Plan Document

Effective January 1, 2017

DAN DRAKE ENTERPRISES, LLC

EDHP™ MVP NEXT GENERATION PLAN

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Table of Contents

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EDHP™ MVP NEXT GENERATION PLAN
PLAN DOCUMENT

MVP

Article 1. Establishment of the Plan

This plan document, made by Dan Drake Enterprises, LLC as of January 1, 2017, hereby sets forth the provisions of the Dan Drake Enterprises, LLC Health and Welfare Benefit Plan.

1.1 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.

1.2 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 the Plan Document, 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: 12/21/16

Signature: 

Name: Dan S Drake

Title: Partner

Article 2. Introduction and Purpose

2.1 Establishment of the Plan. Dan Drake Enterprises, LLC (the "Employer") hereby establishes a Health and Welfare Benefit Plan. The Plan has been established to offer a self-insured minimum essential coverage health and welfare benefit plan to in part or in whole cover the cost of certain medical expenses incurred by Eligible Employees or their eligible dependents.

2.2 Purpose of the Plan. The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a Non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document 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 expenses for medical and prescription drug benefits. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Participant.

2.3 General Plan Information

Employer:	Dan Drake Enterprises, LLC
The Name of this Plan is:	Health and Welfare Benefit Plan
The Type of Plan is:	A self-funded employee health and welfare benefit plan established pursuant to the Employee Retirement Income Security Act of 1974 (ERISA) which provides medical and prescription drug benefits to all Eligible Employees (and their Eligible Dependents) of the Plan Sponsor
The Plan Number is:	78869A
The Calendar year:	Begins January 1 and ends December 31 of each year
The Plan Administrator is:	Dan Drake Enterprises, LLC
The Plan's Funding Medium is:	Contributions provided by the Plan Sponsor and participating employees which are held in trust for use in paying all costs associated with providing benefits under this Plan
The Plan Sponsor:	Dan Drake Enterprises, LLC P.O Box 612 Bakersfield, CA 93302
Telephone number:	661-324-6514
Contact:	Alicia Feliscian

Legal Process may be served upon the Plan Sponsor.

The Plan Sponsor's Identification Number is: 77-0506180

The Plan's Contract and Claim Administrator is:

Employer Driven Insurance Services (EDIS)
P.O. Box 7809
Visalia, CA 93290

Telephone number: (888) 886-7973

Waiting Period: Employees are eligible for coverage the first day after they complete the established Waiting Period. Based on the Waiting Period for this plan, the effective date will be first of the month following 60 days

Method for Determining Full-Time Status of Variable Hour/Seasonal Employees (if applicable): Choose an item.

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process

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

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

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.

Plan Administrator Responsibility, Authority and Discretion

The Plan Administrator will discharge its duties under the Plan solely in the interest of the Employees and its beneficiaries and for the exclusive purpose of providing benefits to Employees and its beneficiaries and defraying the reasonable expenses of administering the Plan.

The Plan Administrator will administer the Plan and will have the authority to exercise the powers and discretion conferred on it by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out its responsibilities under the Plan, the Plan Administrator will have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Plan Administrator may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in its opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Plan Administrator may delegate to any agent, attorney, accountant or other person or third party selected by it, any power or duty vested in, imposed upon, or granted to it by the Plan. However, the Plan Administrator will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Plan Administrator violated its own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Article 3. Definitions

3.1 Definitions. Whenever used in the Plan, the following terms shall have the respective meanings set forth below unless otherwise expressly provide and when the defined meaning is intended, the term is capitalized.

ADA shall mean the American Dental Association.

Adverse Benefit Determination shall mean any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; or
- 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.

AHA shall mean the American Hospital Association.

Allowable Expenses shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section herein, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

AMA shall mean the American Medical Association.

Assignment of Benefits shall mean an arrangement whereby the Plan Participant 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 Plan Participant, 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.

Birthing Center shall mean a special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility which:

- Is in compliance with licensing and other legal requirements in the jurisdiction where it is located;
- Is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;
- Has organized facilities for birth services on its premises;
- Provides birth services which are performed by or under the direction of a Physician specializing in obstetrics and gynecology;
- Has 24-hour-a-day registered nursing services; and
- Maintains daily clinical records.

Calendar Year shall mean the period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Charges Incurred shall mean fees for covered services rendered by a licensed provider of healthcare services. Charges are considered to be incurred on the date the service or supply is rendered or obtained.

Chemical Dependency shall mean an addictive relationship between the Covered Person and any drug or alcohol substance. Chemical Dependency does not include addiction to or dependency on tobacco or food in any form.

Child shall mean, 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.

CHIPRA shall mean 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.

Claimant shall mean any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

Clean Claim shall mean one 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 Plan Participant has failed to submit required forms or additional information to the Plan as well.

Co-Insurance shall mean the percentage of a covered medical charge that is to be paid by the Covered Person.

Co-Payment shall mean the dollar amount to be paid by the Covered Person at the time a covered medical expense is incurred.

Contract Administrator shall mean a company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

The Contract Administrator is EDIS.

Convalescent Hospital - see "Skilled Nursing Facility"

Covered Benefits Medically necessary services, supplies or treatments, and payments for the same, that are recommended or provided by a physician, professional provider or covered facility for the treatment of an illness or injury and:

1. that are sought and provided in accordance with the terms of this document;
2. the charged amount for such services, supplies, or treatments does not exceed the Maximum Payable Amount;
3. that are not specifically excluded from coverage herein.

Covered Benefits applies to service type as well as charged amount.

