. In the case of *covered persons* who do not usually work at, or report to, a single establishment of the *Plan Sponsor*, a copy of the agreement is available for examination at the meeting hall or office of said *Union* in which there are at least 50 *covered persons*.

The purpose of this *plan document and summary plan description* is to set forth the terms and provisions of the *Plan* that provide for the payment or *reimbursement* of all or a portion of certain medical expenses. The *plan document and summary plan description* is maintained by the *Plan Administrator* and may be inspected at any time during normal working hours by any *covered person*.

GENERAL PLAN INFORMATION YOU SHOULD KNOW

Name of Plan:	Sabine-Neches Health & Welfare Fund
Plan Sponsor:	The Joint Board of Trustees Sabine-Neches Health & Welfare Fund P.O. Box 130 Evadale, TX 77615
Named Fiduciary, Plan Administrator & Agent for Service of Legal Process:	The Joint Board of Trustees Sabine-Neches Health & Welfare Fund P.O. Box 130 Evadale, TX 77615
Plan Sponsor ID No. (EIN):	76-6167707
Plan Year:	January 1 through December 31
Plan Number:	501

GENERAL PLAN INFORMATION (Continued)

Plan Type: Medical
Dental
Prescription *Drug*

Third Party Administrator: GreenTree Administrators, LLC
P.O. Box 7306 – Beaumont, TX 77726-7306
87 Interstate 10 North, Suite 225 - Beaumont, TX 77707
(800) 825-2117

Participating Employer(s): MWV

Union Members: USW Local 801
USW Local 825
IBEW Local 2286

The *Plan* shall take effect for each *participating employer* on the *effective date* shown on the cover, unless a different date is set forth on page 1.

The *Plan* is a legal entity. Legal notice may be filed with, and legal process served upon, the *Plan Administrator*.

FUNDING MEDIUM AND TYPE OF ADMINISTRATION

The *Plan* is a self-funded *Plan*. The *Plan* receives *contributions* from *participants*, and holds those assets in trust for the exclusive benefit of *participants*, *dependents* and beneficiaries.

GreenTree Administrators hereafter referred to as “GreenTree” is the *Third Party Administrator*. GreenTree does not serve as an insurer.

GreenTree Administrators, LLC
P.O. Box 7306
Beaumont, Texas 77726-7306

87 Interstate 10 North, Suite 225
Beaumont, Texas 77707
(800) 825-2117

Mental Health Parity

Pursuant to the *Mental Health Parity and Addiction Equity Act of 2008*, this *Plan* applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration *limitations*. For further details, please contact the *Plan administrator*.

Applicable Law

This is a self-funded benefit *plan* coming within the purview of the Employee Retirement Income Security Act of 1974 (“*ERISA*”). The *Plan* is funded with *employee* and/or employer *contributions*. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The *Plan Administrator* shall have sole, full and final discretionary authority to interpret all *Plan* provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the *Plan* and related documents; to make determinations in regards to issues relating to eligibility for *benefits*; to decide disputes that may arise relative to a *covered persons’* rights; and to determine all questions of fact and law arising under the *Plan*.

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the Plan?

In order to be covered under this *Plan*, you must be eligible under the terms described for each enrollment classification, and you must be included through the terms of the collective bargaining agreement or a participation agreement with a *participating employer*. Certain *benefits* of this *Plan* may not be available to all classifications of enrollment. You are not eligible to participate if you are a part-time, temporary, leased or seasonal employee, or an independent contractor who is not covered under the terms of the collective bargaining agreement.

Enrollment Classification I – Active Employees

As a full-time *employee*, regularly scheduled to work at least 30 hours per week, you are eligible for coverage the 1st day of the month following completion of your *waiting period* of **ninety (90) days of continuous active employment**. You must actually begin work for the *participating employer* in order to be eligible. If you are unable to begin work as scheduled, then your coverage will become effective on the date when you begin work.

- **“Actively at work” or “Active employment”** means performance by the *employee* of all the regular duties of his occupation at an established business location of the *participating employer*, or at another location to which he may be required to travel to perform the duties of his employment. An *employee* will be deemed *actively at work* if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered *actively at work* if employment has been terminated.
- **“Employee”** means a person who is a regular full-time *employee* of the *participating employer*, regularly scheduled to work for the *participating employer* in an employer-employee relationship. Such person must be scheduled to work at least 30 hours per week in order to be considered “full-time”. The following are not considered *employees*:
 - Leased *employees* [as defined by § 414 (n) of the Internal Revenue Code];
 - Contract workers and independent contractors;
 - Temporary *employees*, seasonal and casual employees (*employees* hired short-term to meet specific needs of the Employer);
 - Individuals paid by a temporary or other employment or staffing agency; and
 - Any *employees* not covered under the terms of the collective bargaining agreement.
- **“Leave of absence”** means a *leave of absence* of an *employee* that has been approved by his *participating employer*, as provided for in the *participating employer’s* rules, policies, procedures and practices.
- **“Waiting period”** means an interval of time during which the *employee* is in the continuous, active employment of his *participating employer* before he becomes eligible to participate in the *Plan*.

When Both Spouses are Covered Employees Under this *Plan*, no *employee* who is eligible for coverage as an *employee* is eligible to be covered as a *dependent*. In the event a husband and wife are both eligible for coverage under the *Plan* as *employees*, the eligible *dependent child(ren)* may be enrolled as *dependents* of the husband or wife, but not both. If the *employee* who is covering the *dependent child(ren)* terminates coverage, the *dependent* coverage may be continued by the other covered *employee*

ELIGIBILITY FOR PARTICIPATION (Continued)

with no *waiting period* so long as application is promptly made and coverage is continuous. **In no event may a person be enrolled simultaneously as a participant and as a *dependent* under the *Plan*, and no *dependent* can be covered by more than one *participant*.**

Enrollment Classification II – Retirees and Totally Disabled Former Employees UNDER Age 65

You are eligible to continue to participate in the *Plan* if you are under age 65 and a retiree of the *participating employer* or if you are under age 65 and are a *totally disabled former employee*. You and any eligible *dependents* must have been covered under the *Plan* on the date immediately before your retirement or the commencement of *total disability* in order to continue your participation. Individuals who were not covered under the *Plan* on the date immediately before retirement or the commencement of *total disability*, or who are subsequently terminated under the *Plan*, will not be allowed to enter the *Plan* later during the annual open enrollment period or as described in the section, “Special Enrollment Periods”. You must pay any required *contributions* on a timely basis in order to continue participation. If you choose to cancel your coverage at any time, your *dependent(s)* will no longer be eligible to remain on the *Plan*.

“*Total disability*” or “*totally disabled*” means the inability of an *employee* to perform the duties of any occupation for which he may be qualified by reason of training, education or experience. The *Plan Administrator* may, in its sole discretion, require satisfactory evidence of *total disability*

Enrollment Classification III – Eligible Survivors UNDER Age 65

You are eligible to continue to participate in the *Plan* if you are under age 65 and were a covered *dependent* of an *active employee* at the time of the *employee’s* death. You may continue the full *benefits* of this *Plan* provided you pay any required *contributions* on a timely basis.

Eligible survivors under age 65 of retirees and *totally disabled former employees* may continue to participate in the *Plan* provided they were covered under the *Plan* as *dependents* on the date of the death of the retiree or *totally disabled former employee*. You must pay any required *contributions* on a timely basis in order to continue participation. Also, you may remain on the *Plan* indefinitely until you either remarry, become eligible to participate in another group health plan, *Plan* terminates or the *Plan* ceases to offer this survivor healthcare continuation option.

Eligible survivors of an *active employee* are eligible for coverage for thirty-six (36) months. During the first twelve (12) months, payment of the regular premium for *active employees* is required. During the subsequent twenty-four (24) months, payment of the *COBRA* premium is required.

All individuals in both sections of this enrollment classification who were not covered under the *Plan* on the date immediately before the death of the *employee* or former *employee*, or who are subsequently terminated under the *Plan*, will not be allowed to enter the *Plan* later during the annual open enrollment period or as described in the section, “Special Enrollment Periods”.

Enrollment Classification IV – Medicare Eligible Retirees, Totally Disabled Former Employees and Eligible Survivors OVER Age 65

You are eligible to continue to participate in the *Plan* once you become eligible for *Medicare*. You and any eligible *dependents* must have been covered under the *Plan* on the date immediately before your eligibility for *Medicare* in order to continue your participation. Individuals who were not covered under the *Plan* on the date immediately before their eligibility for *Medicare*, or who are subsequently terminated under the *Plan*, will not be allowed to enter the *Plan* later during the annual open enrollment period or as described in the section, “Special Enrollment Periods”. You must pay any required *contributions* on a timely basis in order to continue participation. If you choose to cancel your coverage for any reason, your *dependent* will cease to be eligible to remain on the *Plan*.

ELIGIBILITY FOR PARTICIPATION (Continued)

Eligible survivors of an active *employee* are eligible for coverage for thirty-six (36) months. The first twelve (12) months payment of regular premium is required. The subsequent twenty-four (24) months *COBRA* premium is required.

Are my dependents eligible to participate in the Plan?

Your *dependents* will become eligible for coverage on the latest of the following dates:

- The date you become eligible for coverage,
- The date coverage for *dependents* first becomes available under the *Plan*, and
- The first date upon which you acquire a *dependent*.

Please note: You must be covered under the *Plan* in order to cover any *dependents* except as provided for eligible survivors.

No *dependent child(ren)* may be covered as a *dependent* of more than one *employee* who is covered under the *Plan*.

No person may be covered simultaneously under this *Plan* as both an *employee* and a *dependent*.

- **“*Dependent*”** means one or more of the following person(s):
 - An *employee*’s lawfully wed spouse possessing a marriage license who is not divorced from the *employee*; or
 - An *employee*’s common law or “informal marriage” spouse as recognized by the state with required documentation; or
 - An *employee*’s *child* who is less than 26 years of age (up to the 26th birthday); or
 - An *employee*’s never married *child* who was continuously covered prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his own living and is still primarily dependent upon the *employee* for support. Such *child* must have been mentally or physically incapable of earning his own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the *Plan* must be furnished and approved by the *Plan* within 31 days after the date the *child* attains the limiting age of the bullets above. The *Plan* may require, at reasonable intervals, subsequent proof satisfactory to the *Plan* during the next two years after such date. After such two-year period, the *Plan* may require such proof, but not more often than once each year.

“*Dependent*” does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

REQUIRED DOCUMENTATION

The *Plan* reserves the right to require documentation, satisfactory to the *Plan Administrator*, which establishes a *dependent* relationship. Each *employee* is responsible for providing copies of birth certificates, marriage licenses, proof of common law or informal marriage via declaration form prescribed by the bureau of vital statistics and provided by the county clerk, divorce decrees, QMCSOs and any other *dependent* information deemed necessary.

ELIGIBILITY FOR PARTICIPATION (Continued)

“*Child(ren)*” means, in addition to the *employee’s* own blood descendant of the first degree or lawfully adopted *child*, a *child* placed with a covered Employee in anticipation of adoption, a covered *employee’s child* who is an alternate recipient under a *Qualified Medical Child Support Order* as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an “eligible foster child,” which is defined as an individual placed with the *employee* by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other *child* for whom the *employee* has obtained *legal guardianship*.

When will we become covered persons in the Plan?

Coverage will become effective at 12:01 A.M. (except for newborn *children*) on the date specified below, subject to the conditions of this section.

- If *contributions* are required, coverage will become effective on the first day of the month following the date you or your *dependents* are eligible, provided you and your *dependents* have enrolled for coverage on a form satisfactory to the *Plan Administrator* within 31 days following the date of eligibility.
- If *contributions* are not required, coverage will become effective on the date of eligibility, provided you and your *dependents* have enrolled for coverage on a form satisfactory to the *Plan Administrator* within 31 days following the date of eligibility.
- **NEWBORN CHILD(REN):**
 - If the mother is a *covered person* under the *Plan*, the *dependent child* will be covered from the moment of birth for routine newborn care as part of the mother’s claim during the period of initial *hospitalization*, and no *pre-existing condition limitation* will apply. If you wish to continue coverage beyond this initial period, you must make written application for coverage and agree to any required *contribution* **during the first 60-day period from the *child’s* birth.**
 - If the mother is not a *covered person* under the *Plan*, the *dependent child* will be covered from the moment of birth for routine newborn care during the initial period of *hospitalization* only if written application for coverage is made **during the first 60-day period from the *child’s* birth** and you agree to any required *contribution*.
 - For coverage of an *illness* or *injury* for the newborn *child*, you must make written application and agree to any required *contributions* **during the first 60-day period from the *child’s* birth.** Coverage for the *dependent child* will then become effective from the moment of birth, and no *pre-existing condition limitation* will apply.

<p>ACTUAL ENROLLMENT IS NECESSARY UPON BIRTH OF NEWBORN, ADOPTION, OR PLACEMENT FOR ADOPTION. Please be aware it is necessary to obtain, complete, sign and return a new enrollment form to GreenTree in order to add a newborn or adopted <i>child</i> to the <i>Plan</i>. If the <i>participant</i> fails to complete, sign and return the form within 60 days after the birth of a newborn, adoption or placement for adoption, the dependent will not have coverage or be able to enroll until the next Open Enrollment Period whether or not there is a change in premium.</p>
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ELIGIBILITY FOR PARTICIPATION (Continued)

- If you are required to contribute toward the cost of coverage and you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the first day of the month following the date the *dependent* becomes eligible, provided you make written application for the *dependent* and agree to make any required *contributions*, within 31 days of the date of eligibility. (Excludes newborns and adopted *children* where the deadline is 60 days from the date of eligibility.)
- If you are not required to contribute toward the cost of coverage and you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the date the *dependent* becomes eligible, provided you make written application for the *dependent* within 31 days of the date of eligibility. (Excludes newborns and adopted *children* where the deadline is 60 days from the date of eligibility.)

The *pre-existing condition limitation* will be waived for your adopted *child* under age 18, and for a *child* under age 18 placed in your home in anticipation of adoption, provided the adoption (or *placement for adoption*) occurs while you are covered under the *Plan* and provided that *child* has any *creditable coverage* during the first 30 days following the adoption (or *placement for adoption*) that is not followed by a *significant break in coverage*.

What if I do not enroll during my original eligibility period and later decide to apply for coverage?

You and your *dependents* may enroll for coverage during the *Plan's* annual open enrollment period, which is the month of October in each *plan year*. If you or your *dependents* enroll during an open enrollment period, coverage will be effective at 12:01 A.M. on the first day of the month following the open enrollment period, unless you have not satisfied the *waiting period*. In that case, coverage for you and your eligible *dependents* will be effective on the first day of the month following your completion of the *waiting period*.

The *Plan's pre-existing condition limitation* for *late enrollees* will apply to this coverage. Please refer to the section entitled "Pre-existing *Condition Limitation*" for more information.

Are there any other exceptions for enrollment?

As required under *HIPAA*, this *Plan* allows for enrollment under certain circumstances when the following conditions are met.

SPECIAL ENROLLMENT PERIODS

Loss of Other Coverage

If you declined enrollment for yourself or your *dependents* (including your spouse) because of other health coverage, you may enroll for coverage for yourself and/or your *dependents* if the other health coverage is lost. You must make written application for special enrollment within 30 days of the date the other health coverage was lost.

The following conditions apply to any eligible *employee* and *dependents*:

You may enroll during this special enrollment period:

- If you are eligible for coverage under the terms of this *Plan*;
- If you are not currently enrolled under the *Plan*;

ELIGIBILITY FOR PARTICIPATION (Continued)

- When enrollment was previously offered, you declined because of coverage under another group health plan. You must have provided a written statement that other health coverage was the reason for declining enrollment under this *Plan*, and
- If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer *contributions* for the coverage were terminated.

YOU ARE NOT ELIGIBLE FOR THIS SPECIAL ENROLLMENT RIGHT IF:

- The other coverage was *COBRA* continuation coverage and you did not exhaust the maximum time available to you for that *COBRA* coverage,
- The other coverage was lost due to non-payment of premium, or
- For cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the *other plan*).

If the conditions for special enrollment are satisfied, coverage for you and/or your *dependent(s)* will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the *Plan*.

NEW DEPENDENT

If you acquire a new *dependent* as a result of marriage, birth*, adoption*, or *placement for adoption**, you may be able to enroll yourself and your *dependents* during a special enrollment period. You must submit a completed, signed application (with proper documentation attached) to GreenTree for special enrollments no later than 30 days after you acquire the new *dependent* (see page 6 for requirements). If you do not have proper documentation at the time of the 30-day application process, send in the application and follow up with required documentation once you receive it. **Please note that *dependent(s)* will not be added until final required documentation is received.**

*Special rules apply (see page 7).

The following conditions apply to any eligible *employee* and *dependents*:

- You may enroll yourself and/or your *eligible dependents* during this special enrollment period if:
 - You are eligible for coverage under the terms of this *Plan*; and
 - You have acquired a new *dependent* through marriage, birth, adoption or *placement for adoption*.
- If the conditions for special enrollment are satisfied, coverage for you and your *dependent(s)* will be effective at 12:01 A.M.:
 - For a marriage, on the date of the marriage or certificate of common law marriage:
 - For a birth, on the date of birth: or

ELIGIBILITY FOR PARTICIPATION (Continued)

- For an adoption or *placement for adoption*, on the date of the adoption or *placement for adoption*.

What if a court orders coverage for a child?

Federal law requires the *Plan*, under certain circumstances, to provide coverage for your *child(ren)*. The details of these requirements are summarized below. Be sure you read them carefully.

The *Plan Administrator* shall enroll for immediate coverage under this *Plan* any *alternate recipient* who is the subject of a “*medical child support order*” (“*MCSO*”) or “*national medical support notice*” (“*NMSN*”) that is a “*qualified medical child support order*” (“*QMCSO*”) if the *child* named in the *MCSO* is not already covered by the *Plan* as an eligible *dependent*, once the *Plan Administrator* has determined that the order or notice meets the standards for qualification set forth below:

“*Alternate recipient*” shall mean any *child* of a *covered person* who is recognized under a *MCSO* as having a right to enrollment under this *Plan* as the *covered person’s* eligible *dependent*. “*MCSO*” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- 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
- Enforces a law relating to medical *child* support described in Social Security Act §1908 with respect to a group health plan.

“*NMSN*” shall mean a notice that contains the following information:

- Name of an issuing state agency;
- Name and mailing address (if any) of an *employee* who is a *covered person* under the *Plan*;
- Name and mailing address of one or more *alternate recipients* [i.e., the *child(ren)* 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
- Identity of an underlying *child* support order.

“*QMCSO*” is an *MCSO* 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:

- The name and last known mailing address (if any) of the *covered person* and the name and mailing address of each *alternate recipient* covered by the order;
- 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;
- The period of coverage to which the order pertains; and
- The name of this *Plan*.

ELIGIBILITY FOR PARTICIPATION (Continued)

In addition, a *NMSN* shall be deemed a *QMCSO* if it:

- Contains the information set forth above in the definition of “*NMSN*”.
 - Identifies either the specific type of coverage or all available group health coverage. If the employer receives a *NMSN* that does not designate either specific type(s) of coverage or all available coverage, the employer and the *Plan Administrator* will assume that all are designated; or
 - 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).
- 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* without regard to this section, except to the extent necessary to meet the requirements of a state law relating to *MCSOs*, as described in Social Security Act §1908.

Upon receiving a *MCSO*, the *Plan Administrator* shall, as soon as administratively possible:

- 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
- 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 *NMSN*, the *Plan Administrator* shall:

- 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:
 - Whether the *child* is covered under the *Plan*; and
 - 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.
- 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* shall:

- Establish reasonable, written procedures for determining the qualified status of a *MCSO* or *NMSN*; and
- 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.

PRE-EXISTING CONDITION LIMITATION

Will the Plan cover a pre-existing condition?

A *pre-existing condition limitation* applies for all *employees* and *dependents* entering or reentering the *Plan* as *late enrollees* or during a special enrollment period, except as set forth under *HIPAA*.

“Pre-existing condition” means any *illness* or *injury* (other than *pregnancy*), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a healthcare *provider* or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, during the six months immediately prior to the date your *waiting period* commences (the **“Enrollment Date”**). A *pre-existing condition* does not include genetic information in the absence of a diagnosis or other care or treatment of the *condition* related to the genetic diagnosis.

No coverage is provided for expenses in connection with a *pre-existing condition*.

Full *Plan* coverage will be available for such *condition* for someone entering the *Plan* during a special enrollment period on the day immediately following the expiration of 12 months, or in the case of a *late enrollee*, 18 months after the *enrollment date*. You have the right to demonstrate any *creditable coverage*, and the applicable period will be reduced by any *creditable coverage* unless it occurred before a *significant break in coverage*. The Pre-Existing Condition Exclusion will not apply to any *covered person* and/or *dependent* that is under age 19.

- **“Certificate of coverage”** means a written certification provided by any source that offers medical care coverage, including the *Plan*, for the purpose of confirming the duration and type of an individual’s current or previous coverage.
- **“Creditable coverage”** means coverage of an individual under any of the following: a group health plan, health insurance coverage, *Medicare*, *Medicaid* (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the *uniformed services* and their *dependents*, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children’s Health Insurance Program). To the extent that further clarification is needed with respect to the sources of *Creditable coverage* listed in the prior sentence, please see the complete definition of *Creditable coverage* that is set forth in 45 C.F.R. § 146.113(a).
- **“Late enrollee”** means a *covered person* who enrolls in the *Plan* other than:
 - On the earliest date on which coverage can become effective for the individual under the terms of the *Plan*; or
 - Through special enrollment.
- **“Significant break in coverage”** means a period of 63 consecutive days during each of which an individual does not have any *creditable coverage*.

You may prove *creditable coverage* by either of two methods:

PRE-EXISTING CONDITION LIMITATION (Continued)

- For *creditable coverage* effective on or after July 1, 1996, you may present a written *certificate of coverage* from the source that provided the coverage showing:
 - The date the *certificate of coverage* was issued;
 - The name of the group health plan that provided the coverage;
 - The name of the individual to whom the *certificate of coverage* applies;
 - The name, address, and telephone number of the *Plan Administrator* or issuer providing the *certificate of coverage*;
 - A telephone number for further information (if different);
 - Either:
 - A statement that the individual has at least 18 months (546 days) of *creditable coverage*, not counting days of coverage before a *significant break in coverage*; or
 - The date any *waiting period* (and affiliation period, if applicable) began and the date *creditable coverage* began; and
 - The date *creditable coverage* ended, unless the *certificate of coverage* indicates that coverage is continuing.
- If for any reason you are unable to obtain a *certificate of coverage* from another plan (including because the *creditable coverage* was effective prior to July 1, 1996), you may demonstrate *creditable coverage* by other evidence, including documents, records, third-party statements, or telephone calls by this *Plan* to a third-party *provider* of medical services. This *Plan* will treat an individual as having provided a *certificate of coverage* if that individual:
 - Attests to the period of *creditable coverage*;
 - Presents relevant corroborating evidence of some *creditable coverage* during the period; and
 - Cooperates with the *Plan Administrator*'s efforts to verify his status.

You have the right to request a *certificate of coverage* from your current or prior health plan, and the *Plan Administrator* will help you in obtaining the *certificate of coverage*.

If, within a reasonable time after receiving the information about *creditable coverage*, the *Plan Administrator* determines that a *limitation for pre-existing conditions* applies, he will notify you of that conclusion and will specify the source of any information on which it relied in reaching that determination. The notification will also explain the *Plan's* appeals procedures and give you a reasonable opportunity to present additional evidence.

SELECTION OF YOUR HEALTHCARE PROVIDER

Overview of PPO/Non-PPO Option

The *Plan Administrator* has entered into an agreement with one or more *networks* of *hospitals* and *physicians*, called “*PPO networks*”. These *PPO networks* offer *covered persons* healthcare services at discounted rates. Using a *PPO network provider* may result in a lower cost to the *Plan* as well as to the *covered person*. In no event shall a *PPO network provider* or a non-*PPO network provider* be paid more by the *Plan* than the amount deemed by the *Plan Administrator* to be *reasonable and appropriate*.

Contractual arrangements entered into by the *Plan* are intended to be for the exclusive benefit of the *Plan* and its *participants* and beneficiaries. If the *Plan Administrator*, in its capacity as a fiduciary of the *Plan* and in accordance with *ERISA*, determines, in its sole discretion, the contractual arrangements are not in the best interest of the *Plan* or violate applicable laws, the *Plan Administrator* shall pay *benefits* in accordance with its fiduciary duties regardless of any contractual arrangements to the contrary. Similarly, under *ERISA* §404(a)(1)(B) and §404(a)(1)(D), if any *Plan* documents, in the *Plan Administrator's* sole discretion, contain provisions that are inconsistent with *ERISA*, including *ERISA's* fiduciary duties, the *Plan Administrator* is released from its obligation to administer the *Plan* in accordance with the conflicting provision.