Covered Person shall mean a covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See Eligibility and Effective Dates and COBRA Continuation Coverage sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider shall mean an individual who is:

- Licensed to perform certain health care services which are covered under the Plan and who is acting within the scope of his license; or
- In the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

And who is an:

Certified or Registered Nurse Midwife
- Dentist (DDS or DMD)
- Licensed Clinical Psychologist (PhD or EdD)
- Licensed Clinical Social Worker (LCSW)
- Licensed Vocational Nurse (LVN)
- Optometrist (OD)
- Physician - see definition of "Physician"
- Podiatrist or Chiropodist (DPM, DSP, or DSC)
- Psychiatrist (MD)
- Registered Nurse (RN)

A "Covered Provider" will also include the following when appropriately licensed and providing services which are covered by the Plan:

- Facilities as are defined herein including, but not limited to Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.;
- Licensed Outpatient mental health facilities;
- Freestanding public health facilities;
- Hemodialysis and Outpatient clinics under the direction of a Physician (MD);
- Portable X-ray companies;
- Independent laboratories and lab technicians;

- Speech and hearing centers

NOTE: A Covered Provider does not include a Covered Person treating himself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of General Exclusions. A Covered Provider also does not include an Assistant Surgeon OR Surgical Assistant who is not a Medical Doctor (M.D.).

Custodial Care shall mean any treatment or service primarily for the convenience of the patient. This includes, but is not limited to, assistance in dressing, bathing, meals, housekeeping and transportation.

Deductible shall mean the portion of covered medical expense that is deducted from eligible expense prior to computing the dollar amount of benefits payable, if any.

Dependent shall mean one or more of the following person(s):

- An Employee's lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, "marriage or married" means a legal union between one man and one woman as husband and wife;
- An Employee's common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the Employee has his or her principal residence;
- An Employee's Domestic Partner who has the same principal place of abode for more than one-half of the calendar year, and who relies on the employee for more than one half of his or her support for the calendar year in which the Domestic Partner is enrolled for coverage under the Plan;
- An Employee's Child who is less than 26 years of age; or
- An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her 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 under the bullets above. The time limit for written proof of incapacity and dependency is 60 days following the original eligibility date for a new or re-enrolling Employee. 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.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship

Dialysis Services, diagnostic testing, laboratory tests, equipment and supplies are a covered expense under the Plan only to the extent they are Medically Necessary, and only insofar as their cost does not exceed the maximum benefits specified on the Schedule of Benefits, specific to Dialysis Services.

Dialysis Services, diagnostic testing, lab expenses, equipment and supplies are those services and items used in the dialysis treatment for acute renal failure or chronic irreversible remain insufficiency (treatment of Anemia and other diagnoses related to renal failure). This also includes injectable and intravenous medication, including, but not limited to Heparin, Epogen, Procrit and other medications administered directly before, during or after a dialysis procedure. Dialysis procedures are for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis regardless of whether they are provided on an inpatient or outpatient basis

Secondary Coverage: Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which are payable by such secondary coverage when said coverage is primary, except to the extent that such costs are payable in any event by the Plan.

Applicable to Active Employees and Their Spouses Ages 65 and Over

A Covered Person that is an active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Parts A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

Eligible Person shall mean an Eligible Employee or an Eligible Dependent.

Eligible Expense(s) shall mean the expense which is: (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Plan.

Emergency - see "Medical Emergency"

Emergency Medical Condition shall mean 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 shall mean, with respect to an Emergency Medical Condition:

- 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

- 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 - see Eligibility and Effective Dates section

Employer(s) shall mean the Employer or Employers participating in the Plan as stated in the General Plan Information section. The Employer is also referred to as the Plan Sponsor.

ERISA shall mean the Employee Retirement Income Security Act of 1974, as amended.

FMLA shall mean the Family and Medical Leave Act of 1993, as amended.

Fiduciary shall mean a Fiduciary of the Plan has binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan trustees, if any.

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 shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency shall mean an agency or organization which:

- Is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- Has policies established by a professional group associated with the agency or organization which includes at least one registered nurse (RN) to govern the services provided;
- Provides for full-time supervision of such services by a Physician or by a registered nurse;
- Maintains a complete medical record on each patient;
- Has a full-time administrator.

In rural areas where there are no agencies which meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice or Hospice Agency shall mean an entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital shall mean an institution which:

- Complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- Is primarily engaged in providing medical treatment to sick and injured persons as registered bed patients;
- Is operated under the supervision of a staff of one (1) or more Physicians;
- Continuously provides 24-hour-a-day nursing service;

- Maintains facilities for diagnosis of injury or disease; and
- Maintains permanent facilities for major surgical operations on its premises.

A "Hospital" will also include a specialized public or private facility, or portions thereof, specifically designed to provide modalities of treatment for alcoholism, such as "conditioned reflex" therapy for detoxification, which is appropriately licensed by the state and accredited under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals.

NOTE: A "Hospital" will not include an institution, or part thereof, which is other than incidentally a nursing home, a convalescent hospital, a place for rest, the aged, drug addicts or facilities such as alcohol recovery homes, residential treatment centers or halfway houses.

Inpatient shall mean a person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) which is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

Intensive Care Unit (ICU) shall mean Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and which is separated from the rest of the Hospital's facilities.

Look-Back Measurement Method shall mean one of two methods approved by the Internal Revenue Service for determining full-time status of variable hour/seasonal employees for the purpose of Plan coverage. Under this method, an employer may determine the status of an employee as a full-time employee during what is referred to as the “stability period,” based upon the hours of service of the employee in the preceding period, which is referred to as the “measurement period.”

Maximum Amount and/or Maximum Allowable Charge shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

- The Usual and Customary 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 Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

Maximum Payable Amount, Maximum Amount, or Maximum Allowable Charge shall mean the benefit payable for a specific coverage item or benefit under the Plan. The maximum allowable amount shall be calculated by the Plan Administrator taking into account and after having analyzed:

- The Maximum Allowable Amount in all cases shall be the lesser of:
- The Reasonable and Allowed amount, or
- The amount calculated based on the Plan’s Reference-Based Price provisions; or
- The charge otherwise specified under the terms of the Plan; or
- Plan negotiated rates with provider(s); or
- An amount taking into consideration the findings or assessments of any, some, or all of the following:
    - The National Medical Associations, Societies, and organizations; and

- The Food and Drug Administration; as well as
- Using objective and normative data such as, but not limited to,
  - Medicare Rates,
  - Cost information,
  - Medicare Provider Reimbursement Manual et al, Manufacturer's wholesale pricing (MWP) and/or average wholesale price (AWP) for supplies, devices and/or prescriptions; or

The Plan will reimburse the actual charge(s) if they are less than the Reasonable and Allowed amount(s). The Plan has the discretionary authority to decide if a charge is Reasonable and Allowed, as well as Medically Necessary.

In no event will the Maximum Payable Amount exceed benefits for the Maximum Benefit Amount. Certain services in the Schedule of Benefits are subject to specific limitations, and certain general limitations apply to benefits payable for all services. The Plan will take these limitations into account in calculating its Maximum Allowable Amount. The Maximum Payable will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Emergency shall mean an Accidental Injury or the sudden onset of a medical condition, either of which is of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health or, with respect to a pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

Medically Necessary, Medical Care Necessity, Medical Necessity and similar language shall mean health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Sickness 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 Plan Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant'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 Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition.

- It must not be maintenance therapy or maintenance treatment;
- Its purpose must be to restore health;
- It must not be primarily custodial in nature;
- It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
- 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.

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.

Medical Record Review shall mean 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.

Medicare shall mean Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, and as amended from time to time.

Medical Review Organization shall mean a professional medical review organization authorized by the Plan or Company to determine:

- Medical necessity of the Covered Person's Hospitalization, except in the case of admission to the Hospital or Birthing Center for the delivery of a newborn child;
- If surgery in or out of a Hospital is Medically Necessary;
- The length of stay during a Hospital Confinement, except in the case of admission to the Hospital or Birthing Center for the delivery of a newborn child;
- The medical necessity of certain specified ambulatory care procedures;
- If a second or third surgical opinion is necessary; or
- The need for an independent audit of Hospital charges.

Mental or Nervous Disorder shall mean 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.

Monthly Measurement Method shall mean one of two methods approved by the Internal Revenue Service for determining full-time status of variable hour/seasonal employees for the purpose of Plan coverage. Under this method, the employer determines if an employee is a full-time employee on a month-by-month basis by looking at whether the employee has at least 30 hours per week or 130 hours per month of service.

Outpatient shall mean services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Physician shall mean a Doctor of Medicine, (MD), or Doctor of Osteopathy, (DO), who is licensed to practice medicine or osteopathy where the care is provided.

NOTE: The term "Physician" will not include the Covered Person himself, his relatives (see General Exclusions) or interns, residents, fellows or others enrolled in a graduate medical education program.

Plan shall mean the benefits described by the Plan Document or incorporated by reference and including any prior statement of the Plan. The name of the Plan is shown in the General Plan Information section.

Plan Administrator shall have the meaning set forth in the General Plan Information section.

Plan Document shall mean a formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

Plan Sponsor shall mean the entity sponsoring this Plan. See General Plan Information section for further information.

Pregnancy shall mean pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See "Pregnancy" in the list of Eligible Medical Expenses for further information.

Preventive Care shall mean 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).

Prior to Effective Date or After Termination Date shall mean dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

Qualified Individual shall mean, for the purpose of Approved Clinical Trial, an individual who is a participant or beneficiary in a health plan or coverage and who meets the following conditions:

1. The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-Threatening disease or condition.
2. Either –
    a. the referring health care professional is a participating health care provider and has concluded that that individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
    b. the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions in paragraph (1).

Reasonable and/or Reasonableness shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Reasonable and Allowed for Reference Based Pricing (R&A) shall mean Covered Expenses, necessary for the care and treatment of illness or injury not preventable yet not caused by the treating Provider, deemed to be eligible for payment by the Plan in the Plan Administrator's discretion, after taking into consideration findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration; as well as the fee(s) which Providers of similar training and experience in the same "area" most frequently charge the majority of patients for the service or supply, the amount Providers of similar training and experience in the same "area" accept from others as payment for the service or supply, the cost to the Provider for providing the services, and using objective and normative data such as, but not limited to, Medicare Rates, cost information, Medicare Provider Reimbursement Manual et al, manufacturer's wholesale pricing (MWP) and/or average wholesale price (AWP) for supplies, devices and/or prescriptions. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, zip code, state or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. Reasonable and Allowed fee(s) must be in compliance with generally accepted billing practices for unbundling, multiple procedures, coding and billing guidelines and shall not exceed the fees for the area, applicable to the treatment, supplies, and/or services.

"Reasonable and Allowed" and thus payable amounts may alternatively be determined by the Plan Administrator based upon rates negotiated by the Plan Administrator and Provider, before and/or after services and/or supplies are provided by the Provider.

The term "Reasonable and Allowed" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider's error are not considered Covered Expenses or Reasonable and Allowed. The Plan Administrator will determine whether a specific procedure, service or supply is Reasonable and Allowed. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Appropriate.

Rehabilitation Center shall mean a facility which is designed to provide therapeutic and restorative services to sick or injured persons and which:

- Carries out its stated purpose under all relevant state and local laws; or
- Is accredited for its stated purpose by either the JCAHO or the Commission on Accreditation for Rehabilitation Facilities; or
- Is approved for its stated purpose by Medicare.

Residential Treatment Center shall mean a Facility which provides a specific covered-disease treatment program on a full- or part-time basis, pursuant to a written treatment plan approved and monitored by a Doctor, and which:

- Provides 24-hour nursing and medical supervision; and
- Is licensed, certified or approved as such by the appropriate state agency.