The *plan* will make every effort to pay *PPO network provider* claims within the allotted timeframe. However, for *PPO network provider* claims where there is no available discount or the discount is no longer available, the *plan administrator* must secure an outside independent audit of all of these claims.

There is no requirement for any *covered person* to seek care from a *provider* who participates in the *PPO network*. The choice of *provider* is entirely up to the *covered person*.

If *you* are traveling or reside outside the *PPO network* area (50 miles from the nearest *PPO hospital* or *PPO physician*) and use a non-*PPO network provider*, *your benefits* will be based on the *PPO network provider* level shown in the “*Schedule of Medical Benefits*”. This also applies to *dependent children* who are covered by this *Plan*, and reside outside the *network* area.

Medically necessary services, which must be rendered by a non-*PPO network provider* due to an *emergency* will be paid at the *PPO network provider percentage payable* with *reasonable and appropriate* fees as determined by the *Plan Administrator*.

Services which are covered by this *Plan* and which are not available through a *PPO network provider* are paid at the *PPO network provider percentage payable* with *reasonable and appropriate* fees as determined by the *Plan Administrator*, even when the services are provided by a non-*PPO network provider*.

Services for laboratory and *imaging*, *emergency room physicians* and *anesthesia* which are provided in a *PPO network provider* facility, which are rendered and billed by a non-*PPO network provider*, are reimbursed at the *PPO network provider percentage payable* with *reasonable and appropriate* fees as determined by the *Plan Administrator*.

SELECTION OF YOUR HEALTHCARE PROVIDER (Continued)

Some *PPO network provider hospitals* may have arrangements through which the benefit payable is more than the actual charges, e.g., per diem or diagnosis-related group (DRG) charges. When this occurs, the *Plan* will pay the *PPO network provider hospital's* per diem or DRG rates; not to exceed *reasonable and appropriate* fees for such services, as determined by the *Plan Administrator* regardless of any contractual arrangement to the contrary.

A current list of *PPO network providers* is available, without charge, through the website located at www.greentreadmin.com. You may also contact your *PPO network* at the phone number on your *Plan ID card*.

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 *PPO network 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 *PPO network provider*.

Many *PPO network providers* will require that the *Plan* offer incentives or “steerage” in order to encourage *covered persons* to use their member *providers*. This *Plan* defines “steerage” as lower costs to the *covered person* through reduced charges, resulting in lower *out-of-pocket expense* amounts, or higher rates of reimbursement under the *Plan*. The *Plan Administrator* reserves the right to negotiate discounts with *providers* of service, and those discounts will be used to reduce the amount of otherwise *covered expenses* considered for payment by the *Plan*. In certain cases, the *Plan Administrator*, in its sole discretion, may determine that the benefit payable for a discounted claim will be at the *PPO network provider* reimbursement level, and such payments will be considered to be in full compliance with the terms of the *Plan*.

A *covered person* shall not be liable or balanced billed for the difference between the negotiated *PPO* rate for *PPO Network Providers* and the amount determined by the *Plan Administrator* to be *reasonable and appropriate*.

YOUR COSTS

You must pay for a certain portion of the cost of *covered expenses* under the *Plan*, including *deductibles*, *co-payments*, and the coinsurance percentage that is not paid by the *Plan*. This is called “***out-of-pocket expense***”.

Deductibles, coinsurance, and *co-payments* are shown in the “Schedule of Medical *Benefits*”. A separate *deductible* applies to charges from *PPO network providers* and another for non-*PPO network providers*. These *deductible* amounts are separate, and will not accrue together toward satisfaction of either *deductible* amount. The *Plan* limits the amount of *deductible* and eligible *out-of-pocket expenses* you must pay for individual and *family unit*, as shown in the “Schedule of Medical *Benefits*”.

There may be differences in the coinsurance *percentage payable* by the *Plan* depending upon whether you are using a *PPO network provider* or a non-*PPO network provider*. These payment levels are also shown in the “Schedule of Medical *Benefits*”.

The *Plan* contains a limit for the amount of eligible *out-of-pocket expense* you must pay toward *covered expenses*, shown in the “Schedule of Medical *Benefits*,” and your eligible *out-of-pocket expense* limit may be higher for non-*PPO network providers* than for *PPO network providers*. Please note, however, that **not all covered expenses are accumulated toward your eligible out-of-pocket expense limit. These types of ineligible expenses include:**

- Transplant-related services and supplies by non-*PPO network providers*
- *Co-payments*
- *Deductibles*
- Penalties (See “Cost Containment Provision” section, but not limited to this section)
- Expenses in excess of *Plan* limits (*Plan year* benefit maximums)
- Dental Expenses
- Prescription *Drug Card* Program expenses
- *Medicare Plus Option Plan* expenses

Reimbursement for these types of *covered expenses* will continue at the *percentage payable* shown in the “Schedule of Medical *Benefits*,” subject to the *Plan* maximums.

Once you have paid the eligible *out-of-pocket expense* limit for expenses *incurred* during a *plan year*, the *Plan* will reimburse additional eligible *covered expenses* *incurred* during that year at 100%.

The *Plan* will not reimburse any expense that is not a *covered expense*. In addition, you must pay any expenses to which you have agreed that are in excess of the *reasonable and appropriate* fee as determined by the *Plan Administrator*.

If you have any questions about whether an expense is a *covered expense*, or whether it is eligible for accumulation toward your *out-of-pocket expense* limit, please contact GreenTree’s Customer Service Department for assistance.

SCHEDULE OF MEDICAL *BENEFITS*

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections “*Medical Benefits*” and “*Exclusions and Limitations*”. You may find the “*Definitions*” section helpful in understanding some of the italicized terms used throughout this *plan document and summary plan description*. In addition, the *Plan* has other requirements and provisions that may affect *benefits*, such as “*Cost Containment Provisions*,” and it is strongly recommended that you read the entire *plan document and summary plan description* to ensure a complete understanding of the *Plan* provisions. You may also contact GreenTree Administrators or the *Plan Administrator* for assistance.

Claims Audit

In addition to the *Plan’s Medical record review* process, the *Plan Administrator* may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the *Plan Administrator* has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not *Reasonable and appropriate* and/or *medically necessary*, if any, and may include a patient medical billing records review and/or audit of the patient’s medical charts and records.

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

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

<i>Lifetime Maximum Benefits</i>	Unlimited
<i>Benefit Percentage Payable</i> UNLESS OTHERWISE STATED	PPO (GTA SELECT)=100% PPO (GTA)=80% NON-PPO=65%

SCHEDULE OF MEDICAL BENEFITS (Continued)

PPO & NON-PPO Deductibles/ Out-of-Pocket expenses accumulate separately.

<i>Calendar Year Deductibles</i> GTA Select Network and GTA Network contributes towards each other (<i>eligible expenses only</i>)	GTA SELECT NETWORK (PPO)	GTA NETWORK (PPO)	NON-NETWORK (NON-PPO)
Per individual	\$0	\$1,500	\$3,000
Per family	\$0	\$3,000	\$6,000
<i>Out-of-Pocket Expense Limits</i> GTA Select Network and GTA Network contributes towards each other (<i>eligible expenses only</i>)	GTA SELECT NETWORK (PPO)	GTA NETWORK (PPO)	NON-NETWORK (NON-PPO)
Per individual	\$0	\$4,000 (plus <i>Deductible</i>)	Unlimited
Per family	\$0	\$8,000 (plus <i>Deductible</i>)	Unlimited
<i>Calendar Year Maximum Benefits</i> PER COVERED PERSON			
<i>Ambulance</i>			<ul style="list-style-type: none"> • \$2,000 • \$5,000
Chiropractic services			<i>\$1,500</i>
Extended Care Facility/ <i>Skilled Nursing Facility</i> Care			<i>60 days</i>
Jobst stockings			<i>Three pairs</i>

SCHEDULE OF MEDICAL BENEFITS (Continued)

<i>Benefit Provisions</i>	GTA SELECT NETWORK (PPO)	GTA NETWORK (PPO)	NON-NETWORK (NON-PPO)
Accident Benefit, Supplemental	Any covered expenses incurred within thirty (30) days of an accident are paid at 100% for the first \$300. Any covered expenses exceeding \$300 will be paid in accordance with the Schedule of Medical Benefits by type of service.		
Allergy Care Services <i>Office visits</i>	\$50 <i>co-pay</i> then 100%	\$50 <i>co-pay</i> then 80% after <i>Deductible</i>	\$50 <i>co-pay</i> then, 65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
Injections only	\$50 <i>co-pay</i> then 100%	80% after <i>Deductible</i> <i>co-pay waived</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable) <i>co-pay waived</i>
Ambulance Services <i>Ground: \$2,000 Calendar year Maximum</i> <i>Air: \$5,000 Calendar year Maximum</i> Non-emergent limited to \$350 per day	100%	100% after <i>Deductible</i>	100% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
Chiropractic Care Services All services limited to \$1,500 per calendar year. Office Visits, Therapies & X- rays	\$50 <i>co-pay</i> then 100%	\$50 <i>co-pay</i> then 80% after <i>Deductible</i>	\$50 <i>co-pay</i> , then 65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)

SCHEDULE OF MEDICAL BENEFITS (Continued)

BENEFIT PROVISIONS	GTA SELECT NETWORK (PPO)	GTA NETWORK (PPO)	NON-NETWORK (NON-PPO)
Diagnostic Laboratory and X-ray (Imaging)	\$50 <i>co-pay</i> then 100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
DME and Supplies Includes: Bone Growth Stimulators Oxygen Prosthetics and Orthotics Spinal Cord Stimulators	100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
<u>Emergency Care</u> <u>Accidental Injury and</u> <u>Emergency care</u> NOTE: If <i>Emergency</i> or <i>Urgent Care</i> services are sought at a <i>Non-Network</i> facility for treatment of an <i>illness</i> or <i>injury</i> which is NOT a <i>Medical Emergency</i> as defined by this <i>Plan Document</i> , reimbursement for charges billed by the <u>facility</u> and the <u>Physician</u> shall fall under the <i>Non-Network</i> Benefit. (ER <i>co-pay</i> is waived if admitted or if ER visit is within 72 hours of an accident)	\$50 <i>co-pay</i> (to facility) then 100%	\$50 <i>co-pay</i> (to facility) then 100% after <i>Deductible</i>	\$50 <i>co-pay</i> (to facility) then 100% after <i>Deductible</i> (based on <i>Medicare</i> allowable) <hr/> <i>Benefits</i> will apply to the GTA Network out-of-pocket maximum.
Extended Care Facility/Skilled Nursing Facility Care <i>Limited to 60 days per Calendar year</i>	\$250 <i>co-pay</i> per occurrence then 100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)

SCHEDULE OF MEDICAL BENEFITS (Continued)

BENEFIT PROVISIONS	GTA SELECT NETWORK (PPO)	GTA NETWORK (PPO)	NON-NETWORK (NON-PPO)
Home Health Care Services Includes RN/LVN Private Duty Services Infusion Services	100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
Hospice Care Services	100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
Injectable Medications Requires Pre-certification for each injection over \$500	\$50 <i>co-pay</i> then 100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
Inpatient Hospital Services	\$250 <i>co-pay</i> then 100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
Maternity and Family Planning Services <ul style="list-style-type: none"> • Prenatal and postnatal Outpatient care CO-PAY ON FIRST VISIT <hr/> <ul style="list-style-type: none"> • <i>Inpatient</i> services (Semi- private Room) *Co-pay for mother and sick baby. Well-baby expenses are paid under mother. 	\$50 <i>co-pay</i> on first visit, then 100%	\$50 <i>co-pay</i> on first visit, then 80% after <i>Deductible</i>	\$50 <i>co-pay</i> on first visit, then 65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
	\$250 <i>co-pay</i> * then 100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)

SCHEDULE OF MEDICAL BENEFITS (Continued)

BENEFIT PROVISIONS	GTA SELECT NETWORK (PPO)	GTA NETWORK (PPO)	NON-NETWORK (NON-PPO)
Mental Health and Substance Abuse Treatment <u>Inpatient /Partial-Hospitalization</u>	\$250 <i>co-pay</i> then 100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
<u>Outpatient</u> Includes biofeedback, intensive outpatient (IOP), Licensed professional counselor, social worker, testing and evaluation, group therapy, etc...	\$50 <i>co-pay</i> per visit then 100%	\$50 <i>co-pay</i> per visit then 80% after <i>Deductible</i>	\$50 <i>co-pay</i> per visit then 65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
Outpatient Services	\$75 <i>co-pay</i> per visit then 100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
Outpatient Therapy Services <ul style="list-style-type: none"> • chemotherapy services • dialysis • hyperbaric therapy • intravenous (IV) therapy • radiation therapy *Biofeedback is not covered.	100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)

SCHEDULE OF MEDICAL BENEFITS (Continued)

BENEFIT PROVISIONS	GTA SELECT NETWORK (PPO)	GTA NETWORK (PPO)	NON-NETWORK (NON-PPO)
<p>Physician Services</p> <p><i>Hospital Visits: Inpatient/Outpatient Anesthesia OB Surgical Pathologist fee Radiologist fee</i></p>	100%	80% after <i>Deductible</i>	65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)
<p>Office Visits/Surgeries <i>Consultations</i> ER Visit Second Surgical Opinion All other physician services (i.e. Allergy care, Injections, Lab, and <i>Imaging</i>)</p>	\$50 <i>co-pay</i> then 100%	\$50 <i>co-pay</i> then 80% after <i>Deductible</i>	\$50 <i>co-pay</i> , then 65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)

SCHEDULE OF MEDICAL BENEFITS (Continued)

BENEFIT PROVISIONS	GTA SELECT NETWORK (PPO)	GTA NETWORK (PPO)	NON-NETWORK (NON-PPO)
<p>Preventive and Wellness Services for eligible adults and children in compliance with the Patient Protection and <i>Affordable Care Act</i> of 2010, such as:</p> <ul style="list-style-type: none"> • Adult <i>Wellness</i>-Routine Physical Exam • Prostate Screening • Routine lab tests & x-rays • Immunizations for adults • Colorectal Cancer Screening (fecal occult blood testing, colonoscopy or sigmoidoscopy) Includes all related services-Limited to age 50 and older or family history of colon cancer, once every 5 years) • Well-woman/Routine GYN exam (maximum of one per <i>Calendar year</i>) • Screening Mammogram-Limited to 1 (one) per <i>Calendar year</i>, age 40 and over • Child <i>Wellness Visits</i>-Newborn to age 18 with recommended immunizations • Vision Screening-limited to one annual. 	<p>100%</p>	<p>100%</p>	<p>NOT COVERED Except Screening mammogram, which is 65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)</p>

SCHEDULE OF MEDICAL BENEFITS (Continued)

BENEFIT PROVISIONS	GTA SELECT NETWORK (PPO)	GTA NETWORK (PPO)	NON-NETWORK (NON-PPO)
<p>Rehabilitation Services <i>Inpatient: Must follow 3 days in hospital and be for continued treatment.</i></p> <hr/> <p>Outpatient:</p> <ul style="list-style-type: none"> • cardiac rehabilitation • occupational therapy • physical therapy • speech therapy <p>*Biofeedback is not covered.</p>	<p>\$250 <i>co-pay</i> then 100%</p> <hr/> <p>\$20 <i>co-pay</i> per visit then 100%</p> <p>(<i>co-pay</i> waived for cardiac rehab)</p>	<p>80% after <i>Deductible</i></p> <hr/> <p>80% after <i>Deductible</i></p>	<p>65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)</p> <hr/> <p>65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)</p>
<p>Transplant Procedures (Organ/Tissue Replacement) and Related Expenses</p> <hr/> <p><u>Procurement Maximum:</u> \$10,000 per transplant</p> <p><u>Nursing Care:</u> \$10,000 per transplant</p> <p><u>Transportation, lodging and meals:</u> Maximum benefit payment of \$10,000 (daily limit for lodging and meals: \$250)</p>	<p>\$250 <i>co-pay</i> for inpatient admission –or– \$50 <i>co-pay</i> for physician office visits</p> <p>then 100%</p>	<p>\$250 <i>co-pay</i> for inpatient admission –or– \$50 <i>co-pay</i> for physician office visits</p> <p>then 80% after <i>Deductible</i></p>	<p>\$250 <i>co-pay</i> for inpatient admission –or– \$50 <i>co-pay</i> for physician office visits</p> <p>then 65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)</p>
<p>Additional Eligible Medical Expenses</p>	<p>100%</p>	<p>80% after <i>Deductible</i></p>	<p>65% after <i>Deductible</i> (based on <i>Medicare</i> allowable)</p>

<i>Prescription Drug Care Program</i>	
RETAIL-<i>Generic drug</i> Per 34-day supply/100 units	\$10 <i>co-pay</i> No <i>deductible</i>
MAIL-ORDER-<i>Generic drug</i> Per 90-day supply/100 units	\$20 <i>co-pay</i> No <i>deductible</i>
RETAIL-<i>Brand name drug</i> Per 34-day supply/100 units	\$150 <i>plan year deductible,</i> \$40 <i>co-pay</i>
MAIL-ORDER-<i>Brand name drug</i> Per 90-day supply/100 units	\$150 <i>plan year deductible,</i> \$80 <i>co-pay</i>

About This Summary

This summary reflects the percentages of *eligible expenses* paid by the *Plan* after any required *Deductible* or *co-pay* has been deducted. The percentages apply to *reasonable and appropriate* fees only.

MEDICAL BENEFITS

Please refer to the “Cost Containment Provisions” section for important information concerning any requirements of the *Plan* for *pre-certification* of certain services. The following *covered expenses* must be *incurred* while coverage is in force under this *Plan*. Reimbursement will be made according to the “Schedule of Medical *Benefits*” and will be subject to all *Plan* maximums, *limitations*, *exclusions* and other provisions.

Hospital Emergency Room Services

Covered expenses include:

- *Emergency* treatment of an *injury*.
- *Emergency* treatment of an *illness*.

Covered expenses also include *physician’s* charges, and charges for radiology and pathology, for *emergency surgical* or medical care rendered in the *hospital emergency* room.

Hospital Inpatient Services

Inpatient Care

For medical or *surgical* care of an *illness* or *injury*, the *Plan* will reimburse *covered expenses* for *semi-private room and board* and necessary ancillary expenses. **If the *hospital* does not have *semi-private accommodations*, the *Plan* will allow coverage for an amount equal to 90% of the private room rate.**

Covered expenses will include *cardiac care units* and *intensive care units*, when appropriate for the *covered person’s illness* or *injury*.

Skilled Nursing (or Extended Care) Facility Benefits

Covered expenses for *inpatient skilled nursing* or (extended care) *facilities* include *semi-private room and board* accommodations, and necessary ancillary charges. The confinement must begin following an *inpatient* stay of at least three days in a *hospital* and must be for continued treatment of the *illness* or *injury* being treated in the *hospital*.

Rehabilitation Hospital/Facility Benefits

Covered expenses for *inpatient rehabilitation hospital / facilities* include *semi-private room and board* accommodations and necessary ancillary charges. The confinement must begin following an *inpatient* stay of at least three days in a *hospital* and must be for continued treatment of the *illness* or *injury* being treated in the *hospital*.

Maternity Care

Dependent children are not eligible for coverage for any expenses in connection with *pregnancy*.

Under the Newborns’ and Mothers’ Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict *benefits* for any *hospital* length of stay in connection with childbirth for the mother or newborn *child* to less than 48 hours following a vaginal delivery, or less than 96

MEDICAL BENEFITS (Continued)

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).

Benefits are payable in the same manner as for medical or *surgical* care of an *illness*, shown in the "Schedule of Medical *Benefits*" and this section, and subject to the same maximums.

Hospital Newborn Care

Coverage for a newborn *child* will be available only if you have satisfied the requirements for coverage in the "Eligibility for Participation" section.

- If the mother is a *covered person* under the *Plan*, the *dependent child* will be covered from the moment of birth for routine newborn care as part of the mother's claim during the period of initial *hospitalization*, and no *pre-existing condition limitation* will apply. If you wish to continue coverage beyond this initial period, you must make written application for coverage and agree to any required *contribution* **during the first 60-day period from the *child's* birth.**
- If the mother is not a *covered person* under the *Plan*, the *dependent child* will be covered from the moment of birth for routine newborn care during the initial period of *hospitalization* only if written application for coverage is made **during the first 60-day period from the *child's* birth** and you agree to any required *contribution*.

***ACTUAL ENROLLMENT IS NECESSARY UPON BIRTH OF NEWBORN, ADOPTION, OR PLACEMENT FOR ADOPTION.** Please be aware it is necessary to obtain, complete, sign and return a new enrollment form to GreenTree in order to add a newborn or adopted *child* to the *Plan*. If the *participant* fails to complete, sign and return the form within 60 days after the birth of a newborn, adoption or placement for adoption, the dependent will not have coverage or be able to enroll until the next Open Enrollment Period whether or not there is a change in premium.

Covered expenses for newborn *child(ren)* include nursery and neo-natal intensive care *room and board*, necessary ancillary expenses, and routine newborn care during the period of *hospital* confinement, including circumcision.

NOTE: If the mother's expenses are not covered under this *Plan*, or if the baby is an **ill newborn *child***, all charges will be considered and processed as the baby's own expenses, provided the *child* is eligible for and enrolled in this *Plan* in accordance with the applicable rules for coverage of a newborn.

Hospital-Mental/Nervous Disorder & Substance Abuse (Inpatient & Partial Hospitalization)

Mental or Nervous Disorder and/or Substance Abuse Partial Hospitalization

Covered expenses for *partial-hospitalization of mental or nervous disorder and/or substance abuse services*. Treatment must be rendered in a *hospital, psychiatric treatment facility, or substance abuse treatment center*, as applicable.

Mental or Nervous Disorder and/or Substance Abuse Inpatient Hospitalization

Covered expenses for *inpatient care of a mental or nervous disorder and/or substance abuse* including *semi-private room and board* and necessary ancillary charges, as applicable. Treatment must be rendered in a *hospital, psychiatric treatment facility, or substance abuse treatment center*, as applicable. **If the hospital, psychiatric treatment facility, or substance abuse treatment center does not have semi-private accommodations, the Plan will allow coverage for an amount equal to 90% of the private room rate.**

Physician In-Hospital Services

In-Hospital Medical Services

Covered expenses include professional services rendered by the attending *physician* while the *covered person* is hospitalized.

In-Hospital Concurrent Medical Care

Covered expenses include services rendered concurrently by a *physician* other than the attending *physician* when the *covered person* is being treated for multiple, unrelated *illnesses or injuries*, or which require the skills of a *physician* specialist.

In-Hospital Consultant Services

Covered expenses include the services of a *physician* consultant when required for the diagnosis or treatment of an *illness or injury*.

Mental or Nervous Disorder In-Hospital Medical Care Services

Covered expenses include professional services rendered by the attending *physician* while the *covered person* is hospitalized.

Substance Abuse In-Hospital Medical Care Services

Covered expenses include professional services rendered by the attending *physician* while the *covered person* is hospitalized.

Professional Interpretation Services (Inpatient/Outpatient)

MEDICAL BENEFITS (Continued)

Covered expenses include interpretation and reporting by a licensed radiologist or pathologist for covered diagnostic tests. *Benefits* are provided only for testing required for the diagnosis or treatment of an *illness* or *injury*, unless otherwise provided under “*Preventive Care*”.

Surgical Services (Inpatient/Outpatient)

Anesthesia Services

Covered expenses include the administration of local, regional and general *anesthesia*, or a *drug* or other anesthetic agent by injection or inhalation, rendered by a licensed *provider*. *Benefits* are also payable for these services when rendered by a Certified Registered Nurse Anesthetist (CRNA).

Surgical Assistants

Covered expenses include services by a licensed *physician*, *surgical physician’s assistant (P.A.)* or *nurse practitioner* 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. *Benefits* for surgical *physician’s assistants* and *nurse practitioners* are limited to 25% of the primary surgeon’s fee. Coverage will be provided for these services **only when rendered on an inpatient basis**, and only when the *hospital* does not employ interns and residents qualified to perform the service.

Obstetrical Services

Dependent children are not eligible for coverage for any expenses in connection with *pregnancy*. *Covered expenses* include obstetrical services rendered by the *physician* in charge of the case, including services customarily rendered as prenatal and postnatal care. *Benefits* for obstetrical care will be based upon the *Plan* provisions in effect on the date the services are rendered.

Surgical Services

Covered expenses include *surgical procedures*, including treatment for fractures and dislocations and routine pre- and post-operative care.

When more than one *surgical procedure* is performed during the same operative session, the allowed expense is calculated as follows:

- 100% of the *covered expense*, after any *PPO network provider* discount, for the most complex procedure.
- 50% of the *covered expense*, after any *PPO network provider* discount, for the second and each subsequent procedure.