Semi-Private Room Charge shall mean the standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness shall mean bodily illness or disease (other than mental health conditions), congenital abnormalities, birth defects and premature birth.

Skilled Nursing Facility shall mean an institution which:

- Is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;
- Is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons;
- Is under the full-time supervision of a Physician or a registered nurse;
- Admits patients only upon the recommendation of a Physician (other than the patient's own Physician), maintains complete medical records, and has available at all times the services of a Physician;
- Has established methods and procedures for the dispensing and administering of drugs;
- Has an effective utilization review plan;
- Is approved and licensed by Medicare;
- Has a written transfer agreement in effect with one or more Hospitals; and
- Is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Substance Abuse shall mean 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 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:
    a. 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);
    b. 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);
    c. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
    d. 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);
- The symptoms have never met the criteria for Substance Dependence for this class of substance.

Totally Disabled shall mean the situation when a Covered Person who is an Eligible Employee, because of an Injury or Sickness, is completely prevented from performing the material and substantial duties of any occupation for which he or she is qualified by education, training or experience. For a Covered Person who is

an Eligible Dependent, this means he or she, as a result of bodily Injury or Sickness, is unable to perform his or her daily activities.

Transplant Facility shall mean a Hospital or facility which is accredited under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals to perform a transplant and:

- For organ transplant, is an approved member of the United Network for Organ Sharing for such transplant or is approved by Medicare as a Transplant Facility for such transplant;
- For unrelated allogeneic bone marrow or stem cell transplants, is a participant in the National Marrow Donor Program;
- For autologous stem cell transplant, is approved to perform such transplant by: (1) the state where the transplant is to be performed, or (2) Medicare, or (3) the Foundation for the Accreditation of Hemopoietic Cell Therapy. Outpatient facilities must be similarly approved.

Urgent Care Facility shall mean a facility which is engaged primarily in providing minor emergency and episodic medical care and which has:

- A board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;
- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or which is part of a regular Hospital.

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

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care Facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period shall mean the time an Employee must be employed before becoming eligible for coverage under the terms and conditions of the Plan.

3.2 Gender and Number. Except when otherwise indicated by the context, any masculine terminology shall also include the feminine and the definition of any term in the singular shall also include the plural.

Article 4. Eligibility and Effective Date

4.1 Eligibility. Eligible Employees (those who are eligible to enroll in the Plan) are employees who meet all of the following requirements:

- Is an active employee of this employer;
- Belongs to a class of employees eligible for coverage under the Plan;
- Is working the stipulated minimum number of hours per week at the Employer's regular place of business or at another location approved by the Employer; and
- Is currently a U.S. citizen or legal resident of the U.S.

Eligible Employees may enroll in the Plan upon completion of the Plan's established Waiting or Measurement Period dependent on the selection of the method used for determining full-time status for variable hour/seasonal employees as designated in section 2.3 General Plan Information and Appendix B (if applicable). The Waiting or Measurement Period begins on the employee's first day of employment with the Employer.

4.2 Eligible Employees – How To Enroll In the Plan. In order to enroll in the Plan, the Eligible Employee must:

- Complete the enrollment application and apply for employee coverage on their date of hire or upon first becoming eligible under the Plan.
- Sign an agreement for contributions, if applicable.
- Have completed the Waiting Period specified above.
- Have contributions withheld from the employee's paycheck, if required, beginning with the first pay period of the month prior to the effective date of coverage under the Plan.

Eligible Employees who enroll in the Plan in the manner described above will be covered under the Plan effective as described on page 3. Employees who do not submit an enrollment application to the Employer in accordance with the procedure described above will be deemed to have declined to enroll in the Plan.

- **Standard Full-time Employees -** Employees who decline to enroll in the Plan during their initial eligibility period will be able to enroll in the Plan later only if (a) they enroll in the Plan during an annual open enrollment period the effective date is the next occurring plan anniversary, or (b) enroll in the Plan because of the Special Enrollment Rights available to them.
- **Variable Hour/Seasonal Employees (if applicable) -** Employees who decline to enroll in the Plan once they have initially been determined to be a full-time employee based on hours worked in their Initial Measurement Period will be able to enroll in the Plan later only if they are determined to be a full-time employee following a subsequent Measurement Period.

4.3 Eligible Dependents. Dependents of employees are eligible to enroll in the Plan if they meet all of the following requirements:

- Is the employee's lawful spouse, until the entry of a decree of legal separation or the entry of an interlocutory judgment of dissolution of marriage (whichever comes first);
- Is the employee's adult child age nineteen (19) but less than twenty-six (26), does not have other health coverage or health insurance in force, and is not eligible for other health coverage or health insurance through his/her employment; or
- Is a dependent whose coverage is required by a Qualified Medical Child Support Order (QMCSO). The Plan Administrator will determine whether a Medical Child Support Order (MCSO) is "qualified," that is, a QMCSO.

For purposes of establishing a dependent's eligibility to enroll in the Plan, the term "child" shall mean, 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 the order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

For purposes of establishing an adult child's eligibility to enroll in the Plan, the adult child age of nineteen (19) but less than twenty-six (26) may be eligible for coverage if he/she has no other coverage and is not eligible for other coverage through his/her employment.

In no event shall a child be an Eligible Dependent or Adult Child of more than one employee.

Dependents of employees (including adult children under age 26) who meet the above requirements are eligible to enroll in the Plan after they complete the same Waiting Period as is required of Eligible Employees. The Waiting Period begins on the employee's first day of employment.

4.4 Eligible Dependents and Adult Children– How to Enroll in the Plan. In order for any Eligible Dependents and Adult Children to enroll in the Plan, the Eligible Employee must:

- Complete the enrollment application and apply for dependent coverage on their date of hire or upon becoming eligible under the Plan.
- Sign an agreement for contributions, if applicable.
- Have completed the Waiting Period specified above.
- Have contributions withheld from the employee's paycheck, if required, beginning with the first pay period of the month prior to the effective date of coverage under the Plan.

Please Note that Eligible Employees may not apply for dependent coverage unless they have (or apply for) employee coverage at the time they submit the application for dependent coverage to the employer.

4.5 Eligible Dependents and Adult Children – Effective Date of Coverage. Eligible Dependents and Adult Children who are enrolled in the Plan in the manner described above will be covered under the Plan effective as described on page 7.

Employees who do not submit a dependent enrollment application to the Employer in accordance with the procedure described above will be deemed to have declined coverage for any Eligible Dependents and Adult Children under the Plan. Eligible Dependents and Adult Children who are not enrolled in the Plan during their initial eligibility period will be able to enroll in the Plan later only if (a) they are added to the Eligible Employee's coverage during an annual open enrollment period, or (b) certain events trigger the Special Enrollment Rights.

4.6 Changing Your Coverage during the Year. In addition to making changes during the annual open enrollment period, you can also change your coverage after a qualified status change, provided you are currently deemed to already be eligible to enroll in the Plan based on your designation as a full-time employee (including variable hour/seasonal employees meeting the criteria of full-time employees based on the previous measurement period, if applicable). Status changes include:

- Your marriage, divorce, legal separation, or annulment;
- The birth, adoption, placement for adoption, or appointment of legal guardianship of your child;
- Your death;
- The death of your Eligible Dependent or Adult Child;
- Your Eligible Dependent or Adult Child losing or gaining coverage;
- A change in your (or your Eligible Dependent's or Adult Child's) employment status due to a switch between full-time and part-time, union and management, or exempt and non-exempt status; a strike or lockout; or an unpaid leave of absence;

- Your requirement to cover your Eligible Dependent according to a judgment, decree, or order resulting from your divorce, legal separation, annulment, or change in legal custody;
- Your (or your Eligible Dependent's or Adult Child's) eligibility for COBRA;
- Your (or your Eligible Dependent's or Adult Child's) eligibility for Medicare or Medicaid (you may change the current election for the eligible person only).

You will need to change your coverage within 30 days of the status change. Contact the Plan Administrator for the procedure to make a status change. You may have to provide documentation of the status change in order for the Plan Administrator to process your request.

4.7 Special Enrollment Rights. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you with certain special enrollment rights pertaining to your health care coverage. If you decline enrollment for yourself or your Eligible Dependents (including your Spouse) because of other health insurance coverage (such as coverage through another employer), you may in the future be able to enroll yourself or your Eligible Dependents in this Plan, provided that you request enrollment within 31 days after the other coverage ends.

In addition, if you have a new dependent as a result of marriage, you may be able to enroll yourself and your dependents, provided that you request enrollment in writing within 30 days of the marriage. You must provide documentation of the event. See the section entitled Your Rights Under HIPAA for additional information regarding your special enrollment rights.

If you also have a new dependent as a result of birth, adoption, or placement for adoption, you may be able to enroll yourself, your eligible spouse and your newborn child, adopted child or child placed for adoption provided that you request enrollment in writing within 30 days of the birth, adoption, or placement for adoption. You must provide documentation of the event. See the section entitled Your Rights Under HIPAA for additional information regarding your special enrollment rights. Note children previously declined are not eligible to enroll during this special enrollment period.

Article 5. Benefits

Note: The schedule applies to those Employees (and their eligible and enrolled Dependents) who have elected the MVP Next Generation Plan.

5.1 General Limits. Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out-of-pocket Deductible has been satisfied.

5.2 Network. The Plan contracts with the medical provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

- The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
    - In the event a Network Provider refers a Participant to a non-Network Provider for diagnostic testing, x-rays, laboratory services then charges of the non-Network Provider will be paid as though the services were provided by a Network Provider.
    - The Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area. The Network service area is defined as within 50 miles.
    - The Network Provider level of benefits is payable when a Participant receives emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.
- If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.
- To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Contract Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.
- Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

5.3 Explanation of Payment

Benefits available to Providers are limited such that if a Provider advances or submits claims which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

If the charge billed by a Provider for any Covered Charge is higher than the Maximum Allowable Amount determined by the Plan, Participants are responsible for the excess unless the Provider accepts an Assignment of Benefits as consideration in full for services rendered. When Participating Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.

Providers accepting an Assignment of Benefits shall do so as consideration in full for services rendered, and send the Participant's claims directly to the Third Party Administrator. The Plan will pay the scheduled benefit amount, less any required deductibles and copayments, and subject to any limits or exclusions, directly to the Provider.

When available, benefits will be limited by the terms of the Plan, including provisions which limit benefits to the Reasonable and Allowed amounts. The Plan will not pay any expense that is not a Covered Charge.

5.4 Primary Care Providers. A current list of PPO Providers is available, without charge, through the Contract Administrator's website located at www.BENELECT.com. If you do not have access to a computer at your home, you may be able to access this website at your place of employment.

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

5.5 Individual Deductible. The Deductible shown in the Schedule of Medical Benefits is the amount of covered charges that a Covered Person must incur each Calendar Year before the Plan will provide any benefits.

5.6 Covered Percentage. After the Deductible is met, the Plan will pay benefits for eligible medical expenses at the percentage shown in the Schedule of Medical Benefits. The covered percentage will vary depending on the provider network utilized.

5.7 Maximum Benefit While Covered. The maximum benefit the Plan will pay for any Covered Person while covered under the Plan is shown in the Schedule of Medical Benefits. When the total of benefits paid to, for or on behalf of each Covered Person reaches a specified limit, benefits under the Plan will have been exhausted, and coverage under the Plan will cease with respect to the category of benefits whose limit has been reached.