Outpatient Diagnostic Services

Covered expenses include the following services when provided in an *outpatient* department of a *hospital* or other *institution*:

Outpatient Diagnostic Examinations

Benefits are provided for services such as *imaging* and laboratory examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography

MEDICAL BENEFITS (Continued)

(CAT scan), basal metabolism tests, electroencephalograms (EEG), amniocentesis, ultrasounds, and allergy testing, when the study is directed toward the diagnosis of an *illness* or *injury*.

Pre-Admission Testing

Benefits are provided for *pre-admission testing* for expenses *incurred* within 48 hours prior to the scheduled *hospital* admission, and only when the testing is not duplicated on admission.

Outpatient Facilities

Covered expenses include the following services when provided in an *outpatient* department of a *hospital* or other *institution*:

Outpatient Surgery/Ambulatory Surgical Center

Benefits are provided for charges by a *hospital*, *ambulatory surgical center*, or in a *physician's* office, for services required for a *surgical procedure*. The facility fees may include both services and supplies required for the *surgery*.

Outpatient – Mental/Nervous Disorder & Substance Abuse

Outpatient Mental/ Nervous Disorder Care

Covered expenses include *outpatient mental or nervous disorder* care by a licensed psychologist, psychiatrist, or licensed social worker.

Outpatient Substance Abuse Care

Covered expenses include *outpatient substance abuse* care by a licensed *provider*.

Outpatient Therapy Services

Covered expenses include the following services when provided in an *outpatient* department of a *hospital* or other *institution*:

Cardiac Rehabilitation

Benefits are provided for cardiac rehabilitation program services when certified as *medically necessary* by the attending *physician* in a treatment program that is appropriate for the *covered person's illness*.

Chemotherapy Services

Benefits are provided for administration of chemotherapy treatment, including the *reasonable and appropriate* fee as determined by the *Plan Administrator* for *drugs* and supplies used during the treatment.

Dialysis

Benefits are provided for kidney dialysis treatment, including the *reasonable and appropriate* fee as determined by the *Plan Administrator* for *drugs* and supplies used during the treatment.

Intravenous (IV) Therapy

Benefits are provided for administration of intravenous therapy, including the *reasonable and appropriate* fee as determined by the *Plan Administrator* for *drugs* and supplies used during the treatment.

Occupational Therapy

Benefits are provided for occupation therapy to restore a *covered person* to health, or to social or economic independence. These services must be performed by a licensed *occupational therapist*, who evaluates the performance skills of well and disabled persons of all ages, and who plans and implements programs designed to restore, develop, and maintain the *covered person's* ability to accomplish satisfactorily normal daily tasks. Occupational therapy must be ordered by the attending *physician* as part of a treatment plan that is appropriate for the *covered person's illness* or *injury*. Maintenance care is not covered.

Physical Therapy

Benefits are provided for rehabilitation concerned with restoration of function and prevention of disability following *illness, injury* or loss of a body part. The services must be performed by a licensed *physical therapist* as part of a treatment program which is appropriate for the *illness* or *injury*, and which is ordered by the attending *physician*. Maintenance care is not covered.

Radiation Therapy

Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes, including the *reasonable and appropriate* fee as determined by the *Plan Administrator* for materials.

Speech Therapy

Benefits are provided for the evaluation and treatment of *covered persons* who have voice, speech, language, swallowing, cognitive or hearing disorders. These services must be performed by a licensed and certified *speech therapist* as part of a treatment program which is appropriate for the *illness* or *injury*, and which is ordered by the attending *physician*. Maintenance care is not covered.

Physician Office Services

Covered expenses include the following services rendered in a *physician's* office:

Office Visits

Benefits are provided for services given in a *physician's* office which are required for the diagnosis or treatment of an *illness* or *injury*. Covered services include the services of a *physician's* assistant (P.A.) and/or *nurse practitioner* rendered under the supervision of the *physician*, and billed by the *physician*.

Allergy Care

Benefits are provided for allergy care, including injections, serums and extracts, given in a *physician's* office. Covered services include the services of a *physician's* assistant (P.A.) and/or *nurse practitioner* rendered under the supervision of the *physician*, and billed by the *physician*.

Injections

Benefits are provided for therapeutic injections given in a *physician's* office which are required for the treatment of an *illness* or *injury*. Immunizations and other injections which are not for the treatment of an *illness* or *injury* are not covered unless specified under "*Preventive care*". Covered services include the services of a *physician's* assistant (P.A.) and/or *nurse practitioner* rendered under the supervision of the *physician*, and billed by the *physician*.

Diagnostic Imaging and Laboratory Services

Benefits are provided for diagnostic *imaging* and laboratory services given in a *physician's* office which are required for the diagnosis or treatment of an *illness* or *injury*. Covered services include the services of a *physician's* assistant (P.A.) and/or *nurse practitioner* rendered under the supervision of the *physician*, and billed by the *physician*.

Preventive Care Services

Covered expenses include charges for *preventive care* services.

Benefits mandated through the PPACA (*Affordable Care Act*) legislation include *preventive care* such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA), and the Federal Center for Disease Control (CDC).

See <http://www.healthcare.gov/law/features/rights/preventive-care/index.html> for more details.

Second Surgical Opinions

Covered expenses include a second opinion to determine the *medical necessity* for a recommended *surgical procedure*. The *physician* rendering the second opinion must not be affiliated with the *physician* who recommended the *surgical procedure*. A third opinion will be covered if the two opinions differ, and if it is performed by a *physician* who is not affiliated with the *physicians* who have rendered opinions.

Ambulance Service

(Ground/Air/Sea & Non-emergency)

All *emergency ambulance* services are considered *medically necessary* when the patient's *condition* is such that any other form of transportation would be medically contraindicated and would endanger the patient's health. Convenience is not covered.

Coverage DOES NOT INCLUDE routine transports such as:

- scheduled/non-scheduled transports to or from *physician* offices or *outpatient* facilities for services such as dialysis, chemotherapy or physical therapy;
- transportation services primarily for convenience of the patient or patient's family; or
- transportation services by private vehicles (taxis, vans, etc...) or situations in which some means of transportation other than an *ambulance* could be utilized.

Ground emergency ambulance coverage will be covered for *medically necessary expenses* including:

- local professional *ambulance* service from *your* home to a *hospital*, or
- from the scene of an *accident* or medical *emergency* to the nearest *institution* able to treat the *condition*.

MEDICAL BENEFITS (Continued)

Ambulance - Non-emergency transports coverage will be allowed for:

- ambulance service between institutions when medically necessary for treatment not available in the original facility; or
- when the patient is confined to a bed, is unable to get out of bed with or without assistance, and cannot tolerate activities out of bed.

Precertification is required. Limited to \$350 per day.

Air or sea emergency ambulance services will be covered in exceptional circumstances when medically necessary to transport the covered person to the nearest institution capable of treating the illness or injury.

Chiropractic Care Services

Covered expenses include spinal manipulation and other related therapy treatments, and X-rays. Chiropractic care must be rendered for the active treatment of an illness or injury. Maintenance care is not covered.

Durable Medical Equipment (DME)

Covered expenses include rental of durable medical equipment and medical supplies. The Plan may approve purchase of the equipment at the Plan Administrator's discretion. Benefits for rental will not exceed the total purchase price of the equipment or the reasonable and appropriate fee as determined by the Plan Administrator for purchase. Repairs and/or replacement of equipment will not be covered unless such services are determined to be Medically necessary.

Home Health Care

Services of a Home Health Care Agency, at the percentage shown in the Schedule of Medical Benefits, for services furnished to a covered person in the home in accordance with a Home Health Care plan.

The Home Health Care plan must be established and approved by the physician and must certify that an inpatient hospital confinement would otherwise be required.

Covered Expenses include:

- Part time or intermittent nursing care by or under the supervision of a Registered Nurse (RN), if medically necessary;
- Part time or intermittent home health aide services performing services specifically ordered by a physician;
- Occupational therapy, speech therapy, physical therapy and respiratory therapy provided by a Home Health Care Agency; and
- Medical supplies, medicines, and equipment prescribed by a physician and provided by the Home Health Care Agency if such items would have been covered while hospital confined.

MEDICAL BENEFITS (Continued)

For determining the limit of *benefits* with respect to services set forth in items (1) and (2) above, each *visit* by a member of a *Home Health Care Agency* shall be considered as one *home health care visit* and 4 hours of home health aide services shall be considered as one *home health care visit*.

In addition to the *Limitations* and *Exclusions* below, benefits will NOT be provided for any of the following:

- Services of a person who ordinarily resides in a *covered person's* home or is a member of the *covered person's* family or spouse's family;
- *Custodial Care*, consisting of services and supplies which are provided to an individual primarily to assist in the activities of daily living;
- Any period during which the *covered person* is not under the continuing care of a *physician*;
- Homemaker or housekeeping services except by home health aides as ordered in the *Home Health Care* treatment plan;
- Supportive environmental materials such as handrails, ramps, air conditioners and telephones;
- Services performed by volunteer workers;
- Social services and dietary assistance;
- Separate charges for records, reports or transportation;
- Expenses for the normal necessities of living, such as food, clothing, and household supplies;
- Services rendered or supplies furnished to other than the *covered person*;
- Any services or supplies not included in the *Home Health Care* treatment plan or not specifically set forth as a *covered expense*; and
- Services provided during any period of time in which the *covered person* is receiving benefits under this *Plan's* Hospice care benefit.

Hospice Care

Covered expenses include hospice care services for a terminally ill *covered person* when provided by a *hospice care agency*. The services must be provided through a formal, written hospice care treatment program and certified by the attending *physician* as *medically necessary*. Benefits are provided for:

- *Room and board* for confinement in a licensed, accredited hospice facility.
- Services and supplies furnished by the hospice while the patient is confined.
- Part-time nursing care by or under the supervision of a registered nurse.
- Nutrition services and/or special meals.
- Respite services.

MEDICAL BENEFITS (Continued)

- Counseling services by a licensed social worker or a licensed counselor.
- Bereavement counseling by a licensed social worker or a licensed counselor for the *employee* and/or covered *dependent* (s) during the first three months following death.

The attending *physician* must certify that the *covered person* is expected to continue to live for six months or less in order to qualify for this benefit.

If the *covered person* lives beyond six months, the *Plan* will approve additional hospice care benefits on receipt of satisfactory evidence of the continued *medical necessity* of the services.

Other Covered Expenses

- **Blood transfusions and blood products**, to the extent not replaced. The *Plan* will not cover expenses in connection with autologous blood acquisition and storage.
- **Breast Reconstruction** following a *mastectomy*, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a *mastectomy*, including lymphedemas, in a manner determined in *consultation* with the attending *physician* and the *covered person*. Reimbursement will be made according to the “Schedule of Medical Benefits” section by type of service.
- **Chelation therapy** for a diagnosis of lead poisoning, or a diagnosis of anemia for a *child*.
- Initial purchase (including original fitting, adjustment and placement) of orthopedic braces (but not for dental braces), casts, splints, crutches, cervical collars, head halters, traction apparatus, prosthetic appliance, artificial limbs or eyes to replace lost body parts or to aid in their function when impaired, and for the *Medically necessary* repair of such items. Charges for replacement or subsequent devices will be eligible only when written certification of need is submitted to the *Plan* by a Medical Doctor, replacement is *Medically necessary* due to a change in the patient’s physical *condition*, or replacement is less expensive than modification or repair of the existing device.
- **Lenses, one pair** (contact or frame-type) including the examination and fitting of the lenses) only when *Medically necessary* to replace the human lens lost through intraocular surgery.
- **Oral surgical procedures**, including:
 - Excision of tumors and cysts of the jaws, cheeks, lips, tongues, roof and floor of the mouth.
 - *Emergency* repair due to *injury* to sound natural teeth.
 - *Surgery* needed to correct *accidental injuries* to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
 - Excision of benign bony growths of the jaw and hard palate.
 - External incision and drainage of cellulitis.

MEDICAL BENEFITS (Continued)

- Incision of sensory sinuses, salivary glands or ducts.
- **Ortho-mammary surgical support bras or mastectomy bras** if certified by a *physician* as *medically necessary*.
- **Orthotics.** Initial purchase, fitting, repair and replacement of orthotic appliances that are required for support for an injured or deformed part of the body as a result of a disabling *condition* or an *injury* or *illness*. This does *not include* orthopedic or corrective shoes, arch supports or other supportive appliance for or in connection with the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, or other foot care except when:
 - *Medically necessary* in lieu of or after Surgery, or due to metabolic or peripheral vascular disease,
 - Prescribed by a *Physician*,
 - Medically designed for a given patient, and
 - Used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.
- **Reconstructive surgery** as a result of:
 - An *accidental* Bodily *injury*, providing such Surgery takes place within 12 months of the date of the *injury*;
 - A *congenital disease or anomaly* of a Covered Dependent child;
 - Following prior *Medically necessary* Surgery, providing such reconstructive procedure takes place within 12 months of the initial Surgery;
 - *Mastectomy* as well as reconstruction of the other breast to produce symmetrical appearance; and
 - *Medically necessary* removal of breast implant(s). Reconstructive breast Surgery following removal of implant(s) is covered only if the original implant(s) was/were implanted for other than *cosmetic* reasons.
- **Respiratory therapy**, Oxygen therapy, and Hyperbaric therapy.
- **RN and LVN private duty nursing services** for outpatient care when *medically necessary*.
- **Sterile surgical supplies** following a covered *surgery*.
- **Sterilization procedures, elective.**
- **Surgical dressings, splints, casts**, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an *illness* or *injury*.
- **Surgical support hose or prosthetic socks** if certified by a *physician* as *medically necessary*.
- **Travel** charges related to surgical procedures and *medically necessary* follow-up *visits* to facilities that are out of the area as determined by the *Plan administrator* to be a cost savings to the *plan* as opposed to the same service locally or if the services cannot be done locally. These

MEDICAL BENEFITS (Continued)

charges could consist of transportation, meals and lodging as deemed necessary by the *plan administrator* for charges *incurred* for transportation to and from the site of the covered surgery for the *covered person* and one other individual, or in the event that the *covered person* is a minor, two other individuals. In addition, all *reasonable and appropriate* lodging and meal expenses will be covered if the surgical facility is more than 200 miles from the *covered person's* home. There is a daily limit of \$250 for meals and lodging. Itemized receipts are required for reimbursement.

Transplant Procedures-Replacement of Organs/Tissues & Related Services

The *Plan Administrator* **requires** that any *covered person* who is a candidate for any transplant procedure contact GreenTree's Medical Management Department before making arrangements for the procedure. Please refer to the "Cost Containment Provisions" section for additional information concerning *pre-certification*. The *covered person* also must obtain a second *surgical* opinion from a *physician* who is Board Certified in the specialty appropriate to the proposed transplant which confirms the *medical necessity* for the procedure. This communication may identify certain types of procedures, or expenses associated with the procedures, which will not be covered under the *Plan*, before the actual services are rendered. However, *pre-certification* and a confirming second *surgical* opinion is not a guarantee of coverage or benefits under the *Plan*.

Failure to pre-certify the proposed transplant or to obtain a confirming second *surgical* opinion may result in a loss or reduction in benefits otherwise payable under this *Plan*.

In addition, the *Plan Administrator* may make arrangements with selected *providers* where a *covered person* may receive care at a negotiated rate. Using such a selected *provider* will normally result in lower costs to the *Plan* and the *covered person*. In no event shall a *PPO network provider* or a *non-PPO network provider* be paid more by the *Plan* than the amount deemed by the *Plan Administrator* to be *reasonable and appropriate*. Please contact GreenTree for additional information about locating a *provider* for an expected transplant procedure.

Covered expenses include the following types of transplants:

Solid Organs

Benefits are provided for the transplantation of solid human organs (with other human organs) and related services. This *Plan* excludes transplantation of non-human organs.

Bone Marrow Transplants

Benefits are provided for *medically necessary* bone marrow transplantation procedures, including, but not limited to, synergic and allogenic/homologous bone marrow transplantation, as well as autologous bone marrow transplantation procedures.

Tissue Replacement

Benefits are provided for the replacement of human tissue (with human tissue or prosthetic devices).

MEDICAL BENEFITS (Continued)

Other Benefits Related to Transplantation

Benefits are also provided for:

- The preparation, acquisition, transportation and storage of human organs, bone marrow, or human tissue.
- Travel and lodging for the *covered person*, if the organ recipient, and one other person, to and from the site of the transplant procedure if the recipient lives more than 100 miles from the facility and the *Plan Administrator* has approved the facility. If the recipient is a minor, transportation expenses will be allowed for both parents.

Specific rules apply as to the payment of *benefits* for the donor and recipient of the transplanted organ, bone marrow, or tissue.

- When the transplant recipient and donor are **both** covered under this *Plan*, payment for *covered expenses* is provided for both, subject to each *covered person's* respective benefit maximums.
- When the transplant recipient is covered under this *Plan* but the donor is not, payment for *covered expenses* is provided for both the recipient and the donor to the extent that charges for such services are not payable by any other source. *Benefits* payable on behalf of the donor are charged to the recipient's claim and applied to the recipient's maximums.

<p>With respect to any <i>injury</i> which is otherwise covered by the <i>Plan</i>, the <i>Plan</i> will not deny <i>benefits</i> provided for treatment of the <i>injury</i> if the <i>injury</i> results from an act of domestic violence or a medical <i>condition</i> (including both physical and mental health <i>conditions</i>).</p>

EXCLUSIONS AND LIMITATIONS - MEDICAL

This *Plan* will not reimburse any expense that is not a *covered expense*. This *Plan* does not cover any charge for services or supplies related to any of the following:

- **Abortion.** That is *incurred* directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or when complications arise. This *exclusion* will not apply if the *pregnancy* resulted from rape or incest.
- **Alternative Medicine.** Including but not limited to, hydrotherapy, aromatherapy, naturopathy and homeopathic and holistic treatment.
- **Biofeedback,** except as specifically covered for *mental/nervous disorder* and/or *substance abuse*.
- **Birth control drugs or devices.** For birth control *drugs* or devices, whether or not dispensed by prescription, that are purchased or prescribed for the sole purpose of preventing conception, except as specifically mandated by the *Affordable Care Act* and covered by the provisions of *your Prescription Drug Card Program*.
- **Cochlear implants.**
- **Corrective shoes.**
- **Cosmetic or Reconstructive Surgery.** Services or supplies for *cosmetic* or reconstructive surgeries and related treatments, including but not limited to:
 - Botox;
 - Surgical removal or reformation of sagging skin on any part of the body;
 - Enlargement, reduction or other changes in appearance of any part of the body, unless specifically covered under *covered expenses*;
 - Hair transplant or removal of hair by electrolysis;
 - Treatment to reduce, remove or improve the appearance of varicose veins;
 - Chemical face peels or skin abrasions;
 - Removal of tattoos or birthmarks; and
 - Surgical treatments of scarring secondary to acne or chicken pox, including but not limited to, dermabrasion, chemical peel, salabrasion, and collagen injections.

This *exclusion* shall not apply to *cosmetic* or reconstructive *surgery* specifically as listed as a *covered expense*, or as deemed *medically necessary* in connection with an *illness* or *injury*.

- **Counseling.** For counseling, except as specifically mandated by the *Affordable Care Act* and as the result of a *mental or nervous condition*, for:

EXCLUSIONS AND LIMITATIONS - MEDICAL (Continued)

- Marital difficulties
- Social maladjustment
- Pastoral issues
- Financial issues
- Behavioral issues
- Lack of discipline or other antisocial action
- **Complications of Non-Covered Expenses.** Treatment, service or care required as a result of complications from a treatment or service not covered under the *Plan*.
- **Court Ordered Treatment or Hospitalization.** Excluded unless such treatment is prescribed by a *physician* and is a *covered expense* of the *Plan*.
- **Custodial care.** Except as specified.
- **Dental prescriptions.** (e.g., Peridex, fluoride).
- **Dental.** Related to dental treatment, except as specifically provided in this *Plan*.
- **Developmental delay.** For developmental disorders, including learning disabilities, except as specifically mandated by the *Affordable Care Act*. This *exclusion* does not apply to Attention Deficit Disorders.
- **E-Stims.** For E-Stims, Muscles Stims and TENS units, except as specifically covered.
- **Educational.** That is related to education or vocational training/services.
 - This *exclusion* does not apply to one course per lifetime of educational services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be *medically necessary* by the *Plan Administrator*.
- **Excess over semi-private rate.** That are in excess of the *semi-private* room rate, except as otherwise noted.
- **Experimental.** *Experimental* shall mean any *drug*, device, procedure, service or treatment that is the subject of ongoing Phase I or II clinical trials to determine maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared to other treatments. A *drug*, device, procedure, service or treatment will not be considered *experimental* if it is the subject of ongoing Phase III clinical trials and the *covered person* meets the Phase III protocol requirements to participate. A *drug*, device, procedure, service or treatment will be considered to be the subject of ongoing Phase I or II clinical trials to determine maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared to other treatments unless all of the following criteria are met:
 - The *drug*, device, procedure, service or treatment must have approval from the appropriate government regulatory bodies.

EXCLUSIONS AND LIMITATIONS - MEDICAL (Continued)

A *drug*, device, procedure, service or treatment must have Food and Drug Administration ("FDA") approval for those specific indications and methods of use for which such *drug*, device, procedure, service or treatment is sought to be provided.

Any *drugs*, devices, procedures, services or treatments, which at the time sought to be provided are not approved by the Health Care Financing Administration for reimbursement under *Medicare*, are considered *experimental* procedures.

Drugs are considered *experimental* if they are not commercially available for purchase, and are not approved by FDA for general use. The phrase "approved by FDA for general use" refers to permission for commercial distribution. Any other approvals that are granted as an interim step in the FDA regulatory process, subject to the Phase III exception above, are considered *experimental* procedures.

Drugs and tests approved by the FDA for a specific disease, *injury*, *illness* or *condition*, but which are sought to be provided for another disease, *injury*, *illness* or *condition*, are considered *experimental* procedures.

Drugs that are without at least one ingredient that constitutes a controlled substance as defined by the FDA are considered *experimental* procedures.

- The scientific evidence must permit conclusions concerning effect of the *drug*, device, procedure, service or treatment on health outcomes.

The evidence must consist of well-designed and well-conducted investigations published in peer-review journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

The evidence must demonstrate that the *drug*, device, procedure, service or treatment can measure or alter the sought after changes related to the disease, *injury*, *illness* or *condition*. In addition, there must be evidence or a convincing argument based on established medical facts that such measurement or alteration affects that health outcome.

Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale.

- The *drug*, device, procedure, service or treatment must improve or contribute to the improvement of the net health outcome.

The *drug*, device, procedure, service or treatment's beneficial effects on health outcomes must outweigh any harmful effects on health outcomes.

- The *drug*, device, procedure, service or treatment must be as beneficial as any established alternatives.

The technology must improve the net health outcome as much or more than established alternatives.

- The improvement must be attainable outside the investigational settings.

EXCLUSIONS AND LIMITATIONS - MEDICAL (Continued)

When used under the usual conditions of medical practice, the *drug*, device, procedure, service or treatment must reasonably be expected to satisfy criteria (a) and (b).

Notwithstanding any other provision contained herein, these criteria will be the sole means to construe and determine whether any drug, device, procedure, service or treatment constitutes "*Experimental Procedures*". The *Plan administrator* retains maximum legal authority and discretion to determine what is *Experimental*.

- **Eyeglasses, contact lenses, refractions.** Including the examination for their prescription and fitting, except one pair of lenses following *surgery* for cataracts or as may be provided under the Schedule of Medical *Benefits*.
- **Eye exercises or training and orthoptics.** This *exclusion* does not apply to:
 - Aphakic patients.
 - Soft lenses or sclera shells intended for use as corneal bandages.
 - One pair of lenses following cataract *surgery*.
- **Food supplements.** Related to food supplements or augmentation, in any form (unless *medically necessary* to sustain life in a critically ill person).
- **Foot care services, routine.** For routine foot care, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive and maintenance care, performed in the absence of localized *illness, injury* or symptoms involving the foot.
- **Genetic testing and/or counseling,** except as specifically mandated by the *Affordable Care Act*.
- **Growth hormone therapy.**
- **Hearing aids.** For hearing aids or devices, or the examination for their prescription and fitting.
- **Illegal act.** Charges for injuries suffered, or complications therefrom, while engaged in the commission of a crime, or attempted commission of a crime, or occurs under the influence of *drugs* or alcohol, whether or not it is actually prosecuted; or suffered as a result of driving under the influence of *drugs* or alcohol at a level in excess of lawful limits.
- **Infertility treatment.** Charges for procedures, *drugs* or supplies to correct infertility or to restore or enhance fertility including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), fertility *drugs*, artificial insemination, zygote intrafallopian transfer (ZIFT), and reversal of a sterilization procedure, surrogate mother or donor eggs.
- **Marital counseling.**
- **Massage therapy.** Unless applied in conjunction with other active physical therapy modalities for a specific covered *illness* or *injury*, and approved as *medically necessary* by the *Plan Administrator*.