5.8 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 Usual and Customary and/or Medically Necessary and Reasonable, 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 Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

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

5.9 Pre-authorization/Pre-pricing Language

PRE-CERTIFICATION

Pre-certification Requirements are listed in this plan document indicating services that require pre-certification from the Claim Administrator Utilization Review Department in order for the services to be covered under the Plan.

All services requiring pre-certification, as noted on the Plan Document are to be certified in advance by the Utilization Review Department, except for emergencies. The Member or their representative is required to call the phone number for pre-certification located on the back of their ID card for the services specified above at least seven (7) business days prior to services being rendered. The Member or their representative must identify the services to be rendered and the associated diagnosis and procedure codes necessary for pre-certification determinations and service pre-pricing.

UTILIZATION REVIEW

Utilization review is the process of evaluating if services, supplies or treatment are medically necessary, appropriate and priced at the prevailing rates to help ensure cost-effective care. Utilization review can eliminate unnecessary services, hospitalizations, and shorten confinements while improving quality of care and reducing costs to the Member and the Plan.

Pre-certification establishes the medical necessity of certain care and services covered under the Plan. It ensures that the pre-certified care and services will not be denied on the basis of medical necessity (as defined by this Plan). The Pre-certification process will also establish the reference prices for requested services. However, pre-certification does not guarantee the payment of benefits. Coverage and benefits are always subject to other requirements and provisions of the Plan, such as, Plan limitations, exclusions, and eligibility at the time care and services are provided.

5.10 Schedule of Benefits. See Exhibit A.

Article 6. Termination of Coverage

6.1 Termination Dates of Individual Coverage. A participating employee's coverage under this Plan will end on the earliest of the events described below:

- The last day of the month in which the employee ceases active employment with the Employer unless the employee is on a leave of absence or temporary layoff. In these cases, the employee may continue their coverage by paying the required employee contribution, but not beyond the following limits:
    a. For an approved leave of absence: 12 weeks;
    b. For a temporary layoff: the end of the month which follows the month in which the layoff began.
- The last day of the month during which the employee's scheduled working hours are reduced to the point that the employee no longer meets the definition of a full-time employee under this Plan as defined above on page 6.
- The last day of the month in which the employee retires.
- The last day of the month in which the employee resigns their employment.
- The last day of the month in which the employee is involuntarily terminated from employment.
- The date the participating employee or the Employer fails to make a required contribution toward the cost of the Plan.
- The last day of the month during which the covered employee dies.
- The date the Plan Sponsor terminates the Plan.
- The date coverage is rescinded.

6.2 Rescission of Coverage. The Plan reserves the right to rescind, terminate or modify coverage for any Covered Person because of the intentional material misrepresentation or fraud by or on behalf of such Covered Person, or if the Covered Person allows a non-Covered Person to use the Covered Person's identification card to obtain services.

6.3 Termination Dates of Dependent Coverage. A participating dependent's or adult child's coverage under this Plan will end on the earliest of the events described below:

- The date the participating employee's coverage under this Plan ends.
- The date the participating employee or the Employer fails to make a required contribution for dependent coverage.
- The last day of the month in which the covered dependent ceases to be in a class eligible for dependent coverage.
- The last day of the month in which a dependent ceases to meet the definition of "dependent," whether due to age (if a dependent child or adult child) or due to divorce or legal separation (if a dependent spouse).

If a covered dependent child, upon reaching the termination age for being considered an Eligible Dependent, is unable to sustain employment because of mental retardation or physical handicap, and is solely dependent on the employee for support and maintenance, the participating employee may continue dependent coverage for this child for as long as coverage for the participating employee continues and the child continues to be handicapped and solely dependent upon the participating employee for support and maintenance. The participating employee must notify the Employer of their desire to continue coverage for a dependent child in these circumstances, and provide certification of disability to the Employer, within thirty (30) days after the date the dependent child reaches the termination age for being considered an Eligible Dependent. After the first two (2) years of incapacity and dependency, the employee may be required to furnish proof of the continuation of the dependent's condition once each year.

Article 7. Continuation of Coverage

7.1 Reinstatement of Coverage. If a participating employee's coverage terminates due to a termination of employment, they may be eligible to have coverage under this Plan reinstated effective as of the first day of the month which follows their resumption of employment, if such resumption is within one (1) month following the termination of employment. However, if the resumption of employment begins more than one (1) month following the termination of employment, then the employee will not be eligible to reinstate coverage under this Plan. Instead, the employee will be treated as a new employee for purposes of obtaining coverage under this Plan, and will be required to meet all of the eligibility requirements set forth above, including the Waiting Period.

If a returning employee is eligible for reinstatement of coverage under this Plan, the amount of benefits that will be reinstated will be the lesser of:

- The amount of benefits for which the returning employee was covered on the date of their prior termination; or
- The amount for which the returning employee is eligible under the Plan on the date of reinstatement.

7.2 Extension of Coverage during Military Service

Regardless of the Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee or Eligible Dependent entering military service. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

Also, COBRA coverage will run concurrently with medical continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). That is, if an Employee on military leave continues coverage for 24 months under USERRA, 18 months of COBRA entitlement will be exhausted, unless there was another Qualifying Event.

(See Continuation Coverage Rights Under COBRA)

Article 8. Eligible Medical Expenses

Abortion - Non-elective abortion procedures and any complications arising out of an abortion. Benefits are payable for these services for a covered spouse as well as for a covered dependent child. Elective abortions are not covered: see Limitations and Exclusions.

Allergy Testing and Treatment - Allergy testing and treatment, including allergy injections.

Birthing Center - Services and supplies including prenatal care, delivery for child(ren) and postpartum care rendered with twenty-four (24) hours after the delivery by the Covered Person.

Blood - Blood and blood plasma and autologous blood and its storage, if used, including blood processing and administration services.

Chemotherapy - The use of chemical agents in the treatment or control of disease.

Contraceptive Medications – Oral Contraceptive Medications for birth control purposes are covered under your Prescription Drug Benefit.

Diagnostic Services - Diagnostic laboratory and x-ray expense, including charges for scanning and imaging (e.g. CT scans and MRIs), electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar diagnostic tests generally approved by Physicians throughout the United States.

Foot Care - Foot care services, including removal of plantar warts and removal of nail roots and treatment of feet necessitated by metabolic or peripheral-vascular disease affecting the lower extremities.

Home Infusion Therapy - Administration, by an appropriate Covered Provider, of prescription drugs by injection into a vein, a muscle, the skin or the spinal canal. It also includes drugs administered by aerosol into the lungs or by a feeding tube.

Hospital Services - Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board, ancillary services and supplies.

Hospitalization – Charges incurred during inpatient hospitalization.

Learning and Behavior Disorders – Childhood learning and behavior disorders limited to Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) only.

Medical Supplies - Disposable medical supplies such as casts; splints, trusses, surgical dressings, colostomy bags and related supplies, and catheters.

Mental Healthcare - Outpatient treatment of mental health conditions and substance abuse.

This policy addresses a wide variety of pharmacotherapeutic, behavioral, educational, medicinal, and rehabilitative treatments and therapies used to treat Autism, Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder Not Otherwise Specified (NOS).

Medically Necessary:

Pharmacotherapy for management of co morbidities related to Autism, Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Developmental Disorder Not Otherwise Specified (NOS) is considered medically necessary when required for the treatment of mood disorders or other conditions where the potential for patients to harm themselves or others is present, or when such treatment would otherwise be considered medically necessary.

Behavior modification for management of behavioral symptoms related to Autism, Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Developmental Disorder Not Otherwise Specified (NOS) is considered medically necessary when required for the management of behaviors where the potential for patients to harm themselves or others is present, or when such treatment would otherwise be considered medically necessary.

Interventions to improve verbal and nonverbal communication skills for patients with Autism, Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Developmental Disorder Not Otherwise Specified (NOS) are considered medically necessary.

The following treatments or therapies are considered investigational/not medically necessary for the treatment of Autism, Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder Not Otherwise Specified (NOS):

- Cognitive rehabilitation;
- Elimination diets (e.g., gluten and milk elimination);
- Facilitated communication;
- Immune globulin infusion;
- Lovaas therapy (also known as applied behavior analysis [ABA]), intensive behavioral intervention [IBI], discrete trial training, early intensive behavioral intervention [EIBI], or intensive intervention programs);
- Music therapy and rhythmic entrainment interventions, pet therapy (e.g., Hippo therapy);
- Nutritional supplements (e.g., megavitamins, high-doses pyridoxine and magnesium, dimethylglycine);
- Secretin infusion;
- Sensory integration therapy; and
- Vision therapy.

For Plan purposes, "substance abuse" is physical and/or emotional dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Newborn Care - Routine Physician visits provided to a covered well newborn child during the birth confinement.

Nursing Services - Private Duty - Services of a registered graduate nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.) for private duty nursing services when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type. Does not apply to Minimum Essential Coverage Plan.

Pap Smear - see "Diagnostic Services" (when Sickness-related) or "Preventive Care."

Physical Exams - see "Preventive Care."

Physical Therapy - Professional services of a licensed Physical Therapist, when specifically prescribed by a Physician as to type and duration, but only to the extent that the therapy is for improvement of bodily function. Does not apply to Minimum Essential Coverage Plan.

Physician Services - Medical and surgical treatment by a Physician (M.D. or D.O.), including office, clinic care and consultations. Does not apply to Minimum Essential Coverage Plan.

Pre-Admission Testing - Diagnostic tests performed on an Outpatient basis prior to a scheduled Hospital admission when:

- The admission to the Hospital is confirmed in writing by the attending Physician before the testing takes place;
- The tests are performed within seven (7) days before admission to the Hospital;
- The tests are ordered by the attending Physician;
- The tests are accepted by the Hospital in place of the same tests which would otherwise be done while the individual is Hospital-confined; and
- The tests are not repeated in the Hospital.

Does not apply to Minimum Essential Coverage Plan.

Pregnancy - Eligible Pregnancy-related expenses are covered to the same extent as any other Sickness. Pregnancy-related expenses include:

- Pre-natal visits and routine pre-natal care;
- Non-elective abortion procedures and any complications arising out of a non-elective abortion.

Pregnancy coverage will include expenses incurred by a covered dependent child for both prenatal care and for the delivery of the newborn. Does not apply to Minimum Essential Coverage Plan.

Prescription Drugs (Outpatient) - see Prescription Drug Program section.

Preventive Care (also referred to as Wellness) - The Plan will cover the following "preventive" measures:

Well Baby and Well Child care expenses, Adult Physical Exams, Well Woman care including Pap smears and mammograms where the reason for such services is not an illness or injury, i.e. routine care. In-Network (PPO) only is covered.

Radiation Therapy - Radium and radioactive isotope therapy. Does not apply to Minimum Essential Coverage Plan.

Sterilization Procedures - Surgical procedures for the purpose of sterilization (i.e., a Tubal ligation for a female) which fall under “Women’s Preventive Services.”

Women’s Preventative Services – In addition to any other preventive screening services described in your Plan, the following preventive services are covered for females:

- Well-Woman Visits - One well-woman preventive care visit annually for an adult woman to obtain the recommended preventive screening services that are age appropriate and developmentally appropriate, including preconception and one visit for prenatal care.
- Screening for Gestational Diabetes – One screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be high-risk for diabetes.
- Human Papillomavirus Testing – High-risk human papillomavirus DNA testing in women with normal cytology results. One screening is covered for females over 30 years of age and over and will be covered no more frequently than once every three years.
- Counseling for Sexually Transmitted Infections – One counseling session annually for counseling on sexually transmitted infections for all sexually active women.
- Counseling and screening for human immune-deficiency virus – One counseling session and screening annually for human immune-deficiency virus infection for all sexually active women.
- Contraceptive Methods and Counseling – All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, when prescribed by your physician. This benefit does not include coverage for abortifacient drugs.