EXCLUSIONS AND LIMITATIONS - MEDICAL (Continued)

- **Medically unnecessary.** Services or supplies that are not *medically necessary* for the care and treatment of an *injury* or *illness*, except where otherwise specified, or are not accepted as standard practice by the American Medical Association or the Food and Drug Administration.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is *medically necessary*.

- **Non-prescription medicines and supplies.** That can be purchased without a prescription.
- **Obesity treatment / weight control.** Charges for treatment, *surgery*, supplies, instruction, or activities for weight control or weight reduction, including but not limited to: weight loss programs, physical fitness, vitamins, diet supplements, recreational therapy, educational therapy, non-medical self-care or self-help training, or enrollment in a health, athletic, or similar club, regardless of the adjunctive, medical, or psychological *condition* of the *covered person* has that might be helped by weight control and the services are performed or prescribed by a *physician*, except as specifically mandated by the *Affordable Care Act*.
- **Orthognathic surgery** (jaw realignment *surgery*). For orthognathic *surgery* to correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.
- **Orthotics.** Except as specifically covered.
- **Patient convenience.** Related to the modification of homes, vehicles or personal property to accommodate patient convenience. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment and cervical pillows. This *exclusion* also applies to any services or supplies that are provided during a course of treatment for an *illness* or *injury* that are solely for the personal comfort and convenience of the patient.
- **Personal items.** For personal hygiene or comfort.
- **Preventive care.** For physical examinations, routine and *preventive care*, except as specifically provided under this *Plan*.
- **Pre-existing conditions.** Except as specifically provided under this *Plan* and as required by law.
- **Pregnancy of a dependent child.** Including pre-natal, delivery, related procedures, post-natal care, treatment of miscarriage and complications due to *pregnancy*.
- **Prenatal vitamins.**
- **Psychological Testing.**
- **Residential care facility.** Provided by or at a residential care facility or halfway house.
- **Reversal of sterilization procedures.**
- **Sex change.** Expenses for all services and supplies in connection with gender-reassignment *surgery* or procedures.

EXCLUSIONS AND LIMITATIONS - MEDICAL (Continued)

- **Smoking cessation.** For smoking cessation programs, Nicorette gum, nicotine transdermal patches or other treatment of tobacco dependency, except as specifically mandated by the *Affordable Care Act*.
- **Temporomandibular Joint disorder (TMJ).** Any and all services and supplies for or in connection with diagnosis or treatment of **Temporomandibular Joint disorder (TMJ)**.
- **Therapy.** Related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama or megavitamin therapy.
- **Transplantation of non-human organs.**
- **Travel expenses and accommodations.** For travel, even though prescribed by a *physician*, except as specifically provided under this *Plan*.
- **Trusses, corsets and other support devices** except as specifically provided under this *Plan*.
- **Related Provider.** Services of supplies provided by persons who ordinarily reside at the same household, or who are related by blood, marriage or legal adoption to the *covered person*.
- **Vision correction.** For radial keratotomy, keratomileusis or other vision correction procedures.
- **Vitamins.** Except as specifically provided under this *Plan*.
- **Work-related illness or injury.** Related to an *illness* or *injury* arising out of, or in the course of, any employment for wage or profit, including that of previous employers, without regard to whether such *illness* or *injury* entitles the *covered person* to workers' compensation or similar benefits.

EXCLUSIONS AND LIMITATIONS - GENERAL

This section applies to all *benefits* provided under any section of this *plan document and summary plan description*. This *Plan* does not cover any charge for services or supplies related to any of the following:

- **Absence of coverage.** Charges that would not have been made in the absence of coverage.
 - This includes charges that are submitted to the *Plan* equal to any amount for which the *provider* has discounted fees or has “written off” amounts due.
- **Alcohol.** To a *covered person*, arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for Injured *covered person* other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for *Substance abuse* treatment as specified in this *Plan*, if applicable. This *exclusion* does not apply (a) if the *injury* resulted from being the victim of an act of domestic violence, or (b) resulted from a medical *condition* (including both physical and mental health *conditions*).
- **Civil insurrection or riot.** Resulting from *injuries incurred* or exacerbated while participating in a civil insurrection or riot.
- **Complications.** Resulting from complications arising from a non-covered *illness, injury, or procedure*.
- **Cosmetic.** For *cosmetic surgery* or procedures, or aesthetic services (including complications arising therefrom).
 - This *exclusion* does not apply to procedures required as the result of an *injury*, or if approved as *medically necessary* for a covered *illness*.
 - This *exclusion* does not apply to reconstruction of a breast following a *mastectomy*, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a *mastectomy*, including lymphedemas, in a manner determined in *consultation* with the attending *physician* and the *covered person*.
- **Court-ordered services.** Unless determined by the *Plan Administrator*, in its discretion, to otherwise be appropriate and covered.
- **Deductibles, Co-payments and Coinsurance.** That are not payable due to the application of any specified *deductible, co-payment* or coinsurance provisions of the *Plan*.
- **Duplication of services.**
- **Excess.** Charges that are not payable under the *Plan* due to application of any *Plan* maximum or limit or because the charges are in excess of the *Reasonable and appropriate* fee, or are for services not deemed to be *medically necessary*, based upon the *Plan Administrator's* determination as set forth by and within the terms of this document..
- **Forms.** For the completion of medical reports, claim forms or itemized billings.

EXCLUSIONS AND MEDICAL EXPENSES – GENERAL (Continued)

- **Government services.** To the extent paid, or which the *covered person* is entitled to have paid or obtain without cost, by or through any government, or division thereof, except a program for civilian *employees* of a government.
- **Illegal acts.** For any *injury* or *illness* which is *incurred* while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies as determined by the *plan administrator*. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This *exclusion* does not apply (a) if the *injury* resulted from being the victim of an act of domestic violence, or (b) resulted from a medical *condition* (including both physical and mental health *conditions*).
- **Immediate family.** Provided by a member of *your immediate family* or an individual residing in *your* home.
- **Late Claims.** For which the claim is received by the *Plan* after the maximum period allowed under this *Plan* for filing claims has expired.
- **Malpractice, Malfeasance, or Misfeasance.** Includes treatment of *injuries* that are sustained or an *illness* that is contracted, including infections and complications, while the *covered person* was under the care of a *provider* for a *condition* wherein such *illness, injury, infection* or complication is not reasonably expected to occur. This *exclusion* will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator* in its sole discretion, gave rise to the expense.
- **Military service.** Resulting from, or prolonged as a result of, performing a duty as a member of the military service of any state or country.
- **Missed or broken appointments.**
- **Negligence.** For *injuries* resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed *Physician*.
- **No legal obligation to pay.** That is provided to a *covered person* for which the *provider* customarily makes no direct charge or for which the *covered person* is not legally obligated to pay.
- **Non-prescription medicines and supplies.** Regardless of the relief they may provide for a medical *condition*, charges for *drugs, medicines, equipment, or supplies* that **do not require a physician's prescription** are not covered, except as specified as covered medical expenses under the *Plan*, even if recommended or ordered by a *physician*, and even if a prescription number has been assigned.
- **Not actually rendered.**
- **Not eligible.** Services that were rendered or received prior to or after any period of coverage under this *Plan*, except as specifically provided for in this *plan document and summary plan description*.

EXCLUSIONS AND MEDICAL EXPENSES – GENERAL (Continued)

- **Penalties.** That are related to failure to comply with any requirements for coverage under this *Plan*, or for any *co-payment* amounts identified as a “penalty” in this *plan document and summary plan description*.
- **Prescribed use ONLY.** Any sharing or selling of prescribed medicine is illegal and could result in criminal charges and/or the loss of patient privileges to the *Plan*.
- **Prohibited by law.** For which the *Plan* is prohibited by law or regulation from providing *benefits*.
- **Self-inflicted.** That are the result of intentionally self-inflicted *injuries* or *illnesses*. This *exclusion* does not apply (a) if the *injury* resulted from being the victim of an act of domestic violence, or (b) resulted from a medical *condition* (including both physical and mental health *conditions*).
- **Subrogation.** Of an *injury* or *illness* not payable by virtue of the *Plan*’s subrogation, reimbursement, and/or third party responsibility provisions.
- **Tax and shipping.** For taxes and shipping charges levied on *medically necessary* items and services. This *exclusion* does not apply to surcharges required by law to be paid by the *Plan* in applicable states.
- **Telephone consultations.**
- **Venipuncture.** Deemed inclusive of lab charges.
- **War.** Resulting from war or an act of war, whether declared or undeclared, or any act of aggression, and any complication there from. This *exclusion* does not apply to *covered persons* who are not members of the *uniformed services*.

SCHEDULE OF DENTAL *BENEFITS*

Please note that the *benefits* in this section are **automatically included** in the coverage under “Enrollment Classification I - Active Employees”. All other enrollment classification levels (II, III, IV) do not **automatically** include the *benefits* described in this section. You must pay any required *contributions* on a timely basis in order to continue participation. Coverage must be elected within 31 days of the initial eligibility date and is thereafter not available at open enrollment.

Maximum Benefits

The following maximums apply to each *covered person*:

Maximum Benefits for:	
Class I, II, III Combined Dental Services	\$2,000 per <i>plan year</i>
Class IV Dental Services	\$1,600 per lifetime

Deductible

The following amounts are applied per *plan year*:

	<i>Deductible Amount</i>
Class II, III and IV Expenses	
Individual	\$25
Family	\$50

Payment Levels and Limits

The following types of *covered expenses* are subject to the *deductible* unless otherwise indicated:

Dental Expenses		
Type of Expense	Payment Level by Plan	Limits:
Class I Dental Expenses <i>deductible waived</i>	100% of the <i>reasonable and appropriate</i> fee as determined by the <i>Plan Administrator</i>	<i>Covered expenses</i> limited to twice per <i>plan year</i>
Class II Dental Expenses	80% of the <i>reasonable and appropriate</i> fee as determined by the <i>Plan Administrator</i>	Refer to section, “Dental <i>Covered Expenses</i> ” for certain limits
Class III Dental Expenses	50% of the <i>reasonable and appropriate</i> fee as determined by the <i>Plan Administrator</i>	Refer to section, “Dental <i>Covered Expenses</i> ” for certain limits
Class IV Dental Expenses	50% of the <i>reasonable and appropriate</i> fee as determined by the <i>Plan Administrator</i>	Refer to section, “Dental <i>Covered Expenses</i> ” for certain limits

The *deductible* amount, if any, which is listed above, is the amount each *covered person* must pay each *plan year* toward *covered expenses*. Once the *deductible* is satisfied, additional *covered expenses* will be reimbursed according to the percentages set forth above, subject to the *limitations* and *exclusions* set forth in this section.

DENTAL COVERED EXPENSES

The following is a brief description of the types of expenses that will be considered for coverage under the *Plan*. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with *ADA* accepted standards of practice. Coverage will be limited to the *reasonable and appropriate* fee as determined by the *Plan Administrator*.

Class I Services (Preventive care) **Limited to twice per *Plan* year.**

- Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth. Bitewing X-rays.
- Topical application of fluoride.

Class II Services (Repair and Restoration)

- Full mouth X-rays, or other X-rays necessary to diagnose a dental condition, including periapical and occlusal X-rays.
- Sealants for *dependent child(ren)* under age 14, **but not more than once per molar per lifetime.**
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for *dependent child(ren)* under age 19. **No payment will be made for duplicate space maintainers.**
- Amalgam, silicate, acrylic, plastic, sedative, synthetic porcelain and composite filling restorations to restore diseased or *accidentally* broken teeth, including pin retention when there is insufficient tooth structure to hold the filling. **Gold foil restorations are not eligible.**
- Simple extractions, except for orthodontia.
- Endodontics, including pulpotomy (deciduous teeth only), direct pulp capping and root canal treatment.
- Anesthetic services (**except local infiltration or block anesthetics**) performed by, or under the direct personal supervision of, and billed for by a *provider* other than the operating *dentist* or his assistant.
- Local *anesthesia*, including regional block *anesthesia* and injections. Desensitizing medications.
- Oral *surgery*, **limited to gingival curettage, gingivectomy, gingivoplasty, apicoectomy and osseous surgery.**
- Palliative *emergency* treatment of an acute condition requiring immediate care.
- Laboratory tests (oral pathology).
- Injections of antibiotic *drugs*.
- Stainless steel crowns.

DENTAL COVERED EXPENSES (Continued)

- Adjusting, relining or rebasing of dentures.
- Necessary repair of dentures or bridgework.
- Periodontal examinations, prophylaxis, treatment and *surgery*.

Class III Services (Major Dental Repair and Restoration)

- Inlays and onlays.
- Removal of impacted teeth.
- Gold foil restorations.
- Installation of crowns, including post and core or crown buildup when there is insufficient tooth structure to hold the crown.
- Temporary crowns.
- Repair or re-cementing of crowns, inlays and onlays.
- Necessary replacement of crowns, but only when the crown was placed at least five years prior to its replacement.
- Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth.
- Temporary bridges.
- Pins and posts for bridges and crowns.
- Stress breakers.
- Initial installation of dentures.
- Temporary partial or full dentures.
- Tissue conditioning in connection with dentures.
- Overdentures.
- Replacement of an existing full or removable denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
 - Where the denture or bridgework is necessary to replace teeth extracted after the existing denture or bridgework was installed, and the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or

DENTAL COVERED EXPENSES (Continued)

- Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 6 months.

Class IV Services (Orthodontics)

- Preliminary study, including cephalometric radiographs (**limited to one in any two year period**), diagnostic casts (**limited to one per covered person**) and treatment plan.
- Interceptive, interventive or preventive orthodontic services.
- Fixed and removable appliance placement, and active treatment per month after the first month.
- Extractions in connection with orthodontic services.

Benefits for covered orthodontic treatment will be **payable as an initial amount of one third of the total covered orthodontic treatment charges** for the course of orthodontic treatment. This payment will be considered to include the initial *dentist's* fee for diagnosis, evaluation, pre-orthodontic treatments, and the insertion of orthodontic appliances (not to exceed the *dentist's* actual charge, if less). **Thereafter, benefits will be paid in equal monthly amounts** during the period that:

- Begins when the first orthodontic appliance is installed; and
- Ends when the last appliance is originally scheduled to be removed, providing the *covered person* remains covered under this *Plan* for these *benefits*.

Pre-determination of Dental Benefits

If a *covered person's* proposed course of treatment reasonably can be expected to involve dental charges of \$300 or more, a description of the procedures to be performed and an estimate of the charges may be filed with the *Plan Administrator* or *third party administrator* prior to the commencement of the course of treatment. **However, approval is not required prior to treatment.** Any *pre-determination* of dental *benefits* is provided only as a convenience to the *covered person*.

If requested, the *Plan Administrator* or GreenTree will notify the *covered person*, and the *dentist* or *physician*, of the *pre-determination* based upon such proposed course of treatment. In determining the amount of *benefits* available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The *pre-determination* is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post-service claim, which will be subject to all applicable *Plan* provisions.**

DENTAL EXCLUSIONS AND *LIMITATIONS*

This *Plan* does not cover any dental-related charges for the following services or supplies:

- **Adjustments.** Charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet or mesh); to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint.
- **After the termination date.** The *Plan* will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, *benefits* for *covered expenses incurred* for the following procedures will be payable as though the coverage had continued in force:
 - A prosthetic device, such as full or partial dentures, if the *dentist* took the impression and prepared the abutment teeth while the patient was a *covered person* in the *Plan*, and delivers and installs the device within 30 days following termination of coverage;
 - A crown, if the *dentist* prepared the tooth for the crown while the patient was a *covered person* in the *Plan*, and installs the crown within 30 days following termination of coverage; and
 - Root canal therapy if the *dentist* opened the tooth while the patient was a *covered person* in the *Plan*, and completes the treatment within 30 days following termination of coverage.
- **Athletic mouth guards.**
- **Cosmetic dental work.** This includes, but is not limited to, characterization of dentures and services to correct *congenital* or developmental malformations. This *exclusion* will not apply to *cosmetic* work needed as a result of *accidental injuries*, but damage resulting from biting or chewing is not considered an *accidental injury*. This *exclusion* also does not apply to covered orthodontic treatment.
- **Education.** This includes, but is not limited to, charges for instruction in oral hygiene, plaque control or diet.
- **Excess Charges.** Charges in excess of *Reasonable and appropriate* fees. Charge for the service or supply received or charges in excess of any maximum payable under this *Plan*;
- **Experimental.** Charges for *experimental* dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the *ADA*.
- **Government provided.** Charges for dental care paid for or provided by the laws of any government or treatment given in a government-owned facility, unless the *employee* or *dependent* is legally required to pay.
- **Immediate Relative.** Services rendered by a person who is an immediate relative of, or who ordinarily resides with, the *covered person* requiring treatment. “Immediate relative” means spouse, child, brother, sister or parent of the *covered person*, whether by birth, adoption or marriage;

DENTAL EXCLUSIONS AND LIMITATIONS (Continued)

- **Miscellaneous.** The *Plan* does not cover any charge, service or supply which is:
 - For treatment other than by a *dentist* or *physician*, except:
 - Cleaning, scaling, and application of fluoride performed by a licensed dental hygienist under the supervision of a *dentist*; and
 - Non-*experimental* services performed at a dental school under the supervision of a *dentist*, if the school customarily charges patients for its services.
 - For personalization or characterization of dentures or veneers or any *cosmetic* procedures or supplies;
 - For oral hygiene or dietary instruction;
 - For a plaque control program (a series of instructions on the care of the teeth);
 - For implants, including any appliances and/or crowns and the surgical insertion or removal of implants;
 - For periodontal splinting;
 - For substances or agents which are administered to minimize fear, or charges for analgesia, unless the patient is handicapped by cerebral palsy, mental retardation or spastic disorder;
 - Paid, payable or required to be provided under any no-fault or equivalent automobile insurance law. Any uninsured motorist will be considered to be self-insured to the minimum coverage mandated by the governing state insurance law;
 - Charges for missed appointments or completion of claim forms; and
 - Services performed by a *physician* or other *provider* enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.
- **Missing appliances.** Charges for replacement of lost, missing or stolen appliances or prosthetic devices.
- **More expensive course of treatment.** In all cases involving *covered expenses* in which the *provider* and the *covered person* select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, coverage under the *Plan* will be based upon the charge allowed for the less expensive procedure.
- **Multiple provider care expenses.** Specifically in the event that a *covered person* transfers from the care of one *provider* to that of another during a course of treatment or if more than one *provider* performs services for one or more dental procedures, the *Plan* shall consider only such expense as would be appropriate had a single *provider* performed the service. An appropriate expense in this case will be within *reasonable and appropriate* fees.

DENTAL EXCLUSIONS AND LIMITATIONS (Continued)

- **No Legal Obligation.** Charges for which the *covered person* has no legal obligation to pay, or for which no charge would be made in the absence of a Treatment Plan;
- **Not necessary.** Charges for care which is not *dentally necessary* treatment, services or supplies, including replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability.
- **Not recommended.** And/or approved by a *dentist* or *physician*.
- **Occupational.** Charges for dental care which results from any employment, if covered to any extent by worker's compensation or similar law.
- **Photographs.**
- **Replacements.** Made within five 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*. (Damage resulting from biting or chewing is not considered an *accidental injury*).
- **Self-Inflicted.** Charges for care, treatment, services and supplies needed as a result of intentionally self-inflicted *injury* or *illness*;
- **Veneers.**

“MEDICARE PLUS” OPTION PLANS

If you are a *covered person* who is eligible under enrollment classification IV in the “Eligibility for Participation” section, you may choose to continue coverage under this *Plan* when you reach age 65 and become eligible for *Medicare*. You must enroll for coverage and agree to any required *contribution* within 31 days of your eligibility for *Medicare*.

With the exception of prescriptions *drugs* under “*Medicare Plus Plan 2*,” the *benefits* under each option supplement the benefits available through *Medicare*. This means that *covered expenses* will be determined by *Medicare*, as well as *exclusions* and *limitations*. In addition, if you fail to enroll in any voluntary coverage through *Medicare*, the *benefits* of this *Plan* will be calculated as though you had enrolled, based on an estimate of the applicable *Medicare* benefit, and you will be responsible for payment of any resulting amount that is unpaid by this *Plan*. *Covered expenses* for prescription *drugs* under “*Medicare Plus Plan 2*” will exclude any *drugs* not covered under the “Prescription *Drug Benefit*” of this *Plan*.

The following tables contain the amounts payable under the *Plan* for each option, and your costs for expenses.

Medicare Plus Plan 1 (Temple Inland Retirees Only)		
Medicare Part A Type of Expense	Amount of Plan Benefit	Amount You Must Pay
<i>Inpatient Hospital Expenses Days 1 through 60</i>	\$500	Full balance due after <i>Medicare Part A deductible</i>
<i>Inpatient Hospital Expenses Days 61 through 90</i>	Full balance after <i>Medicare Part A</i> daily coinsurance	\$0
<i>Inpatient Hospital Expenses Lifetime Reserve 60 days</i>	Full balance after <i>Medicare Part A</i> daily coinsurance	\$0
<i>Inpatient Skilled Nursing Facility Days 1 through 20</i>	\$0	\$0 (Paid in full by <i>Medicare Part A</i>)
<i>Inpatient Skilled Nursing Facility Days 21 through 100</i>	\$50 per day toward cost of <i>Medicare Part A</i> daily coinsurance	Full balance due after payment by <i>Medicare Part A</i> and <i>Plan</i> payment of \$50 per day
Medicare Part B Type of Expense	Amount of Plan Benefit	Amount You Must Pay
<i>Medicare Part B Deductible</i> Applicable to All <i>eligible expenses</i>	Full cost of <i>Medicare Part B deductible</i>	\$0
<i>Outpatient Physician Services</i>	\$0	Full balance after <i>Medicare Part B</i> coinsurance
<i>Outpatient Hospital Services</i>	\$0	Full balance after <i>Medicare Part B</i> coinsurance
Laboratory Tests and Flu Vaccinations	\$0	\$0 (Paid in full by <i>Medicare Part B</i>)
<i>Home Health Care Services</i>	\$0	\$0 (Paid in full by <i>Medicare Part B</i>)
<i>Outpatient Services for Mental or Nervous Conditions</i>	Full balance after <i>Medicare Part B</i> coinsurance	\$0
Prescription <i>Drugs</i>	\$0	Full cost

Medicare Plus Plan 2		
Medicare Part A Type of Expense	Amount of Plan Benefit	Amount You Must Pay
<i>Inpatient Hospital Expenses Days 1 through 60</i>	Full cost of <i>Medicare Part A deductible</i>	\$0

“MEDICARE PLUS” OPTION PLANS (Continued)

Medicare Plus Plan 2		
Medicare Part A Type of Expense	Amount of Plan Benefit	Amount You Must Pay
<i>Inpatient Hospital Expenses</i> Days 61 through 90	Full balance after <i>Medicare</i> Part A daily coinsurance	\$0
<i>Inpatient Hospital Expenses</i> Lifetime Reserve 60 days	Full balance after <i>Medicare</i> Part A daily coinsurance	\$0
<i>Inpatient Skilled Nursing Facility</i> Days 1 through 20	\$0	\$0 (Paid in full by <i>Medicare</i> Part A)
<i>Inpatient Skilled Nursing Facility</i> Days 21 through 100	Full balance after <i>Medicare</i> Part A daily coinsurance	\$0
Medicare Part B Type of Expense	Amount of Plan Benefit	Amount You Must Pay
<i>Medicare Part B Deductible</i> Applicable to All eligible expenses	\$0	Full cost of <i>Medicare</i> Part B <i>deductible</i>
<i>Outpatient Physician Services</i>	Full balance after <i>Medicare</i> Part B coinsurance	\$0
<i>Outpatient Hospital Services</i>	Full balance after <i>Medicare</i> Part B coinsurance	\$0
Laboratory Tests and Flu Vaccinations	\$0	\$0 (Paid in full by <i>Medicare</i> Part B)
<i>Home Health Care Services</i>	\$0	\$0 (Paid in full by <i>Medicare</i> Part B)
<i>Outpatient Services for Mental or Nervous Conditions</i>	Full balance after <i>Medicare</i> Part B coinsurance	\$0
Medicare Plus Plan 2 - Prescription Drug Card Program		
Prescription Drug Card Program — Retail <i>Brand name drug</i>	\$250 <i>plan year deductible per member,</i> then 50% of cost of covered <i>drug.</i> Maximum 34-day supply	Maximum benefit \$1250.00 per member per <i>calendar year</i> for combined retail and mail service <i>Brand name drugs</i>
Prescription Drug Card Program — Retail <i>Generic drug</i>	No <i>deductible</i> , \$10 <i>co-payment.</i> Maximum 34-day supply	
Prescription Drug Card Program: Mail Service — <i>Brand name drug</i>	\$250 <i>plan year deductible per member,</i> then 50% of cost of covered <i>drugs</i> Maximum 90-day supply	Maximum benefit \$1250.00 per member per <i>calendar year</i> for combined retail and mail service Brand Name <i>drugs</i>
Prescription Drug Card Program: Mail Service — <i>Generic drug</i>	No <i>deductible</i> , \$20 <i>co-payment.</i> Maximum 90-day supply	

Please contact the *Plan Administrator* or the *third party administrator* (GreenTree) with any questions concerning the *Medicare Plus Options Plan*.

COST CONTAINMENT PROVISIONS

Medical Management

Our medical management program provides an appropriate level of support to all *Plan* members, from those with simple, everyday concerns to those with chronic or catastrophic *conditions*. The goal of our medical management program is to assist *Plan* members in receiving high-quality care, provided in the most appropriate setting, while carefully managing costs.

Neither the *Plan Administrator* nor the *third party administrator* will interfere with your course of treatment or the *physician-patient* relationship. All decisions regarding treatment and use of facilities will be *yours* and should be made independently of this program.

We employ a multi-faceted approach, including predictive modeling, to identify and enroll members into appropriate programs.

- Utilization Management
- Case Management
- Disease Management

Pre-certification Review

This health benefit *Plan* requires several areas for which *plan* members must pre-certify their care. These include but not limited to the following: *illness* confinements, selected *outpatient* surgical procedures, selected *outpatient diagnostic services*/procedures, behavioral health. Our *pre-certification* reviews help you reduce claims costs by evaluating these high dollar claim expenses before a *plan* member's utilization of such medical services or procedures (see *Pre-certification* List for pre-cert requirements). ****Failure to contact GreenTree's Medical Management Department @ (409) 832-2335 or toll-free @ (800) 825-2117 within the following timeframes specified in this section will result in a penalty reducing the *benefits* otherwise payable. ****

Pre-Certification Notification Timeframes and Penalties

TYPE OF SERVICE	TIMEFRAME to notify GreenTree's Medical Management Department	PENALTY **Will not count toward any <i>out- of-pocket expense</i> limit
<u>All <i>illness</i> services, at a <i>hospital</i> or other <i>institution</i></u>	See below	See below
Urgent/emergent <i>illness</i> admissions (except transplant-related services)	Within 48 hours of admission (or on next regular business day following a weekend or holiday)	\$400 **
Non-emergent <i>illness</i> admission.	At least 5 working days prior to admission	\$400 **
<i>Outpatient</i> urgent/emergent care	Not required. See above if admitted.	\$0
Non-emergent <i>outpatient</i> care	At least 5 working days prior to services	Reduction of covered expense by 50% **
SEE PRE-CERT LIST BELOW FOR REQUIREMENTS Do not delay seeking medical care for any <i>covered person</i> who has a serious <i>condition</i> that may jeopardize his life or health because of the requirements of this program.		

Contact can be made by *Employee*, friend or family member, or *physician/facility*.
Failure to abide by above timeframes will result in a penalty reducing the *benefits* otherwise payable.

Pre-Certification List

- ALL *INPATIENT* SERVICES

Non-emergency outpatient care as follows:

- *Ambulance (non-emergency transport)*, Limited to \$350 per day
- Angiography (heart catheterization)
- Angioplasty
- Arthroscopic *surgery* (shoulder or knee)
- Back or neck *surgery*
- Breast reduction *surgery* (reduction mammoplasty)
- Bronchoscopy
- Carpal Tunnel or Tarsal Tunnel Release
- Cataract removal
- Chemotherapy
- Cholecystectomy (gallbladder removal)
- Colonoscopy (over age 45 and if more than once per *plan year*)
- CT (CAT) scans
- Dialysis (Kidney/Renal)
- *Durable medical equipment (DME)*, if expected cost is greater than \$500 total for rental or purchase
- EGD (Upper GI endoscopy)
- Endometrial ablation
- Epidural steroid injections (ESI)
- Facial (maxillomandibular) *surgery*
- Foot or hand *surgery*
- *Home health care* services
- Hospice care services
- Hyperbaric oxygen treatments
- Hysterectomy
- IV infusions (*outpatient* or home)
- Laparoscopy, diagnostic
- Lithotripsy
- MRI
- *Mastectomy*
- Mental Health Services (*outpatient*) **First 5 *visits* for counseling paid through EAP.
- Myelography or diskography
- Nerve blocks
- Organ/tissue replacement (transplant procedures)
- PET scans
- Prostate procedures
- Prosthetic devices and supplies
- Radiation therapy
- Rehabilitation services (*outpatient*), includes but not limited to PT/OT/ST, cardiac & pulmonary
- Thyroid *surgery*
- Uterine artery embolization
- Wound care (*outpatient*)

COST CONTAINMENT PROVISIONS (Continued)

Additional Utilization Management Services

In addition to *pre-certification* reviews, our Medical Management staff provides:

Concurrent Reviews – Effectively manages length of stay and medical services by monitoring the medical necessity and/or appropriateness of ongoing services.

Retrospective Reviews – Determines the *medical necessity* for services that require *pre-certification* when a *Plan* member fails to complete the *pre-certification* process prior to services being rendered. *If found **NOT** *medically necessary*, claim may be denied coverage.

Discharge Planning – In coordination with Case Management, identifies *Plan* members for whom timely discharge to less acute care is appropriate, assists the *Plan* member in finding alternative care and addresses potential discharge needs.

Referrals to Other Medical Management Programs – Recommends *Plan* members who could benefit from our Case Management and Disease Management programs.

A *pre-certification* or concurrent review determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based on the provisions of the *Plan* and the decision of the *Plan Administrator* in its sole discretion.

Pre-Determination of Benefits

This is a service provided by the *Plan* to help you determine, in advance, whether a proposed treatment will be a *covered expense* under the *Plan*. It is a voluntary provision, and you are under no obligation to obtain *pre-determination* of your treatment. However, you are encouraged to use this service to avoid incurring *non-covered expenses* for which you will be responsible.

In order to evaluate the proposed treatment, the *Plan administrator* will require detailed medical information from the *physician*, including:

- Identity of the *covered person* (date of birth and sex);
- Diagnosis code (ICD-9);
- Procedure code (CPT); and
- Amount of proposed charge.

This information should be submitted to:

GreenTree Administrators, LLC
Medical Management Department
87 IH-10 N, Suite 225
Beaumont, Texas 77707
Phone (800) 825-2117
Fax (409) 832-2301

A *pre-determination* under this section will **not** be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this *Plan* and the decision of the *Plan Administrator* in its sole discretion.

You will receive a written response with the *Plan Administrator's* determination, which you may furnish to your *physician* if you so desire.

Do not delay seeking medical care for any *covered person* who has a serious condition that may jeopardize his life, health or is in severe pain in order to pre-determine benefits. Pre-determination of benefits is not recommended under these circumstances.

Case Management

Members are identified for Case Management through our predictive modeling system, Utilization Management program and Claims and Customer Service areas. We can project a member's future Members are identified for Case Management through our predictive modeling system, Utilization Management program and Claims and

COST CONTAINMENT PROVISIONS (Continued)

Customer Service areas. We may project a member's future burden of *illness* so that earlier referrals to Case Management may be made. Earlier referrals help mitigate overall health care costs.

When a *Plan* member is enrolled in our Case Management program, a Personal Healthcare Consultant will work directly with that *covered person* and their healthcare *providers* to establish patient-centered goals, managing care across the continuum. The Personal Healthcare Consultant is dedicated to each case through completion of treatment, centralizes the referral process and concentrates on cases needing additional support.

Measures are taken to help the *Plan* member effectively manage their *benefits* and medical care to assure the best clinical and financial outcomes. Case Management programs focus on *conditions* that may lead to extended, highly specialized or resource-intensive care. Enhanced case management (also called Large Case Management) focuses on oncology management, transplant care and other specific healthcare services.

What are Personal Healthcare Consultants?

They are experienced, licensed *nurses* (RN/LVN) who provide support and may help with the following:

- Answer questions and provide information about the member's *condition, illness* or *injury*.
- Serve as a member advocate by helping navigate the healthcare system.
- Work with the member's *physician* and support treatment plans.
- Act as a liaison and communicate available community and/or social services.
- Provide assistance in coordination between all services provided by GreenTree Administrators.

Disease Management

Participation in our disease management program is completely voluntary.

We identify potential candidates for the program using medical and prescription *drug* claims information and then contact candidates and ask them to participate. If they volunteer, they receive:

- A call from a Personal Healthcare Consultant to discuss medical history, lifestyle behaviors and current disease state
- Follow-up calls to monitor health and provide support for the *physician's* treatment plan
- Toll-free access to a program *nurse*

We help *covered person's* learn about their *conditions*, make informed health care decisions, stay healthy and avoid unnecessary medical costs.

It is not the intention of GreenTree Administrators or its representatives to provide specific medical advice or opinions related to our case/disease management programs, but rather to provide *covered persons* with information to better understand their health and diagnosed disorders. Specific medical advice will not be provided, and GreenTree urges you to consult with a qualified *physician* for diagnosis and for answers to *your* personal questions. Our case/disease management programs are designed to support, not replace, the relationship that exists between a patient and his/her *physician*.

PRESCRIPTION DRUG BENEFIT

Please note that *covered persons* under the “Medicare Plus Option Plans” have different prescription drug benefits than offered in this section. Refer to the section entitled “Medicare Plus Option Plans” for details.

Benefits are provided for the purchase of *drugs* through the *Plan’s* Prescription Drug Card Program. The *covered person* must purchase the prescription *drugs* through the Prescription Drug Card Program, and use either a participating pharmacy or the “mail order option”.

The *Plan’s* Prescription Drug Card Program is administered by Script Care, LTD. Script Care has a *network* of pharmacies which can identify *covered persons* and the *Plan’s* coverage provisions. To find participating pharmacies contact Script Care @ (800) 880-9988 or online @ www.scriptcare.com.

Deductibles, Co-payments, and Maximums

Prescription Drug Card Program	
Prescription Drug Card Program — Retail <i>Brand Name drug</i>	\$150 <i>plan year deductible</i> , then \$40 <i>co-payment</i> . Maximum 34-day supply or 100 units, whichever is greater
Prescription Drug Card Program — Retail <i>Generic drug</i>	No <i>deductible</i> , \$10 <i>co-payment</i> . Maximum 34-day supply or 100 units, whichever is greater
Prescription Drug Card Program: Mail Service — <i>Brand Name drug</i>	\$150 <i>plan year deductible</i> , then \$80 <i>co-payment</i> . Maximum 90-day supply or 100 units, whichever is greater
Prescription Drug Card Program: Mail Service — <i>Generic drug</i>	No <i>deductible</i> , \$20 <i>co-payment</i> . Maximum 90-day supply or 100 units, whichever is greater

Covered Prescriptions

Under the Prescription Drug Card Program, *covered expenses* include:

- Compound prescriptions (of which at least one ingredient is a *legend drug* in a therapeutic amount, limited to \$200 per prescription).
- Diabetic supplies.
- Injectibles.
- Insulin syringes/needles.
- Insulin.
- *Legend drugs* (as defined below and as specifically limited).
- *Legend* vitamins.
- Non-insulin syringes/needles.
- Oral contraceptives.
- Prenatal vitamins.
- Retin A/Tretinoin (under 26 years of age).
- Vitamins with fluoride.

“*Legend drugs*” means any medicinal substance which bears the legend “Caution: Federal law prohibits dispensing without a prescription” and shall include State Restricted *drugs* (any non-federal *legend drug* which, according to state law, may not be dispensed without a prescription) and compounded prescriptions of which at least one ingredient is a *legend drug* in a therapeutic amount (limited to \$200 per prescription).

Certain *drugs* are not covered, even when prescribed by *your physician*. Please refer to the list of “Exclusions and Limitations” below.

How the Program Works

There are two ways to purchase *drugs* through the *Plan’s* Prescription Drug Card Program. You may save money by using the “mail order option” if you have prescription *drug(s)* that you must take on an on-going basis.

PRESCRIPTION DRUG BENEFIT (Continued)

- To fill a prescription at a participating pharmacy (the “pharmacy option”), simply present *your Plan ID card* and pay *your* portion of the cost. The *pharmacist* will file the claim for you.
- To fill a prescription through the *Drug Card Program’s “mail order option”*:
 - Obtain a copy of the mail order form from Script Care, LTD.
 - Complete the patient profile questionnaire (for *your* first order only).
 - Ask *your physician* to prescribe the needed medication for a 90-day supply, plus refills.
 - If you are presently taking medication, you will need a new prescription.
 - If you need the medication immediately, **but will be taking it on an on-going basis**, ask *your physician* for two prescriptions: one for a 14-day supply that you can have filled at a local pharmacy, and one for the balance of the prescription, up to a 90-day supply, that you can submit through the “mail order option”.
 - Send the completed patient profile questionnaire to the address on the form with *your* original prescription(s), along with *your* check for payment of *your* portion of the cost.

Once *your* order is processed, it will be sent to you via First Class Mail and it will include instructions for the re-order of future prescriptions and/or refills.

Co-payments for the Prescription *Drug Card Program* do not accumulate toward the eligible *out-of-pocket expense* limit.

Exclusions and Limitations

The *Plan* will not cover the following, except as noted, even when prescribed by the *covered person’s physician*:

- **Allergy serums.**
- **Amphetamines.**
- **Anabolic steroids (unless pre-authorized for *medical necessity*).**
- **Any charge for the administration of any *legend drug*.**
- **Any *experimental drug* even though a charge is made to the *participant*.**
- **Any *legend drug* for which the intended use has not been approved by the Food and Drug Administration and is therefore termed “Investigational.”**
- **Biological serums (*immunological vaccines*).**
- **Contraceptive devices, except as specifically mandated by the *Affordable Care Act*.**
- ***Cosmetic* indications and anti-wrinkle agents (e.g. Botox, Renova) for *covered persons* 26 years of age and over, except with *physician’s* written statement of *medical necessity*.**
- **Coverage for *participants* who have other primary group medical coverage.**
- **Diagnostic agents (test kits).**
- **Diet control *drugs* (anorexics)**

PRESCRIPTION DRUG BENEFIT (Continued)

- *Drug charges exceeding the cost for the same drug in conventional packaging.*
- *Drugs which are not medically necessary for the treatment of an illness, injury or pregnancy.*
- **Erectile dysfunction/organic impotence drugs** (for diagnosed impotence only, requires *physician's* written statement of *medical necessity*, then limited to a 30 day supply of 6 tablets).
- *Experimental drugs* or *drugs* required to be labeled: "Caution—Limited by Federal Law to Investigational Use".
- **Fertility drugs/agents.**
- **Growth hormones.**
- **Hair growth stimulants (e.g., Rogaine).**
- **Immunological vaccines.**
- *Legend drugs* which are to be taken or administered to the *participant*, in part or in whole, while *participant* is a patient in a licensed *hospital*, rest home, sanitarium, extended care facility, *convalescent hospital*, nursing home or similar *institution* which requires special unit-dose type packaging of *legend drugs* for its patients.
- **Medical devices/supplies, except as otherwise noted.**
- **Medications for which the cost is recoverable under any WORKERS COMPENSATION or occupational disease law or any state or governmental agency.**
- **Medication furnished by any other drug or medical service where no charge is made to the participant.**
- **Non-drug items, including but not limited to stockings or devices, even if a prescription is required.**
- **Over-the-counter (OTC) drugs.**
- **Prescription drugs for which a 30-day supply costs more than \$500, unless pre-authorized for medical necessity.**
- **Refills obtained more than one year after the original prescription date or prior to 75% of the completion of the projected usage.**
- **Retin A/Tretinoin (26 years of age and above requires physician's written statement of medical necessity).**
- **RU486 (mifepristone).**
- **Smoking cessation drugs/oral smoking deterrents.**
- **Topical dental fluorides.**
- **Vitamins, except as otherwise noted.**

NOTE: Prescriptions are for the use of the prescribed person only. Any sharing or selling of prescribed medicine is illegal and violations could result in criminal charges and/or the permanent loss of privileges to the Plan.

TERMINATION OF COVERAGE

When does my participation end?

Your participation will end at 12:01 A.M. on the earliest of the following dates:

- The date the *Plan* terminates;
- The date of the month on which you request that your coverage be terminated, provided your request is made on or before that date;
- If you fail to make any *contribution* when it is due, the last date of the period for which you made a *contribution*;
- The date of the month on which you cease to be eligible for coverage under the *Plan*;
- The date of termination of the collective bargaining agreement or participation agreement obligating *contributions* to the fund. (It is the responsibility of the *participating employers* to advise *covered persons* of the termination and any new coverage arrangements.)
- The last date of the month in which you terminate employment; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.

For purposes of this *Plan*, cessation of *active work* is deemed termination of employment unless:

- The covered *employee* is *totally disabled* and has been certified to receive disability benefit payments from the *participating employer's* pension and/or disability plan. In that case, medical coverage under this *Plan* may be continued for the duration of such *total disability* subject to the enrollment classification rules.
- The covered *employee* ceases active work and is eligible to continue coverage under the *Plan* as a qualified retiree of the *participating employer*. In this case, medical coverage under the *Plan* may be continued provided any required *contributions* are paid timely and the *Plan* continues to offer coverage to retirees.

A *covered person's* coverage for any specific benefit under this *Plan* will terminate on the earlier of:

- The date coverage under the *Plan* for such *benefits* ends; or
- The date the *covered person* ceases to be eligible for that benefit.

When does participation end for my dependents?

The coverage for your *dependents* will end at 12:01 A.M. on the earliest of the following dates:

- The date the *Plan* terminates;
- The date the *Plan* discontinues coverage for *dependents*;
- The date your *dependent* becomes covered as an *employee* under the *Plan*;
- The date your coverage terminates;
- If you fail to make any *contribution* when it is due, the last date of the period for which you made a *contribution* for your *dependents*;

TERMINATION OF COVERAGE (Continued)

- In the case of a *child* for whom coverage is being continued due to mental or physical inability to earn his own living, the earliest of:
 - Cessation of the inability;
 - Failure to furnish any required proof of the uninterrupted continuance of the inability or to submit to any required examination; or
 - Upon the *child's* no longer being *dependent* on you for their support.
- On the date a *dependent child* marries;
- In the case of a *child* other than a *child* for whom coverage is continued due to mental or physical inability to earn his own living, the date on which the *child* reaches age 19, or age 25 in the case of a *child* who is a full-time student attending an accredited high school, junior college, college, university or licensed trade school (see page 5 for full-time student requirements);
- The date on which person ceases to be a *dependent*; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.

When does participation end for eligible survivors?

The coverage for eligible survivors will end at 12:01 A.M. on the earliest of the following dates:

- The date of failure to make timely payment of any required *contributions*;
- The date the surviving *dependent(s)* comes eligible to participate in another group health plan (either as an *employee* or *dependent*);
- The date the surviving spouse remarries;
- The date a *child* ceases to qualify as a *dependent* under this *Plan*;
- The date the *Plan* ceases to offer coverage to eligible survivors; or
- The date this *Plan* is terminated.

The period of continued coverage for eligible survivors will run concurrently with *COBRA* continuation coverage.

Will the Plan provide evidence of coverage?

The *Plan* generally will automatically provide a *certificate of coverage* to anyone who loses coverage in the *Plan* or upon request. In addition, a *certificate of coverage* will be provided upon request within 24 months after the individual loses coverage under the *Plan*.

The *Plan* will make reasonable efforts to collect information applicable to any *dependents* and to include that information on the *certificate of coverage*, but the *Plan* will not issue an automatic *certificate of coverage* for *dependents* until the *Plan* has reason to know that a *dependent* has lost coverage under the *Plan*.

May I continue participation during FMLA leave?

The *Plan* will at all times comply with *FMLA*. During any leave taken under *FMLA*, you may maintain coverage under this *Plan* on the same conditions as if you had been continuously employed during the entire leave period. To continue your coverage, you must comply with the terms of the *Plan*, including election during the *Plan's annual enrollment period*, and pay your *contributions*, if any. Contact your *participating employer* for information concerning your eligibility for *FMLA* and any requirements of the *Plan*.

TERMINATION OF COVERAGE (Continued)

May I continue participation while I am absent under USERRA? Will my coverage be reinstated on return from USERRA leave?

You Have Rights Under Both COBRA and USERRA. Your rights under *COBRA* and *USERRA* are similar but not identical. Any election that you make pursuant to *COBRA* will also be an election under *USERRA*. *COBRA* and *USERRA* will both apply with respect to the continuation coverage elected. If *COBRA* and *USERRA* give you or your covered *dependents* different right, the law that provides the greater benefit will apply. The administrative policies and procedures for *COBRA* also apply to *USERRA* coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (“*USERRA*”) established requirements that employers must meet for certain *employees* who are involved in the *Uniformed Services*. In addition to the rights that you have under *COBRA*, you are entitled under *USERRA* to continue the coverage you (and your covered *dependents*) had under the *Plan*.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time National Guard duty pursuant to orders issued under federal law, and the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of war or national *emergency*.

Service in the *Uniformed Services* or Service means the performance of duty on a voluntary or involuntary basis in the *Uniformed Services* under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain duty and training by intermittent disaster response personnel of the National Disaster Medical System.

Duration of USERRA Coverage

General rule 24 months maximum. When a *participant* takes a leave for service in the *Uniformed Services*, *USERRA* coverage for the *participant* (and covered *dependents* for whom coverage is elected) begin the day after the *participant* (and covered *dependents*) lose coverage under the *Plan*, and it may continue for up to 24 months. However, *USERRA* coverage will end earlier if one of the following events takes place:

- You fail to make a premium payment within the required time;
- You fail to return to work within the timeframe required under *USERRA* (see below) following the completion of your service in the *Uniformed Services*; or
- You lose your rights under *USERRA* as a result of a dishonorable discharge or other conduct specified in *USERRA*.

Returning to Work. Your right to continue coverage under *USERRA* will end if you do not notify your employer of your intent to return to work within the timeframe required under *USERRA* following the completion of your service in the *Uniformed Services* by either reporting to work (when absence was for less than 31 days) or applying for reemployment (if absence was for more than 30 days). The time for returning to work depends on the length of the absence, as follows:

Period of Absence	Return to Work Requirement
Less than 31 days	Report to work at the beginning of the first regularly scheduled work period following the end of service plus 8 hours or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the <i>employee</i> .

TERMINATION OF COVERAGE (Continued)

More than 30 days but less than 181 days	Submit an application for employment not later than 14 days after the completion of the service, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the <i>employee</i> .
More than 180 days	Submit an application for employment not later than 90 days after the completion of the service.
Any period, if the absence was for purposes of an examination for fitness to perform service	Report to work at the beginning of the first regularly-scheduled work period following the end of service plus 8 hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the <i>employee</i> .
Any period, if you were hospitalized for or are convalescing from an <i>injury</i> or <i>illness incurred</i> or aggravated as a result of your service	Apply for work or submit application as described above (depending on length of absence) when recovery is over, but recovery time is limited to two years. The two-year period is extended by any minimum time required to accommodate circumstances beyond the <i>employee's</i> control that make compliance with these deadlines unreasonable or impossible.

Premium Payments for USERRA Continuation Coverage. If you elect to continue health coverage pursuant to *USERRA*, you will be required to pay 102% of the full premium for the coverage elected (the same rate as *COBRA*). However, if your *Uniformed Services leave of absence* is less than 31 days, you are not required to pay more than the amount that you would pay as an active *employee* for that coverage.

How do we continue our coverage under COBRA?

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 *participating employer* to see if *COBRA* applies to you and your *dependents*.

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*". *COBRA continuation coverage* cannot be obtained for life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your *participating employer's* plan).

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 child(ren)* 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:

- Your hours of employment are reduced, or
- 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:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

TERMINATION OF COVERAGE (Continued)

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to *Medicare* benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your *dependent child(ren)* will become *qualified beneficiaries* if they lose coverage under the *Plan* because any of the following *qualifying events* happens:

- The parent-covered *employee* dies;
- The parent-covered *employee's* hours of employment are reduced;
- The parent-covered *employee's* employment ends for any reason other than his or her gross misconduct;
- The parent-covered *employee* becomes entitled to *Medicare* benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- 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 a collectively bargained *participating employer*, 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 child(ren)* also will become *qualified beneficiaries* if bankruptcy results in the loss of their coverage under the *Plan*.

The participating 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 *participating employer* must notify the *Plan Administrator* of the *qualifying event* within fourteen days.

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* 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 up to 36 months, as applicable under *COBRA* law;
4. Notice that a *qualified beneficiary* entitled to receive *COBRA 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 *COBRA continuation coverage*; and
5. Notice that a *qualified beneficiary*, with respect to whom a notice described in the bulleted item above has been provided, has subsequently been determined by the SSA to no longer be disabled.

TERMINATION OF COVERAGE (Continued)

Please send these notices to the *third party administrator*:

GreenTree Administrators, LLC
P.O. Box 7306
Beaumont, Texas 77726-7306
409/832-2335
409/832-2301 fax

A form of notice is provided, free of charge, from the *third party 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:

- The date on which the relevant *qualifying event* occurs;
- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *plan document and summary plan description* 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:

- The date of the disability determination by the SSA;
- The date on which a *qualifying event* occurs;
- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *plan document and summary plan description* 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 *COBRA 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:

- The date of the final determination by the SSA that the *qualified beneficiary* is no longer disabled; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *plan document and summary plan description* 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 written 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

TERMINATION OF COVERAGE (Continued)

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 continuation 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 shall 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:

- Name and address of the *covered employee* or former *employee*;
- 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;
- 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);
- 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;
- 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*;
- 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, lost student status, married or other);
- 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*;
- 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;
- 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
- 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. Such notice will be deemed 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* will make its determination without the benefit of the requested information and may reject the notice if it does not contain enough information for the *Plan Administrator* to

TERMINATION OF COVERAGE (Continued)

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 notice is received 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 *child(ren)*.

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* within 14 days after the *Plan Administrator* has been furnished with notice of a *qualifying event*, a second *qualifying event* or a disability.

How long does COBRA continuation coverage last?

COBRA continuation coverage will be available up to the maximum time period shown below. 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*. When the *qualifying event* is "entitlement to *Medicare*," the 36-month continuation period is measured from the date of the original *qualifying event*. 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.

1. 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*. In the case of a disability extension of the maximum coverage period, the *Plan* may charge up to 150% of the applicable premium during the extension (i.e. in the 19th month and subsequent months of *COBRA* coverage).

2. 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 child(ren)* 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*

TERMINATION OF COVERAGE (Continued)

properly is given to the *Plan* as set forth above. This extension may be available to the spouse and any *dependent child(ren)* receiving *COBRA continuation coverage* if the *covered employee* or former *employee* dies, becomes entitled to *Medicare* benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the *dependent child* stops being eligible under the *Plan* as a *dependent child*, 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:

- The date your *participating employer* ceases to provide a group health plan to any *employee*;
- The date on which coverage ceases by reason of the *qualified beneficiary's* failure to make timely payment of any required premium;
- 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. However, a *qualified beneficiary* who becomes covered under a group health plan which has a pre-existing *condition* limit must be allowed to continue *COBRA continuation coverage* for the length of a pre-existing *condition* or to the *COBRA* maximum time period, if less; or
- 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;
- 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.

Two provisions under the *Trade Act* affect the benefits received under *COBRA*. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including *COBRA* premiums. Second, eligible individuals under the *Trade Act* who do not elect *COBRA continuation coverage* within the election period will be allowed an additional 60-day period to elect *COBRA continuation coverage*. If the *qualified beneficiary* elects *COBRA continuation coverage* during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the *Plan Administrator* if you believe the *Trade Act* applies to you.

Additional Information

Additional information about the *Plan* and *COBRA continuation coverage* is available from the *third party administrator*, who is:

GreenTree Administrators, LLC
P.O. Box 7306
Beaumont, Texas 77726-7306
409/832-2335

Current Addresses

In order to protect your family's rights, you should keep the *Third Party Administrator* (who is identified above) informed of any changes in the addresses of family members.

CLAIM PROCEDURES

Health Claims

All claims and questions regarding health claims should be directed to the *third party administrator*. The *Plan Administrator* shall 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 *covered person* is entitled to them. The responsibility to process claims in accordance with the *plan* Document may be delegated to the *third party administrator*; provided, however, that the *third party administrator* is not a fiduciary of the *plan* and does not have the authority to make decisions involving the use of discretion.

Each *covered person* claiming *benefits* under the *plan* shall 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 is covered under the *plan*. If the *Plan Administrator* in its sole discretion shall determine that the *covered person* has not *incurred* a *covered expense* or that the benefit is not covered under the *plan*, or if the *covered person* shall fail to furnish such proof as is requested, no *benefits* shall be payable under the *plan*.

A call from a Provider who wants to know if an individual is covered under the *plan*, or if a certain procedure is covered by the *plan*, prior to providing treatment is not a “claim,” since an actual claim for *benefits* is not being filed with the *plan*. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a *clean claim* must be filed with the *Plan* (which will be a “Post-service Claim”). At that time, a determination will be made as to what *benefits* are payable under the *Plan*.

A *covered person* has the right to request a review of an *adverse benefit determination*. If the claim is denied at the end of the appeal process, as described below, the *Plan's* final decision is known as a final *adverse benefit determination*. If the *covered person* receives notice of a final *adverse benefit determination*, or if the *Plan* does not follow the claims procedures properly, the *covered person* then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a *Plan covered person*, or to a Provider that has accepted an *Assignment of benefits* as consideration in full for services rendered.

According to Federal regulations which apply to the *Plan*, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

- **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 *covered person* or the *covered person's* ability to regain maximum function, or, in the opinion of a *physician* with knowledge of the *covered person's* medical *condition*, would subject the *covered person* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

CLAIM PROCEDURES (Continued)

If the *Plan* does not require the *covered person* to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The *covered person* 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.

- 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:
 - The *Plan Administrator* determines that the course of treatment should be reduced or terminated; or
 - The *covered person* requests extension of the course of treatment beyond that which the *Plan Administrator* has approved.

If the *Plan* does not require the *covered person* 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 *covered person* 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.

- Post-service Claims. A “post-service claim” is a claim for a benefit under the *Plan* after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed with the *third party administrator* within [180] days of the date charges for the service were *incurred*. *Benefits* are based upon the *Plan*'s provisions at the time the charges were *incurred*. **Claims filed later than that date shall be denied.**

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 the *third party administrator* in accordance with the *Plan*'s procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the *Plan*. The *third party administrator* 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 the *third party administrator* within 45 days from receipt by the *covered person* 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* shall notify the *covered person*, 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:

- Pre-service Urgent Care Claims:
 - If the *covered person* 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.
 - If the *covered person* has not provided all of the information needed to process the claim, then the *covered person* will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.
 - The *covered person* will be notified of a determination of *benefits* as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:

CLAIM PROCEDURES (Continued)

- The *Plan*'s receipt of the specified information; or
 - (i)
 - The end of the period afforded the *covered person* to provide the information.
- If there is an *adverse benefit determination*, a request for an expedited appeal may be submitted orally or in writing by the *covered person*. All necessary information, including the *Plan*'s benefit determination on review, may be transmitted between the *Plan* and the *covered person* by telephone, facsimile, or other similarly expeditious method. Alternatively, the *covered person* may request an expedited review under the external review process.
- Pre-service Non-urgent Care Claims:
 - If the *covered person* 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.
 - (i)
 - If the *covered person* has not provided all of the information needed to process the claim, then the *covered person* 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 *covered person* 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 *covered person* (if additional information was requested during the extension period).
 - Concurrent Claims:
 - Plan Notice of Reduction or Termination. If the *Plan Administrator* is notifying the *covered person* 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 *covered person* will be notified sufficiently in advance of the reduction or termination to allow the *covered person* to appeal and obtain a determination on review of that *adverse benefit determination* before the benefit is reduced or terminated. This rule does not apply if *benefits* are reduced or eliminated due to *plan amendment* or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
 - Request by Covered Person Involving Urgent Care. If the *Plan Administrator* receives a request from a *covered person* 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 72 hours after receipt of the claim, as long as the *covered person* makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the *covered person* 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.
 - Request by Covered Person Involving Non-urgent Care. If the *Plan Administrator* receives a request from the *covered person* 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).

CLAIM PROCEDURES (Continued)

- Request by Covered Person Involving Rescission. With respect to rescissions, the following timetable applies:
 - Notification to *covered person* (i) 30 days
 - Notification of *adverse benefit determination* on appeal (ii) 30 days
- Post-service Claims:
 - If the *covered person* 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.
 - If the *covered person* has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the *covered person* 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 *covered person* will be notified of the determination by a date agreed to by the *Plan Administrator* and the *covered person*.
- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
- 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 *covered person*, 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.
- 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 *covered person*, 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.
- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall 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* shall provide a *covered person* 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). The notice will contain the following information:

- Information sufficient to allow the *covered person* to identify the claim involved (including date of service, the healthcare *provider*, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the *plan* provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the *Plan*'s standard, if any, that was used in denying the claim;

CLAIM PROCEDURES (Continued)

- A description of any additional information necessary for the *covered person* to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan's* internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the *covered person's* right to bring a civil action under section 502(a) of *ERISA* following an *adverse benefit determination* on final review;
- A statement that the *covered person* 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 *covered person's* claim for *benefits*;
- 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);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the *covered person*, free of charge, upon request;
- 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 *covered person's* medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the *covered person*, free of charge, upon request;
- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and
- 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 *covered person* believes the claim has been denied wrongly, the *covered person* may appeal the denial and review pertinent documents. The claims procedures of this *Plan* provide a *covered person* with a reasonable opportunity for a full and fair review of a claim and *adverse benefit determination*. More specifically, the *Plan* provides:

- *Covered persons* at least 180 days following receipt of a notification of an initial *adverse benefit determination* within which to appeal the determination;
- *Covered persons* the opportunity to submit written comments, documents, records, and other information relating to the claim for *benefits*;
- *Covered persons* the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

CLAIM PROCEDURES (Continued)

- 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 shall be neither the individual who made the *adverse benefit determination* that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the *covered person* relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- 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 shall 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;
- 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;
- That a *covered person* will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the *covered person's* claim in possession of the *Plan Administrator* or *third party administrator*; ; (b) information regarding any voluntary appeals procedures offered by the *Plan*; (c) information regarding the *covered person's* right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *covered person's* medical circumstances; and
- That a *covered person* will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal *adverse benefit determination* is required, with new or additional evidence considered, relied upon, or generated by the *Plan* in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the *covered person* to respond to such new evidence or rationale.

Requirements for Appeal

The *covered person* must file the 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 *covered person* chooses to orally appeal, the *covered person* may telephone:

GreenTree Administrators, LLC
P.O. Box 7306 – Beaumont, TX 77726-7306
87 Interstate 10 North, Suite 225 - Beaumont, TX 77707
(800) 825-2117

To file an appeal in writing, the *covered person's* appeal must be addressed as follows and mailed or faxed as follows:

GreenTree Administrators, LLC
P.O. Box 7306 – Beaumont, TX 77726-7306
87 Interstate 10 North, Suite 225 - Beaumont, TX 77707
(800) 825-2117
Fax (409) 832-2301

CLAIM PROCEDURES (Continued)

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

- The name of the employee/*covered person*;
- The employee/*covered person*'s social security number;
- The group name or identification number;
- 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 *covered person* will lose the right to raise factual arguments and theories which support this claim if the *covered person* fails to include them in the appeal;**
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the *covered person* has which indicates that the *covered person* is entitled to *benefits* under the *Plan*.

If the *covered person* provides all of the required information, it may be that the expenses will be eligible for payment under the *Plan*.

Timing of Notification of Benefit Determination on Review

The *Plan Administrator* shall notify the *covered person* of the *Plan*'s benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- 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.
- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
- Calculating Time Periods. The period of time within which the *Plan*'s determination is required to be made shall 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 Review

The *Plan Administrator* shall provide a *covered person* 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:

- Information sufficient to allow the *covered person* to identify the claim involved (including date of service, the healthcare *provider*, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

CLAIM PROCEDURES (Continued)

- A reference to the specific portion(s) of the *plan* provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the *Plan*'s standard, if any, that was used in denying the claim, and a discussion of the decision;
- A description of any additional information necessary for the *covered person* to perfect the claim and an explanation of why such information is necessary;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- A description of the *Plan*'s review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the *covered person*'s right to bring a civil action under section 502(a) of *ERISA* following an *adverse benefit determination* on final review;
- A statement that the *covered person* 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 *covered person*'s claim for *benefits*;
- 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);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the *covered person*, free of charge, upon request;
- 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 *covered person*'s medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the *covered person*, free of charge, upon request; and
- 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* shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of *adverse benefit determination* on Review" as appropriate.

Decision on Review

If, for any reason, the *covered person* does not receive a written response to the appeal within the appropriate time period set forth above, the *covered person* 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 and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought.**

External Review Process

A. Scope

1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a *participant* or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.
2. The Federal external review process applies only to:
 - (a) An *adverse benefit determination* (including a final internal *adverse benefit determination*) by a *plan* or issuer that involves medical judgment (including, but not limited to, those based on the *plan's* or issuer's requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is *experimental* or investigational), as determined by the external reviewer; and
 - (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The *Plan* will allow a claimant to file a request for an external review with the *Plan* if the request is filed within four (4) months after the date of receipt of a notice of an *adverse benefit determination* or final internal *adverse benefit determination*. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the *Plan* will complete a preliminary review of the request to determine whether:
 - (a) The claimant is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided;
 - (b) The *adverse benefit determination* or the final *adverse benefit determination* does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the *Plan* (e.g., worker classification or similar determination);
 - (c) The claimant has exhausted the *Plan's* internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
 - (d) The claimant has provided all the information and forms required to process an external review.Within one (1) business day after completion of the preliminary review, the *Plan* will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the *Plan* will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
3. Referral to Independent Review Organization. The *Plan* will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the *Plan* will take action against bias and to

CLAIM PROCEDURES (Continued)

ensure independence. Accordingly, the *Plan* will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the *Plan* and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of *benefits*.

4. Reversal of *Plan*'s decision. Upon receipt of a notice of a final external review decision reversing the *adverse benefit determination* or final internal *adverse benefit determination*, the *Plan* will provide coverage or payment for the claim without delay, regardless of whether the *plan* intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. Expedited external review

1. Request for expedited external review. The *Plan* will allow a claimant to make a request for an expedited external review with the *Plan* at the time the claimant receives:
 - (a) An *adverse benefit determination* if the *adverse benefit determination* involves a medical *condition* of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
 - (b) A final internal *adverse benefit determination*, if the claimant has a medical *condition* where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received *emergency services*, but has not been discharged from a facility.
2. Preliminary review. Immediately upon receipt of the request for expedited external review, the *Plan* will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The *Plan* will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.
3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the *Plan* will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The *Plan* will provide or transmit all necessary documents and information considered in making the *adverse benefit determination* or final internal *adverse benefit determination* to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the *Plan*'s internal claims and appeals process.
4. Notice of final external review decision. The *Plan*'s (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical *condition* or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the *Plan*.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision applies to all *benefits* provided under any section of this *Plan*.

Excess Insurance

If at the time of *injury, illness, disease or disability* there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the *benefits* under this *Plan* shall apply only as an excess over such other sources of Coverage.

The *Plan's* benefits will be excess to, whenever possible:

- a) Any primary payer besides the *Plan*;
 - b) Any first party insurance through medical payment coverage, personal *injury* protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c) Any policy of insurance from any insurance company or guarantor of a third party;
 - d) Worker's compensation or other liability insurance company; or
 - e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.
-

Vehicle Limitation

When medical payments are available under any vehicle insurance, the *Plan* shall pay *excess benefits* only, without reimbursement for vehicle plan and/or policy *deductibles*. This *Plan* shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

“*Allowable expenses*” shall mean any *medically necessary* item of expense within the *reasonable and appropriate* fee as determined by the *Plan Administrator*, at least a portion of which is covered under this *Plan*. When some *other plan* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be the benefit.

It is important that you fulfill any requirements of *other plan(s)* for payment of benefits. If you fail to properly file for, and receive payment by, any *other plan(s)*, this *Plan* will estimate the benefits that would otherwise have been payable and apply that amount, as though actually paid, to the “Application to Benefit Determination” calculation explained in this section.

In the case of HMO (Health Maintenance Organization) plans, 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*.

EFFECT ON BENEFITS

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no *other plan* involved. If this *Plan* is a secondary or subsequent plan, this *Plan* will pay the balance due up to 100% of the total cumulative *allowable expenses* for that *calendar year*; however, in no event will this *Plan* pay more than it would have in the absence of any *other plan(s)*. When there is a conflict in the order of benefit determination, this *Plan* will never pay more than 50% of *allowable expenses*.

COORDINATION OF BENEFITS (Continued)

When medical payments are available under automobile insurance, this *Plan* will always be considered the secondary carrier regardless of the individual's election under personal *injury* protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the *other plan* will be ignored for the purposes of determining the *benefits* under this *Plan*. This is the case when:

- The *other plan* would, according to its rules, determine its benefits after the *benefits* of this *Plan* have been determined; and
- The rules in the section entitled "Order of Benefit Determination" would require this *Plan* to determine its *benefits* before the *other plan*.

Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

- A plan without a coordinating provision will always be the primary plan;
- The benefits of a plan which covers the person on whose expenses claim is based, other than as a *dependent*, will be determined before the benefits of a plan which covers such person as a *dependent*;
- If the person for whom claim is made is a *dependent child* covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - When the parents are separated (whether or not ever legally married) or divorced, and the parent with the custody of the *child* has not remarried, the benefits of a plan which covers the *child* as a *dependent* of the parent with custody will be determined before the benefits of a plan which covers the *child* as a *dependent* of the parent without custody; or
 - When the parents are separated (whether or not ever legally married) or divorced and, the parent with custody of the *child* has remarried, the benefits of a plan which covers the *child* as a *dependent* of the parent with custody shall be determined before the benefits of a plan which covers that *child* as a *dependent* of the stepparent, and the benefits of a plan which covers that *child* as a *dependent* of the stepparent will be determined before the benefits of a plan which covers that *child* as a *dependent* of the parent without custody.

Notwithstanding the above provisions, if there is a court decree which would otherwise establish financial responsibility for the *child's* healthcare expenses, the benefits of the plan which covers the *child* as a *dependent* of the parent with such financial responsibility shall be determined before the benefits of any *other plan* which covers the *child* as a *dependent child*; and

- When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

COORDINATION OF BENEFITS (Continued)

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any *other plan*, this *Plan* may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the *Plan* deems to be necessary for such purposes. Any person claiming *benefits* under this *Plan* shall furnish to the *Plan* such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be *benefits* paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this *Plan* with respect to Allowable Expenses in a total amount, at any time, in excess of the *maximum amount* of payment necessary at that time to satisfy the intent of this Article, the *Plan* shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this *Plan* shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the *Plan* determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the *covered person* or his or her *dependents*. Please see the Recovery of Payments provision above for more details.

Coordination of Benefits with Medicare

If you are eligible for *Medicare*, and you are eligible for coverage under this *Plan*, you may choose to continue coverage under this *Plan*, and any *Medicare* benefits to which you are entitled may be used to supplement the *benefits* of this *Plan*.

In all cases, coordination of benefits with *Medicare* will conform to Federal law. When coordination of benefits with *Medicare* is permitted, each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage whether or not the individual has enrolled for full coverage. *Your benefits* under this *Plan* will be secondary to *Medicare* to the extent allowed by Federal law.

Coordination of Benefits with Medicaid

In all cases, benefits available through a state or Federal *Medicaid* program will be secondary or subsequent to the *benefits* of this *Plan*.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

1. The *Plan*, in its sole discretion, may elect to conditionally advance payment of *benefits* in those situations where an *injury, illness, disease or disability* is caused in whole or in part by, or results from the acts or omissions of *covered persons*, and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “*covered person(s)*”) or a third party, where any party besides the *Plan* may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively “Coverage”).
2. *Covered Person(s)*, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the *Plan’s* conditional payment of medical *benefits* is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the *Plan’s* conditional payment of *benefits* or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the *Plan* or the *Plan’s* assignee. By accepting *benefits* the *covered person(s)* agrees the *Plan* shall have an equitable lien on any funds received by the *covered person(s)* and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The *covered person(s)* agrees to include the *Plan’s* name as a co-payee on any and all settlement drafts.
3. In the event a *covered person(s)* settles, recovers, or is reimbursed by any Coverage, the *covered person(s)* agrees to reimburse the *Plan* for all *benefits* paid or that will be paid by the *Plan* on behalf of the *covered person(s)*. If the *covered person(s)* fails to reimburse the *Plan* out of any judgment or settlement received, the *covered person(s)* will be responsible for any and all expenses (fees and costs) associated with the *Plan’s* attempt to recover such money.
4. If there is more than one party responsible for charges paid by the *Plan*, or may be responsible for charges paid by the *Plan*, the *Plan* will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the *covered person(s)* is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the *plan* may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving *benefits* under this *Plan*, the *covered person(s)* agrees to assign to the *Plan* the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the *covered person(s)* is entitled, regardless of how classified or characterized, at the *Plan’s* discretion.
2. If a *covered person(s)* receives or becomes entitled to receive *benefits*, an automatic equitable lien attaches in favor of the *Plan* to any claim, which any *covered person(s)* may have against any Coverage and/or party causing the *illness or injury* to the extent of such conditional payment by the *Plan* plus reasonable costs of collection.
3. The *Plan* may, at its discretion, in its own name or in the name of the *covered person(s)* commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such *benefits* or conditional payments advanced by the *Plan*.
4. If the *covered person(s)* fails to file a claim or pursue damages against:
 - a) the responsible party, its insurer, or any other source on behalf of that party;
 - b) any first party insurance through medical payment coverage, personal *injury* protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c) any policy of insurance from any insurance company or guarantor of a third party;
 - d) worker’s compensation or other liability insurance company; or
 - e) any other source, including but not limited to crime victim restitution funds, any medical, disability or

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT (Continued)

other benefit payments, and school insurance coverage;

The *covered person(s)* authorizes the *Plan* to pursue, sue, compromise and/or settle any such claims in the *covered person(s)*' and/or the *Plan*'s name and agrees to fully cooperate with the *Plan* in the prosecution of any such claims. The *covered person(s)* assigns all rights to the *Plan* or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The *Plan* shall be entitled to recover 100% of the *benefits* paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the *covered person(s)* is fully compensated by his/her recovery from all sources. The *Plan* shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the *Plan*'s equitable lien and right to reimbursement. The obligation to reimburse the *Plan* in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the *covered person(s)*' recovery is less than the *benefits* paid, then the *Plan* is entitled to be paid all of the recovery achieved.
 2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the *Plan*'s recovery without the prior, expressed written consent of the *Plan*.
 3. The *Plan*'s right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the *covered person(s)*, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating *Plan*'s recovery will not be applicable to the *Plan* and will not reduce the *Plan*'s reimbursement rights.
 4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the *Plan* and signed by the *covered person(s)*.
 5. This provision shall not limit any other remedies of the *Plan* provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable *illness, injury, disease or disability*.
-

Excess Insurance

If at the time of *injury, illness, disease or disability* there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the *benefits* under this *Plan* shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the *Plan*'s Coordination of Benefits section. The *Plan*'s *benefits* shall be excess to:

- a) the responsible party, its insurer, or any other source on behalf of that party;
 - b) any first party insurance through medical payment coverage, personal *injury* protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c) any policy of insurance from any insurance company or guarantor of a third party;
 - d) worker's compensation or other liability insurance company; or
 - e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.
-

Separation of Funds

Benefits paid by the *Plan*, funds recovered by the *covered person(s)*, and funds held in trust over which the *Plan* has an equitable lien exist separately from the property and estate of the *covered person(s)*, such that the death of the *covered person(s)*, or filing of bankruptcy by the *covered person(s)*, will not affect the *Plan*'s equitable lien, the funds over which the *Plan* has a lien, or the *Plan*'s right to subrogation and reimbursement.

Wrongful Death

In the event that the *covered person(s)* dies as a result of his or her injuries and a wrongful death or survivor claim is

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT (Continued)

asserted against a third party or any Coverage, the *Plan's* subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these *Plan* rights and terms by which benefits are paid on behalf of the *covered person(s)* and all others that benefit from such payment.

Obligations

1. It is the *covered person(s)*' obligation at all times, both prior to and after payment of medical benefits by the *Plan*:
 - a) to cooperate with the *Plan*, or any representatives of the *Plan*, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the *Plan's* rights;
 - b) to provide the *Plan* with pertinent information regarding the *illness*, disease, disability, or *injury*, including *accident* reports, settlement information and any other requested additional information;
 - c) to take such action and execute such documents as the *Plan* may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d) to do nothing to prejudice the *Plan's* rights of subrogation and reimbursement;
 - e) to promptly reimburse the *Plan* when a recovery through settlement, judgment, award or other payment is received; and
 - f) to not settle or release, without the prior consent of the *Plan*, any claim to the extent that the *covered person* may have against any responsible party or Coverage.
 2. If the *covered person(s)* and/or his or her attorney fails to reimburse the *Plan* for all benefits paid or to be paid, as a result of said *injury* or condition, out of any proceeds, judgment or settlement received, the *covered person(s)* will be responsible for any and all expenses (whether fees or costs) associated with the *Plan's* attempt to recover such money from the *covered person(s)*.
 3. The *Plan's* rights to reimbursement and/or subrogation are in no way dependent upon the *covered person(s)*' cooperation or adherence to these terms.
-

Offset

Failure by the *covered person(s)* and/or his or her attorney to comply with any of these requirements may, at the *Plan's* discretion, result in a forfeiture of payment by the *Plan* of medical benefits and any funds or payments due under this *Plan* on behalf of the *covered person(s)* may be withheld until the *covered person(s)* satisfies his or her obligation.

Minor Status

1. In the event the *covered person(s)* is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the *Plan* to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
 2. If the minor's parents or court-appointed guardian fail to take such action, the *Plan* shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.
-

Language Interpretation

The *Plan Administrator* retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the *Plan's* subrogation and reimbursement rights. The *Plan Administrator* may amend the *Plan* at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and *Plan*. The section shall be fully severable. The *Plan* shall be construed and enforced as if such invalid or illegal sections had never been inserted in the *Plan*.

DEFINITIONS

In this section you will find the definitions for the italicized words found throughout this *plan document and summary plan description*. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this *plan document and summary plan description* for that information.**

“Accident” means a sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

“Actively at work” or “Active employment” means performance by the *employee* of all the regular duties of his occupation at an established business location of the *participating employer*, or at another location to which he may be required to travel to perform the duties of his employment. An *employee* will be deemed *actively at work* if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered *actively at work* if employment has been terminated.

“ADA” means the American Dental Association.

“Adverse Benefit Determination” means any of the following:

1. A denial in benefits;
 2. A reduction in benefits;
 3. A rescission of coverage;
 4. A termination of benefits; or
 5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant’s eligibility to participate in the *Plan*.
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“Affordable Care Act” means the comprehensive health care reform law enacted in March 2010, as amended. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

“AHA” means the American Hospital Association.

“AMA” means the American Medical Association.

“Ambulance” means a specially designed or equipped vehicle that is licensed for transferring the sick or injured. It must have customary patient care, safety, and life-saving equipment, and must utilize trained personnel.

“Ambulance - Non-emergency transports” means *medically necessary* transport for non-emergent or non-urgent care between the member’s home and *physician’s* office, *outpatient* facility or *hospital*; or, a transport between facilities for non-life threatening *conditions*. *Medical necessity* is determined with *pre-certification*.

“Ambulatory surgical center” means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of *physicians*, with permanent facilities that are equipped and operated primarily for the purpose of performing *surgical procedures*, with continuous *physician* services and registered professional nursing service whenever a patient is in the *institution*, and which does not provide service or other accommodations for patients to stay overnight.

“Amendment” means a formal document that changes the provisions of the *Plan document*, duly signed by the authorized person or persons as designated by the *Plan administrator*.

DEFINITIONS (Continued)

“Anesthesia” means general *anesthesia* that produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local *anesthesia* produces similar effects to a limited region of the body without causing loss of consciousness. *anesthesia* is administered by a *Physician, Dentist, or Certified Registered Nurse Anesthetist (CRNA)*.

“Assignment of Benefits” means an arrangement whereby the *covered person* assigns their right to seek and receive payment of eligible *Plan benefits*, in strict accordance with the terms of this *Plan Document*, to a *Provider*. If a *provider* accepts said arrangement, *Providers’* rights to receive *Plan benefits* are equal to those of a *covered person*, and are limited by the terms of this *Plan Document*. A *Provider* that accepts this arrangement indicates acceptance of an “*Assignment of Benefits*” as consideration in full for services, supplies, and/or treatment rendered. If a *Provider* requires assignment, then this provision will supersede the *Provider’s* assignment. Under no conditions will assignment prevent the *Plan* from exercising their fiduciary responsibilities to the *Plan* and/or *covered person*.

“Benefits” means amounts paid to or on behalf of a *covered person* under the *Plan* for eligible charges, as set forth in this *Plan*.

“Benefit Percentage” means that portion of *eligible expenses* to be paid by the *Plan* in accordance with the coverage provisions as stated in the *Plan*. It is the basis used to determine any Out-of-Pocket expenses in excess of the *Deductible(s)* and/or *Co-pays* that are to be paid by the *covered person*.

“Birthing Center” means any freestanding health facility that is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

“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” means a period of time commencing on January 1 and ending on December 31 of the same year.

“Cardiac care unit” means a separate, clearly designated service area which is maintained within a *hospital* and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical *condition*;
 - It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the *hospital*;
 - It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
 - It contains at least two beds for the accommodation of critically ill patients; and
 - It provides at least one professional registered *nurse*, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.
-

“Certificate of coverage” means a written certification provided by any source that offers medical care coverage, including the *Plan*, for the purpose of confirming the duration and type of an individual’s previous coverage.

“Child(ren)” means, in addition to the *employee’s* own blood descendant of the first degree or lawfully adopted *child*, a *child* placed with a covered *employee* in anticipation of adoption, a covered *employee’s child* who is an alternate recipient under a *Qualified Medical Child Support Order* as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an “eligible foster child,” which is defined as an individual placed with the *employee* by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other *child* for whom the *employee* has obtained *legal guardianship*.

DEFINITIONS (Continued)

“CHIP” refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

“CHIPRA” refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic care” means all services related to a chiropractic *visit*.

“Clean Claim” means a claim that can be processed in accordance with the terms of this document without obtaining additional information from the service *provider* or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A *clean claim* does not include claims under investigation for fraud and abuse or claims under review for *Medical necessity* and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being *covered expenses* in accordance with the terms of this document.

Filing a Clean Claim. A *provider* submits a *clean claim* by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the *provider* has knowledge. The *Plan Administrator* may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute *covered expenses* as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a *clean claim* if the *covered person* has failed to submit required forms or additional information to the *Plan* as well.

“COBRA” (Consolidated Omnibus Budget Reconciliation Act of 1985), as amended. A federal law that gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

“Company” means Sabine-Neches.

“Condition” means a *Medical condition*. Refer to the definition of “*Medical condition*”.

“Congenital Anomaly/Defect/Malformation” means a defective development or formation of a part of the body that is determined by the *Physician* to have been present at the time of birth.

“Consultation” means a service provided by another *Physician* or *Dentist* at the request of the *Physician* or *Dentist* in charge of *your* case. The consulting *Physician* or *Dentist* often has specialized skills that are helpful in diagnosing or treating the *illness* or *injury*.

“Contribution” means the amount payable by the Employer or the amount payable by the Employer/Employee jointly for participation in the *benefits* of the *Plan*.

“Convalescent Hospital” - Refer to the definition of “*Skilled Nursing Facility*”.

“Co-pay” or “Co-payment” means a specific dollar amount (as noted in the Schedule of *Medical Benefits*) payable by the *covered person* for certain *visits*, services, and/or purchases at the time received.

“Cosmetic” or “cosmetic surgery” means any *surgery*, service, *drug* or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an *injury*.

“Covered expense” means a *medically necessary* service or supply which is within the *reasonable and appropriate* fee as determined by the *Plan Administrator*, and which is listed for coverage in this *Plan*.

DEFINITIONS (Continued)

“Covered person” means a covered *employee* and his covered *dependents*, which are eligible for *benefits* under the *Plan*.

“Creditable coverage” shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, *Medicare*, *Medicaid* (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the *uniformed services* and their *dependents*, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children’s Health Insurance Program). To the extent that further clarification is needed with respect to the sources of *creditable coverage* listed in the prior sentence, please see the complete definition of *creditable coverage* that is set forth in 45 C.F.R. § 146.113(a).

Creditable coverage does **not** include: (1) *accident* only coverage including accidental death and dismemberment; (2) disability income insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) coverage issued as a supplement to liability insurance; (5) workers’ compensation or similar insurance; (6) automobile medical payment insurance; (7) credit-only insurance (for example, mortgage insurance); (8) coverage for on-site medical clinics; (9) *Limited Scope Benefits* - refer to the definition of “Limited Scope Benefits”; (10) Long-term care benefits; (11) *Supplemental Benefits* - refer to the definition of “*Supplemental Benefits*”; and (12) non-coordinated benefits such as: (a) coverage for only a specific disease or *illness* (for example, cancer only policies) or Hospital indemnity or other fixed dollar indemnity insurance (for example, \$100/day) which are provided under a separate policy, certificate, or contract of insurance; (b) there is no coordination between the provision of benefits and an *Exclusion* of benefits under any group health plan maintained by the same plan administrator; and (c) the benefits are paid with respect to an event without regard to whether benefits are provided under any group health plan maintained by the same plan administrator.

“Custodial care” means care or confinement provided primarily for the maintenance of the *covered person*, essentially designed to assist the *covered person*, whether or not *totally disabled*, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical *condition*, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

“Deductible” means an amount of money that must be paid by a *covered person* for *covered expenses* before the *Plan* will reimburse additional *covered expenses* incurred during that *plan year*.

“Dentist” means 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.

“Dependent” means one or more of the following person(s):

- An *employee’s* lawfully wed spouse possessing a marriage license who is not divorced from the *employee*; or
- An *employee’s* common law or “informal marriage” spouse as recognized by the state with required documentation; or
- An *employee’s* *child* who is less than 26 years of age (up to the 26th birthday); or
- An *employee’s* never married *child* who was continuously covered prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his own living and is still primarily *dependent* upon the *employee* for support. Such *child* must have been mentally or physically incapable of earning his own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the *Plan* must be furnished and approved by the *Plan* within 31 days after the date the *child* attains the limiting age of the bullets above. The *Plan* may require, at reasonable intervals, subsequent proof satisfactory to the *Plan* during the next two years after such date. After such two-year period, the *Plan* may require such proof, but not more often than once each year.

DEFINITIONS (Continued)

“*Dependent*” does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The *Plan* reserves the right to require documentation, satisfactory to the *Plan Administrator*, which establishes a *dependent* relationship.

“***Diagnostic service***” means a test or procedure performed for specified symptoms to detect or to monitor an *illness* or *injury*. It must be ordered by a *physician* or other professional *provider*.

“***Drug***” means insulin and prescription legend *drugs*. A prescription legend *drug* is a Federal legend *drug* (any medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription”) or a state restricted *drug* (any medicinal substance which may be dispensed only by prescription, according to state law) and which, in either case, is legally obtained from a licensed *drug* dispenser only upon a prescription of a currently licensed *physician*.

“***Durable medical equipment***” means equipment that is ordered by a doctor for use in the home which:

- Can withstand repeated use,
- Is primarily and customarily used to serve a medical purpose, and
- Generally is not useful to a person in the absence of an *illness* or *injury*.

“***Effective date***” means, *January 1, 2001*, the original *effective date* of the *Plan*.

“***Eligible Expenses***” Refer to the definition of “*Covered Expenses*”.

“***Emergency***” means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute *condition*. An *emergency* includes poisoning, shock, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, unconsciousness, partial or complete severing of a limb, and convulsions. See definition “*Emergency Medical Condition*”.

Other emergencies and acute *conditions* may be considered on receipt of proof, satisfactory to the *Plan*, that an *emergency* did exist.

“***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 a *condition* described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to 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; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“***Emergency Services***” means, with respect to an *Emergency Medical Condition*:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a *Hospital*, including ancillary services routinely available to the emergency department to evaluate such *Emergency Medical Condition*; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the *Hospital*, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

“***Employee***” means a person who is a regular full-time *employee* of the *participating employer*, regularly scheduled to work for the *participating employer* in an employer-*employee* relationship. Such person must be scheduled to

DEFINITIONS (Continued)

work at least 30 hours per week in order to be considered “full-time”. An *employee* is not a seasonal, temporary or leased *employee*, or an independent contractor.

“Enrollment Date” means the first day of coverage under this *Plan*, or if earlier, the beginning of any applicable *waiting period* (as defined in this *Plan*).

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended. It is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

“Essential Health Benefits” means, under section 1302(b) of the Patient Protection and *Affordable Care Act*, those health 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 abuse* disorder services, including behavioral health treatment; *prescription drugs*; rehabilitative and habilitative services and devices; laboratory services; preventive and *Wellness Services* and chronic disease management; and pediatric services, including oral and vision care.

“Exclusion” means any provision of the *Plan* whereby coverage for a specific service or *condition* is entirely eliminated regardless of *medical necessity*.

“Experimental” shall mean any *drug*, device, procedure, service or treatment that is the subject of ongoing Phase I or II clinical trials to determine maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared to other treatments. A *drug*, device, procedure, service or treatment will not be considered *experimental* if it is the subject of ongoing Phase III clinical trials and the *covered person* meets the Phase III protocol requirements to participate. A *drug*, device, procedure, service or treatment will be considered to be the subject of ongoing Phase I or II clinical trials to determine maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared to other treatments unless all of the following criteria are met:

- The *drug*, device, procedure, service or treatment must have approval from the appropriate government regulatory bodies.

A *drug*, device, procedure, service or treatment must have Food and Drug Administration (“FDA”) approval for those specific indications and methods of use for which such *drug*, device, procedure, service or treatment is sought to be provided.

Any *drugs*, devices, procedures, services or treatments, which at the time sought to be provided are not approved by the Health Care Financing Administration for reimbursement under *Medicare*, are considered *experimental* procedures.

Drugs are considered *experimental* if they are not commercially available for purchase, and are not approved by FDA for general use. The phrase “approved by FDA for general use” refers to permission for commercial distribution. Any other approvals that are granted as an interim step in the FDA regulatory process, subject to the Phase III exception above, are considered *experimental* procedures.

Drugs and tests approved by the FDA for a specific disease, *injury*, *illness* or *condition*, but which are sought to be provided for another disease, *injury*, *illness* or *condition*, are considered *experimental* procedures.

Drugs that are without at least one ingredient that constitutes a controlled substance as defined by the FDA are considered *experimental* procedures.

- The scientific evidence must permit conclusions concerning effect of the *drug*, device, procedure, service or treatment on health outcomes.

DEFINITIONS (Continued)

The evidence must consist of well-designed and well-conducted investigations published in peer-review journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

The evidence must demonstrate that the *drug*, device, procedure, service or treatment can measure or alter the sought after changes related to the disease, *injury*, *illness* or *condition*. In addition, there must be evidence or a convincing argument based on established medical facts that such measurement or alteration affects that health outcome.

Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale.

- The *drug*, device, procedure, service or treatment must improve or contribute to the improvement of the net health outcome.

The *drug*, device, procedure, service or treatment's beneficial effects on health outcomes must outweigh any harmful effects on health outcomes.

- The *drug*, device, procedure, service or treatment must be as beneficial as any established alternatives.

The technology must improve the net health outcome as much or more than established alternatives.

- The improvement must be attainable outside the investigational settings.

When used under the usual conditions of medical practice, the *drug*, device, procedure, service or treatment must reasonably be expected to satisfy criteria (a) and (b).

Notwithstanding any other provision contained herein, these criteria will be the sole means to construe and determine whether any *drug*, device, procedure, service or treatment constitutes "Experimental Procedures".

The *Plan Administrator* retains maximum legal authority and discretion to determine what is *experimental*.

"Family unit" means the *employee*, his spouse and his *dependent child(ren)*.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"FMLA leave" means a *leave of absence*, which the *company* is required to extend to an *employee* under the provisions of the *FMLA*.

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

"GINA" shall mean 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.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended. It provides rights and protections for *participants* and beneficiaries in group health plans.

"Home health care" means certain services and supplies required for treatment of an *illness* or *injury* in the *covered person's* home as part of a formal treatment plan certified by the attending *physician* and approved by the *Plan Administrator*.

DEFINITIONS (Continued)

“Home health care agency” means an agency or organization which provides a program of *home health care* and which:

- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
- Meets all of the following requirements:
 - It is an agency which holds itself forth to the public as having the primary purpose of providing a *home health care* delivery system bringing supportive services to the home;
 - It has a full-time administrator;
 - It maintains written records of services provided to the patient;
 - Its staff includes at least one registered *nurse* (RN) or it has nursing care by a registered *nurse* (RN) available; and
 - Its *employees* are bonded and it provides malpractice insurance.

“Hospice Care Agency” means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements:

- Has obtained any required certificate of need;
- Provides 24 hour a day, seven days a week service, supervised by a qualified practitioner;
- Has a full-time coordinator;
- Keeps written records of services provided to each patient;
- Has a *nurse* coordinator who is a registered *nurse* (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and
- Has a licensed social service coordinator.

A *Hospice Care Agency* will establish policies for the provision of hospice care, assess the patient’s medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

“Hospital” means an *institution* that meets all of the following requirements:

- It provides medical and *surgical* facilities for the treatment and care of injured or sick persons on an *inpatient* basis;
- It is under the supervision of a staff of *physicians*;
- It provides 24-hour-a-day nursing service by registered *nurses*;
- It is duly licensed as a *hospital*, except that this requirement will not apply in the case of a state tax-supported *institution*;

DEFINITIONS (Continued)

- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type *institution*, or an *institution* which is supported in whole or in part by a federal government fund; and
- It is accredited by the Joint Commission on Accreditation of *hospitals* sponsored by the *AMA* and the *AHA*.

The requirement of *surgical* facilities shall not apply to a *hospital* specializing in the care and treatment of mentally ill patients, provided such *institution* is accredited as such an *institution* by the Joint Commission on Accreditation of *hospitals* sponsored by the *AMA* and the *AHA*.

“Illness” means a *condition*, sickness or disease not resulting from trauma.

“Imaging” means creating images of the human body or parts of it, to diagnose or examine disease. The *imaging* procedure groups include angiography, barium studies, CT angiography (CTA), CT scans, MR angiography (MRA), MRI, Nuclear Medicine, Positron Emission Tomography (PET), Ultrasound and X-rays.

“Immediate family” means spouse, *child*, brother, sister or parent of the *covered person*, whether by birth, adoption or marriage.

“Incurred” means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, 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.

“Infertility Treatment” means artificial insemination, fertility *drugs*, G.I.F.T. (Gamete Intrafallopian Transfer), impotency *drugs* such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

“Injury” means physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an *accident*.

“Inpatient” refers to the classification of a *covered person* when that person, upon the recommendation of a *physician*, is admitted to or assigned to a bed in any department other than its *outpatient* department in any *institution* (including but not limited to) a *hospital*, hospice or convalescent facility for treatment, and charges are made for room, board, and/or ancillary services as the result of such admission and treatment. **Any admission or confinement to a facility for more than twenty-three (23) hours will be considered by this Plan to be an inpatient admission, regardless of the facility’s designation of the patient as any other classification.** Charges for any such confinement will be subject to and processed under the *Plan’s* provisions and requirements relating to *inpatient* admissions, including *pre-certification* and *utilization review*.

“Institution” means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community mental health center, residential treatment facility, *substance abuse treatment center*, alternative *birthing center*, *home health care center*, or any other such facility that the *Plan* approves.

“Intensive care unit” means a separate, clearly designated service area which is maintained within a *hospital* and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical *condition*;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the *hospital*;

DEFINITIONS (Continued)

- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered *nurse*, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

“Leave of absence” means a *leave of absence* of an *employee* that has been approved by his *participating employer*, as provided for in the *participating employer’s* rules, policies, procedures and practices.

“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.

“Limitation” means any provision other than an *exclusion* that restricts coverage and/or *benefits* under the *Plan*, regardless of *medical necessity*.

“Limited Scope Benefits” are dental, vision or other types of benefits that are not deemed an integral part of the *Plan* and the *Participant* has the right to elect to receive such coverage and pay an additional *contribution* for such coverage; or a benefit provided under a separate plan or policy. They are limited in scope to a narrow range or type of benefits that are generally excluded from *Hospital/medical/surgical* benefit packages.

“Mastectomy” means the *surgical* removal of one or both breasts, partially or completely.

“Maternity” means that physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

“Maximum Amount” and/or “Maximum Allowable Charge” means the benefit payable for a specific coverage item or benefit under the *Plan*. *Maximum allowable charge(s)* will be the lesser of:

- The *Reasonable and appropriate* fee amount,
- The allowable charge specified under the terms of the *Plan*,
- The negotiated rate established in a contractual arrangement with a Provider, or
- The actual billed charges for the covered services

The *Plan* will reimburse the actual charge billed if it is less than the *Reasonable and appropriate* fee. The *Plan* has the discretionary authority to decide if a charge is *Reasonable and Appropriate* and for a *medically necessary* and reasonable service.

The *Maximum allowable charge* will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed or *illnesses* or *injuries* determined to be caused by the medical *provider*.

“Medicaid” means Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

“Medical Condition” means any *condition*, whether physical or mental, including, but not limited to, any *condition* resulting from *illness*, *injury* (whether or not the *injury* is *accidental*), *Pregnancy*, or *congenital malformation*. However, Genetic Information is not a *condition*.

“Medical Record Review” is the process by which the *Plan*, based upon a *medical record review* and audit, 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 the *Maximum allowable charge* according to the *medical record review* and audit results.

DEFINITIONS (Continued)

“Medically necessary” “Medical Care Necessity”, “Medical Necessity” and similar language refers to health care services ordered by a *Physician* exercising prudent clinical judgment provided to a *covered person* for the purposes of evaluation, diagnosis or treatment of that *covered person’s illness* or *injury*. Such services, to be considered *medically necessary*, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the *covered person’s illness* or *injury*. The *medically necessary* setting and level of service is that setting and level of service which, considering the *covered person’s* medical symptoms and *conditions*, cannot be provided in a less intensive medical setting. Such services, to be considered *medically necessary* must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the *covered person’s illness* or *Injury* without adversely affecting the *covered person’s Medical Condition*.

- A) It must not be maintenance therapy or maintenance treatment.
- B) Its purpose must be to restore health.
- C) It must not be primarily custodial in nature.
- D) It must not be a listed item or treatment not allowed for reimbursement by CMS (*Medicare*).
- E) The *Plan* reserves the right to incorporate CMS (*Medicare*) guidelines in effect on the date of treatment as additional criteria for determination of *Medical necessity* and/or an Allowable Expense.

For *hospital* stays, this means that acute care as an *inpatient* is necessary due to the kind of services the *covered person* is receiving or the severity of the *covered person’s condition* and that safe and adequate care cannot be received as an *outpatient* or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a *physician* does not mean that it is “*medically necessary*.” In addition, the fact that certain services are excluded from coverage under this *Plan* because they are not “*medically necessary*” does not mean that any other services are deemed to be “*medically necessary*.”

To be *medically necessary*, all of these criteria must be met. Merely because a *physician* or *dentist* recommends, approves, or orders certain care does not mean that it is *medically necessary*. The determination of whether a service, supply, or treatment is or is not *medically necessary* may include findings of the American Medical Association and the *Plan Administrator’s* own medical advisors. The *Plan Administrator* has the discretionary authority to decide whether care or treatment is *medically necessary*.

“Medicare” means the program of healthcare for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

“Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA)” means in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
2. The treatment *limitations* applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment *limitations* applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage), and that there are no separate treatment *limitations* that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

“Mental or nervous disorder” means any disease or *condition*, regardless of whether the cause is organic, that is classified as a *Mental or nervous disorder* in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

DEFINITIONS (Continued)

“Midwife” means a person licensed or certified to practice as a Midwife who has completed the academic and clinical requirements set forth by specific states that provide this license or certification in the area of managing the care of mothers and babies throughout the *Maternity* cycle.

“Network” means the *Preferred Provider Organization (PPO) network of providers* offering discounted fees for services and supplies to *covered persons*. The *network* will be identified on the *covered person’s Plan* (ID) identification card.

“Non-Network/Non-PPO Network Provider” means a legally licensed health care *provider* which provides services and supplies within the scope of its authority, but which has not entered into a contract with the Preferred Provider Organization.

“Nurse” means a licensed Registered *Nurse* (R.N.), licensed practical *Nurse* (L.P.N.), or licensed vocational *Nurse* (L.V.N.). The individual has received specialized nursing training and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

“Nurse Practitioner” means a Registered *Nurse* who: (a) completes a program of study affiliated with a College or university; (b) passes a *Nurse practitioner* certification examination given by the American Nurses Association; (c) acts within the scope of that certification in treating the *injury* or *illness*; and (d) who is licensed by the law of the state in which services are rendered.

“Occupational Therapist” means a licensed practitioner who primarily treats the loss of motor function of skeletal muscles by educating the patient to use other muscles and/or artificial devices to enable them to perform acceptably in any particular occupation or the ordinary tasks of daily living.

“Office visit” means any *visit* to a *Physician’s* office or clinic that results in a billing that includes one of the *Office visit* codes in accordance with the Current Procedural Terminology (CPT) coding system developed by the American Medical Association.

“Orthopedic Appliance or Device” means an external type of corrective appliance or device, either customized or available “over the counter” designed to support a weakened body part

“Out-of-pocket expense” means the cost to the *covered person* for coinsurance.

“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, an *Outpatient psychiatric facility*, an *Outpatient Substance abuse* (alcoholism and drug addiction) facility, or at a *hospital* or other medical facility if not considered an *inpatient* (as defined by this *Plan*).

“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. This includes *Substance abuse* (alcoholism and drug addiction) facilities.

“Partial-hospitalization” means a type of program used to treat mental *illness* and *substance abuse* provided on or in affiliation with a *hospital*. The program provides clinical diagnostic and treatment services on a level of intensity equal to an *illness* program, but on less than a 24-hour basis, **but does need up to eight hours of clinical services**. *Partial-hospitalization* is used as a time-limited response to stabilize acute symptoms. As such, it can be used both as a transitional level of care (i.e., step-down from *illness*) as well as a stand-alone level of care to stabilize a deteriorating *condition* and avert hospitalization.

“Participant” means a person employed in an eligible class (as defined by the *Plan sponsor*), and properly enrolled in this *Plan*. Such term will also include a person who is qualified to continue coverage and properly enrolled in this *Plan* as a qualified beneficiary as defined by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

DEFINITIONS (Continued)

“Participating employer(s)” means MWV.

“Percentage Payable” means the *Percentage payable* by the *Plan* for a Covered Expense in accordance with the provisions stated in the *Plan*. A *covered person* may be required to pay the remaining percentage to the *provider* of service.

“Pharmacist” means a person who is licensed under the laws of the state or jurisdiction where the services are rendered, and trained to prepare, compound, and dispense *drugs* and medicines, and who acts within the scope of his license.

“Physical Therapist” means a licensed practitioner who treats patients by means of electro-, hydro-, aero-, and mechanotherapy, massage and therapeutic exercises. Where there is no licenser law, the *Physical therapist* must be certified by the appropriate professional body.

“Physician” means a **licensed** Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental *Surgery* (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.).

“Placement for Adoption” means the date the *participant* assumes and retains a legal obligation for total or majority support of a child in anticipation of the adoption of that child. For purposes of the *Plan*, these provisions override state laws requiring the *legal guardianship* of a child placed for adoption to remain with the appropriate agency until the adoption is finalized.

“Plan” means the Sabine-Neches Health & Welfare Fund *Plan* of medical expense *benefits* as described in this document.

“Plan Administrator/Plan Sponsor” means the Joint Board of Trustees of the Sabine-Neches Health & Welfare Fund. The *Plan administrator* is responsible for the functions and management of the *Plan*. The *Plan Administrator* may employ person or firms to process claims and perform other *Plan*-connected services; however, the *Plan Administrator* retains discretionary authority and control of the *Plan* and its assets, and has the ultimate responsibility for the payment of claims and other expenses incidental to the *Plan*.

“Plan Document” means this *Plan Document* and *Summary Plan Description*.

“Plan Sponsor” see *Plan administrator/Plan sponsor*.

“Plan year” means the period commencing January 1st through December 31st of each year.

“Pre-admission testing” means those *diagnostic services* done before a scheduled *hospital inpatient* admission, provided that:

- The tests are required by the *hospital* and approved by the *physician*;
 - The tests are performed on an *outpatient* basis prior to *hospital* admission;
 - The tests are not duplicated on admission to the *hospital*; and
 - The tests are performed at the *hospital* where the confinement is scheduled, or at a qualified facility approved by the *hospital* to perform the tests.
-

“Pre-Authorization” means verification by prior assessment by the *Plan Administrator* that the proposed member’s medical care or healthcare services are a covered benefit and *medically necessary* and appropriate, if required. A pre-authorized claim cannot be denied, but must be paid according to the member’s available *benefits*.

“Pre-Certification” means prior assessment decision of *medical necessity* and appropriateness by the *Plan Administrator* for the proposed member’s medical care of healthcare services. *Pre-certification* is not a guarantee of *benefits*, but assures member/requesting *provider* that claim will not be denied for lack of *medical necessity*.

DEFINITIONS (Continued)

“Pre-Determination” means prior assessment for payment by the *Plan Administrator* that the proposed member’s medical care or healthcare services are a covered benefit under the *Plan*, at the request of the *provider*, facility, or member.

“Pre existing Condition” is any Sickness, *illness*, Disease or *injury* (other than Pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a *provider* or practitioner duly licensed to provide such care under applicable State law and operating within the scope of practice authorized by such State law, during the six months immediately prior to the date an *employee’s* Service *waiting period* commences (the “*Enrollment date*”).

Coverage will be available for such *condition* on the day immediately following the expiration of twelve months or, in the case of a Late Enrollee, eighteen months after the *Enrollment date*. A *covered person* has the right to demonstrate any *creditable coverage*, and the applicable period shall be reduced by any *creditable coverage* unless that *creditable coverage* occurred before a *Significant Break in Coverage*.

The Pre-existing *Condition limitation* does not apply to any *covered person* or *dependent* that has not yet reached age 19.

“Preferred Provider Organization” or **“PPO”** means the *network* of *providers* offering discounted fees for services and supplies to *covered persons*. The *network* will be identified on the *covered person’s* *Plan Identification Card*. In no instance can the *PPO* prevent the *Plan* or the *Plan Administrator* from exercising its fiduciary responsibilities to the *Plan* and *Plan Participants*.

“Pregnancy” means carrying a *child*, resulting childbirth, miscarriage and non-elective abortion. The *Plan* considers *pregnancy* as an *illness* for the purpose of determining *benefits*.

“Preventive Care” means certain *preventive care* services.

This *Plan* intends to comply with the Patient Protection and *Affordable Care Act’s* (PPACA) requirement to offer *in-network* coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the *Plan* will provide *in-network* coverage for:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention; and
- Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here:

<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>.

“Privacy Standards” means the standards for privacy of individually identifiable health information, as enacted pursuant to *HIPAA*.

“Private Duty Nursing Services” means services that require the training, judgment, and technical skills of an actively practicing Registered *Nurse* (R.N.) or licensed practical *Nurse* (L.P.N.). The attending *Physician* must prescribe such services, and they must be *Medically necessary* (as defined in this *Plan*) for the continuous medical treatment of *your condition*.

“Provider” means a *physician*, a licensed speech or *occupational therapist*, licensed professional *physical therapist*, physiotherapist, psychiatrist, audiologist, speech language pathologist, licensed professional counselor, certified *nurse practitioner*, certified psychiatric/mental health clinical *nurse*, certified *midwife*, or other practitioner or facility defined or listed herein, or approved by the *Plan Administrator*.

DEFINITIONS (Continued)

“Psychiatric hospital” means an *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

- It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a *physician*;
- It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
- It is licensed as a *psychiatric hospital*;
- It requires that every patient be under the care of a *physician*; and
- It provides 24-hour-a-day nursing service.

It does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care* or educational care.

“Qualified Medical Child Support Order (QMCSO)” means a judgment, decree, or order issued by a court that provides for child support related to health benefits or enforces a state medical child support order under the Social Security Act (for *Medicaid* purposes). It requires that the *child(ren)* named in the order have the right to receive benefits from their parent through any group medical plan under which the parent is enrolled, whether or not the parent has Family coverage. The QMCSO must contain: (1) the name and last known mailing address of the *Participant*; (2) the name and mailing address of each child covered by the order; (3) a reasonable description of the type of coverage to be provided by the group health plan to each child or the manner in which coverage will be determined; (4) the period of time to which the order applies; and (5) the identification of each plan to which the order applies.

“Reasonable and appropriate” means services and supplies which are *medically necessary* for the care and treatment of *illness* or *injury*, but only to the extent that such fees are reasonable. Determination that a fee is reasonable will be made by the *Plan Administrator*. The following parameters may be taken into account when considering whether or not a fee is reasonable:

- **Procedures.** Charges for procedures will be compared with the fees of other *providers* rendering the same type of service in the same geographical region*. If the billed procedure charge exceeds the 90th percentile for the same procedure performed by other *providers* in the same geographic area then such procedure charge is reduced to the 90th percentile, the highest percentile reflected in the *Physician Fee Reference* (“PFR”).
- **Pharmaceuticals.** Pharmacy charge reimbursement is determined by applying the Average Wholesale Price (AWP) as defined by REDBOOK at the following rates:
 - 200% of AWP if AWP is \$100 or less;
 - 110% of AWP if AWP is over \$100.
- **Bundling/Unbundling/Upcoding/Error.** The claim may be reviewed to determine whether the claim contains any of the following errors: bundling, unbundling, upcoding and or errors. If it is determined that the claim contains any of the aforementioned errors, the submitted claim may be reduced based on discovered errors.
- **Medical and Surgical Supplies.** Supplies will be reviewed for reasonableness based on list price (invoices, receipts, cost list etc.) plus 10%. Charges in excess of this price may be reduced to a reasonable amount.

DEFINITIONS (Continued)

- Lab, Imaging, Therapy and Physician. Charges will be compared with the fees for the same type of service in the same geographical region*. If the claim for such services exceed the 80th percentile for the same service performed by other *providers* in the same geographic region, such claim may be reduced to the 80th percentile.
- Implants will be reviewed for reasonableness based on 110% of invoice.
- Hospital Room Rates will be reviewed for reasonableness based on 110% of the *hospital's* most recent cost ratio as reported to CMS ("CMS-Cost"). If there are special circumstances such as special levels of care (e.g. ICU or CCU) or if the *hospital* does not charge for supplies, reimbursement may be increased to a maximum of 150% of the CMS-cost for the indicated level.
- OR, RR, Anesthesia charge will be reviewed for reasonableness based on:
 - Patient in regular (not critical care) room: 200% of *hospital's* CMS-cost.
 - Patient in ICU or CCU: 110% of *hospital's* CMS-cost.
- Emergency Room charges will be reviewed for reasonableness based on 200% of *hospital's* CMS-cost.
- Reimbursement will be at the actual charge billed if it is less than the reasonable charge as calculated above.

*"Geographical region" means the *Physician Fee Reference* ("PFR") 5 digit zip code prefix adjustment factors, (multipliers).

The aforementioned parameters does not increase nor alleviate the *Plan Administrator's* fiduciary duty to pay more or less than the amount it deems to be reasonable in its sole discretion and in accordance with *ERISA*. The *Plan* will pay the *PPO network provider hospitals'* per diem or DRG rates; not to exceed the *reasonable and appropriate* fee as determined by the *Plan Administrator* for such services, as determined by the *Plan Administrator* regardless of any contractual arrangement to the contrary.

"Reconstructive Surgery" means Surgery to restore or improve bodily function to the level experienced before the event that necessitated the Surgery or, in the case of a *congenital defect*, to a level considered normal. Such Surgery may have a coincidental *cosmetic* effect.

"Rehabilitation hospital" means an *institution* which mainly provides therapeutic and restorative services to sick or injured people. It is recognized as such if:

- It carries out its stated purpose under all relevant federal, state and local laws;
- It is accredited for its stated purpose by either the Joint Commission on Accreditation of *Hospitals* or the Commission on Accreditation for Rehabilitation Facilities; or
- It is approved for its stated purpose by *Medicare*.

"Rehabilitation Services" means the process of providing, in a coordinated manner, those comprehensive services deemed appropriate to the needs of a person with a disability, in a program designed to achieve objectives of improved health, welfare and the realization of one's maximum physical, social, psychological and vocational potential for useful and productive activity.

"Room and board" means an *institution's* charge for:

- Room and linen service;
- Dietary service, including meals, special diets and nourishment;

DEFINITIONS (Continued)

- General nursing service; and
- Other conditions of occupancy which are *medically necessary*.

“Security standards” mean the final rule implementing *HIPAA’s security standards* for the Protection of *Electronic PHI*, as amended.

“Semi-private” refers to a class of accommodations in a *hospital* or *Skilled Nursing Facility* in which at least two patient beds are available per room.

“Significant break in coverage” means a period of 63 consecutive days during each of which an individual does not have any *creditable coverage*.

“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 graduate Registered Nurse (R.N.) or by a licensed practical Nurse (L.P.N.) and physical restoration service 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 the full-time supervision of a *Physician* or graduate Registered Nurse (R.N.); (3) it provides 24 hour per day nursing service by licensed *Nurses*, under the direction of a full-time graduate Registered Nurse (R.N.); (4) it maintains a complete original record on each patient; (5) it has an effective organization review plan; (6) it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, residential, custodial or educational care, or care of mental disorders; and (7) it is approved and licensed by *Medicare*. This term shall also apply to an *institution* referring to itself as a convalescent nursing home, convalescent nursing facility, extended care facility, or any such other similar nomenclature.

“Speech Therapist” means an individual who is skilled in the use of special techniques for the correction of speech and vocal disorders and who is a member of the American Speech and Hearing Association and has a Certificate of Clinical Competence.

“Substance abuse” means any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
 2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
 3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct);
or
 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
- B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

“Substance abuse treatment center” means an *institution* which provides a program for the treatment of *substance abuse* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be:

- Affiliated with a *hospital* under a contractual agreement with an established system for patient referral;

DEFINITIONS (Continued)

- Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
- Licensed, certified or approved as an alcohol or *substance abuse* treatment program or center by a state agency having legal authority to do so.

“Summary plan description” means an important document that the *Plan Administrator* must provide to *participants* and beneficiaries that explains what coverage the *Plan* offers, how the *Plan* operates and the rights and responsibilities of *participants* and beneficiaries, which is this *Plan Document* and *Summary Plan Description*.

“Supplemental Benefits” means benefits that are provided under a separate policy, certificate, or contract of insurance, such as: (a) *Medicare* supplemental health insurance, also known as Medigap or Med-Supp insurance; (b) coverage supplemental to that provided under the Civilian Health & Medical Program of the Uniformed Services (also known as CHAMPUS supplemental programs); and (c) similar supplemental coverage provided to coverage under a group health plan.

“Surgery” or “Surgical Procedure” means any of the following:

- The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
 - The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
 - The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
 - The induction of artificial pneumothorax and the injection of sclerosing solutions;
 - Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
 - Obstetrical delivery and dilation and curettage; or
 - Biopsy.
-

“Third party administrator” also known as a claims administrator means the person or firm employed and works at the discretion of the *Plan Administrator* to provide consulting services in connection with the operation of the *Plan* and any other administrative services and functions, including the processing of claims for *benefits* under the *Plan*, membership functions, *PPO network* arrangements, arrangement of *utilization review* and stop loss, as established by agreement between the parties. Under this agreement, the duties of the *third party administrator* “TPA” are strictly nondiscretionary and ministerial in nature. GreenTree Administrators, LLC is identified as the *third party administrator*.

The *third party administrator* is not the insurer, the policyholder, *Plan Sponsor*, *Plan Administrator*, *Employer*, or a fiduciary of the *Plan*. The TPA does not insure or underwrite the liability of the *Plan* or the *Plan Administrator*.

“Total disability” or “totally disabled” means the inability of an *employee* to perform the duties of any occupation for which he may be qualified by reason of training, education or experience. The *Plan Administrator* may, in its sole discretion, require satisfactory evidence of *total disability*.

“Trade Act” means the *Trade Act* of 2002, as amended.

“Uniformed services” means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps

DEFINITIONS (Continued)

of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or *emergency*.

“USERRA” means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended.

“Utilization Review” is a system for prospective or concurrent review of the *medical necessity and appropriateness* of health care services being provided or proposed to be provided to an individual within the state. *Utilization review* shall *not include* elective requests for clarification of coverage.

“Visit” means a personal meeting between the patient and the *Physician, Dentist,* or other health care *provider* regarding the health *condition* or care of the patient, and which is properly classified or coded in accordance with the Current Procedural Terminology (CPT) manual of the American Medical Association.

“Waiting period” means an interval of time during which the *employee* is in the continuous, *active employment* of his *participating employer* before he becomes eligible to participate in the *Plan*.

“Well-Baby and Well-Child Care” means medical treatment, services or supplies rendered to a healthy Child or Newborn solely for the purpose of routine and preventive health maintenance and not for the treatment of an *illness* or *injury*.

“Wellness” or “Wellness Services” means medical treatment, services, or supplies rendered to a *covered person* for the purpose of pre-symptomatic detection of *Medical Condition(s)*, and routine and preventive health maintenance, but not for the treatment of an *illness* or *injury*.

“You” or “Your” means any *covered person*, unless the language specifically refers only to the *employee* or only to the *dependents*.

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the *Plan*?

The *Plan* is administered by the *Plan Administrator* in accordance with *ERISA*. The *Plan Administrator* has retained the services of the *Third Party Administrator* to provide certain claims processing and other ministerial services. 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.

The *Plan Administrator* will administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* will 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*. 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, shall 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.

Duties of *Plan administrator*

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a *covered person's* rights;
- 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;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a *third party administrator* to pay claims;
- To perform all necessary reporting as required by *ERISA*;
- To establish and communicate procedures to determine whether *MCSOs and NMSNs* are *QMCSOs*;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan's* administration.

May changes be made to the *Plan*?

The Sabine-Neches Health & Welfare Fund reserves the right to merge or consolidate the *Plan*, and to make any *amendment* or restatement to the *Plan* from time-to-time, including those which are retroactive in effect. Such *amendments* may be applicable to any *covered person*.

Any *amendment* or restatement shall be deemed to be duly executed by the Sabine-Neches Health & Welfare Fund when signed by the *plan administrator*.

The Sabine-Neches Health & Welfare Fund is intended to be permanent, but the *Plan* may be terminated at any time by a majority trustee vote.

If the *Plan* is terminated, the rights of *covered persons* are limited to expenses *incurred* before termination. All *amendments* to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

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). This includes amending the benefits under the *Plan*.

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 shall 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 shall 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 shall 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 shall be taken by the sole proprietor, in his or her own discretion.

If the *Plan* is terminated, the rights of the *Participants* are limited to expenses *incurred* before termination. All *amendments* to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

Who pays the cost of the *Plan*?

A fund shall be established pursuant to the *Plan* to which *contributions* shall be made. *Contributions* to the fund shall be deposited in a bank or similar financial institution. The fund shall be held in trust to be utilized for the purpose of providing *benefits* for *covered persons* and defraying reasonable expenses of administering the *Plan*.

The *Plan Sponsor* shall from time to time evaluate the costs of the *Plan* and determine the *benefits* to be provided by the *Plan* and the amount to be contributed by the Employer and/or each *covered person*. Notwithstanding any other provision of the *Plan*, the *Plan Sponsor's* obligation to pay claims otherwise allowable under the terms of the *Plan* shall be limited to its obligations as set forth herein. Payment of the said claims in accordance with these procedures shall discharge completely the *Plan Sponsor's* obligation with respect to such payments.

In the event the *Plan* is terminated, then as of the effective date of termination, all previous *contributions* shall continue to be issued for the purpose of paying *benefits* under the provision of this *Plan* with respect to claims arising before such termination, or shall be used for the purpose of providing similar *benefits* to *covered persons* until all *contributions* are exhausted.

Will the *Plan* release my information to anyone?

For the purpose of determining the applicability of and implementing the terms of these *benefits*, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *covered person* for *benefits* under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the *privacy standards*. Any *covered person* claiming *benefits* under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

What if the *Plan* makes an error?

Clerical errors made on the records of the *Plan* and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this *Plan* regardless of whether any *contributions* with respect to *covered persons* have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such *contributions* will be made.

Will the *Plan* conform to applicable laws?

This *Plan* shall be deemed automatically to 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 that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this *plan document and summary plan description*. It is intended that the *Plan* will conform to the requirements of *ERISA*, as it applies to employee welfare plans, as well as any other applicable law.

What constitutes a fraudulent claim?

The following actions by you, or *your* knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this *Plan* for the entire *family unit* of which you are a member:

- 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*;
- Attempting to file a claim for a *covered person* for services that were not rendered or *drugs* or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan*; or
- Providing any false or misleading information to the *Plan*.

Rescission is permitted only for an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage. Rescission is not permitted in the case of inadvertent misstatements of fact. The rescission restriction applies regardless of any contestability period that may otherwise apply.

How will this document be interpreted?

The use of masculine pronouns in this *plan document and summary plan description* shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this *plan document and summary plan description* are used for convenience of reference only. *Covered persons* are advised not to rely on any provision because of the heading.

The use of the words, “**you**” and “**your**” throughout this *plan document and summary plan description* applies to eligible or covered *employees* and, where appropriate in context, their covered *dependents*.

How may a *Plan* provision be waived?

No term, condition or provision of this *Plan* shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Is this *plan document and summary plan description* a contract between the employer and covered persons?

This *plan document and summary plan description* and any *amendments* constitute the terms and provisions of coverage under this *Plan*. The *plan document and summary plan description* shall not be deemed to constitute a contract of any type between the *employer* and any *covered person* or to be consideration for, or an inducement or condition of, the employment of any *employee*. Nothing in this *plan document and summary plan description* shall be deemed to give any *employee* the right to be retained in the service of the *employer* or to interfere with the right of the *employer* to discharge any *employee* at any time.

What if there is coverage through workers’ compensation?

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 you received or are 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 you receive from workers’ compensation. The *Plan* will exercise its right to recover against you. The *Plan* reserves its right to exercise its rights under this section and the section entitled “*Recovery of Payment*” even though:

- The workers’ compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that the *injury* or *illness* was sustained in the course of or resulted from your employment;
- The amount of workers’ compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers’ compensation carrier; or
- The healthcare expense is specifically excluded from the workers’ compensation settlement or compromise.

You are required to notify the *Plan Administrator* immediately when you file a claim for coverage under workers’ compensation if a claim for the same *injury* or *illness* is or has been filed with this *Plan*. Failure to do so, or to reimburse the *Plan* for any expenses it has paid for which coverage is available through workers’ compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the *Plan* for *recovery* and disciplinary action.

Will the *Plan* cover an alternate course of treatment?

The *Plan Administrator* may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this *Plan*, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply.

MISCELLANEOUS INFORMATION (Continued)

If a *covered person*, in cooperation with his *provider*, elect a course of treatment that is deemed by the *Plan Administrator*, in its sole discretion, to be more extensive or costly than is necessary to satisfactorily treat the *illness* or *injury*, this *Plan* will allow coverage within the *reasonable and appropriate* fee as determined by the *Plan Administrator*, of the less costly or extensive course of treatment.

If the *Plan* elects to provide alternative *benefits* for a *covered person* in one instance, it shall not be obligated to provide the same or similar *benefits* for other *covered persons* under this *Plan* in any other instance, nor shall it be construed as a waiver of the right to administer this *Plan* thereafter in strict accordance with its express terms.

HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the *Plan* of your health information:

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with *HIPAA's* Standards for Privacy of Individually Identifiable Health Information (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:

- Obtaining premium bids from health plans for providing health insurance coverage under this *Plan*; or
- 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.

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:

- 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*);
- 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*;
- 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*;
- 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;
- Make available *PHI* in accordance with section 164.524 of the *privacy standards* (45 CFR 164.524);
- 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);
- 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);
- 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*);

HIPAA PRIVACY PRACTICES (Continued)

- 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
- 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:
 - The following *employees*, or classes of *employees*, or other persons under control of the *Plan Sponsor*, shall be given access to the *PHI* to be disclosed:
The Joint Board of Trustees for the Sabine-Neches Health & Welfare *Plan*
 - The access to and use of *PHI* by the individuals described above shall be restricted to the *plan administration* functions that the *Plan Sponsor* performs for the *Plan*.
 - In the event any of the individuals described in above do not comply with the provisions of the *Plan* documents relating to use and disclosure of *PHI*, the *Plan Administrator* shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall 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 healthcare 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.

The *Plan* shall disclose *PHI* to the *Plan Sponsor* only upon receipt of a certification by the *Plan Sponsor* that:

- The *Plan* documents have been amended to incorporate the above provisions; and
- The *Plan Sponsor* agrees to comply with such provisions.

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*.

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 the *third party administrator*, 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 shall be made in accordance with the *privacy standards*.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of *PHI*, the *Plan* shall comply with the *privacy standards*.

HIPAA 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:

- Implement Administrative, Physical, and Technical Safeguards that reasonably protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the *Plan*;
- 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 Security Measures;
- 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 Security Measures to protect the Electronic PHI; and
- Report to the *Plan* any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the *security standards*.

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, all documents governing the *Plan*, including insurance contracts (if any), collective bargaining agreements, 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 (if any) and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *plan document and summary plan description*. The *Plan Administrator* may make a reasonable charge for the copies.

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 healthcare 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 *plan document and summary plan description* and the documents governing the *Plan* on the rules governing your *COBRA* continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another plan. You should be provided a *certificate of coverage*, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of *creditable coverage*, you may be subject to a *pre-existing condition exclusion or limitation* for 12 months (18 months for *late enrollees*) after your *enrollment date* in your coverage.

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 *participating employer*, your union, 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

STATEMENT OF ERISA RIGHTS (Continued)

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, a *medical child support order* or a *national medical support notice*, 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 the *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.