- Breastfeeding Support, Supplies and Counseling in Conjunction with Each Birth – Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period. Coverage includes the cost for the rental of breastfeeding equipment.
- Screening and Counseling for Interpersonal and Domestic Violence – One screening and counseling for interpersonal and domestic violence per Calendar Year.

Article 9. Limitations and Exclusions

Except as specifically stated otherwise, no benefits will be payable for:

Acupuncture/Acupressure - Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

Air Purification Units, Etc. - Air conditioners, air-purification units, humidifiers and electric heating units.

Alcohol - Any activity of a Plan Participant made illegal due to the use of alcohol. Expenses will be covered for Injured Plan Participants 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:

- If the injury resulted from being the victim of an act of domestic violence; or
- Resulted from a medical condition (including both physical and mental health conditions);

Ambulance - Professional ground or air ambulance service when used to transport the Covered Person to or returning from a Hospital or other medical institution for covered medical treatment.

Ambulatory Surgical Center - Services and supplies provided by an Ambulatory Surgical Center (see Definitions) in connection with a covered Outpatient surgery.

Anesthesia - Anesthetics and services of a Physician or certified registered nurse anesthetist (C.R.N.A.) for the administration of anesthesia.

Biofeedback - Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

Chiropractic Care - Modalities (hot, cold therapy, etc.), manipulation and adjunctive therapy by a Covered Provider to correct disorders of the vertebrae such as subluxation, incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

Cosmetic Surgery, Etc. - 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 Accidental Injury;
- Surgery is performed to reconstruct the breast, on which a mastectomy has been performed, or surgery and reconstruction of the other breast to produce symmetrical appearance. The plan will also cover physical complications of all stages of a mastectomy, including lymphedemas. Coverage will be provided for such care as determined by the attending Physician in consultation with the patient; or
- As necessary to correct a congenital abnormality in a covered Dependent child.

Court-Ordered Care/Confinement/Treatment - Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order.

Custodial Care - Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training. Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal

Hospice care program. Services or supplies that cannot reasonably be expected to lessen the patient's disability or enable him to live outside of an institution.

Dance or Art Therapy - Dance, poetry, music or art therapy.

Dental Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except for:

- Treatment of tumors of the gum;
- Reduction of fractures of the jaw or facial bones;
- Surgical correction of harelip, cleft palate or protruding mandible;
- Removal of stones from salivary ducts;
- Removal of bony cysts of the jaw, torus palatinus, leukoplakia, or malignant tissues;
- Freeing of muscle attachments; or
- The repair or alleviation of damage to sound natural teeth caused solely by Accidental Injury and then only for expenses which are incurred within ninety (90) days of the accident.

Diagnostic Hospital Admissions - Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Dialysis Services - Dialysis services, including the training of a person to assist the patient with home dialysis, when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

Dietician-Nutritional Counseling – Any nutritional counseling or consultation/treatment with a dietician except as covered under ACA Preventive Care.

Durable Medical Equipment - Rental of durable medical equipment or purchase of such equipment for purposes other than “Preventive Health.” “Durable medical equipment" includes such items as non-dental braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc.

Drugs in Testing Phases - Medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing, drugs which are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Ecological or Environmental Medicine - Chelation or chelation therapy, orthomolecular substances, use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing or Training - Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

Elective Abortions and Elective Treatment/Complications - Any elective service, supply or surgical procedure that is not medically necessary. This includes any complications resulting from the above exclusion unless a Covered Person’s life is threatened. “Life threatening,” means either or both of the following: (a) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Error - Injuries requiring treatment that are sustained or an illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a Provider 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, unreasonably gave rise to the expense.

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 Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

Excess Charges - Charges in excess of the Reasonable and Allowed charges for services or supplies provided.

Exercise Equipment/Health Clubs/Recreational Therapy - Exercising equipment, vibratory equipment, swimming or therapy pools, enrollment in health, athletic or similar clubs, recreational, art, dance, or music therapy.

Experimental/Investigational – Charges for services, supplies or treatment that are Experimental/Investigational.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Genetic Counseling or Testing - Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary during the course of a high-risk Pregnancy which is covered by the Plan or for the purpose of diagnosis and treatment of a Genetic disease.

Governmental Benefits Limitations - If a Covered Person is entitled to, or could have been entitled to, if proper application had been made, any medical benefits provided under the authority of any governmental agency, such benefit will discharge the Plan's obligation as though it had been paid under this coverage. However, the Plan will not deny a claim solely because treatment or services are rendered in a Hospital owned or operated by a State or by a political subdivision of a State.

Government-Operated Facilities - Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government (except for treatment of non-service related disabilities), or by any state government or any agency or instrumentality of such government, for which the Covered Person has no legal obligation to pay.

Hair Replacement - Replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body for treatment of alopecia (baldness), or any other surgeries, treatments, drugs or supplies for baldness.

Hearing Aids - Hearing aids or the fitting of hearing aids.

Home Healthcare - Services and supplies which are furnished by a Home healthcare Agency.

Holistic or Homeopathic Medicine – Therapies, including but not limited to: Bioenergetics Therapy; Confrontation Therapy; Crystal Healing Therapy; Education Remediation; EST (Erhard Seminar Training); Guided Imagery; Marathon Therapy; Primal Therapy; Rolfing; Sensitivity Training; Training Analysis (Tutorial, Orthodox); Transcendental Meditation; Z Therapy; certain organic therapies as follows: aversion therapy (includes electric shock for behavioral modification or alcoholism), carbon dioxide therapy, environmental ecological treatments or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, L-Tryptophan and vitamins, except thiamine injections (X-1-3) or admission for alcoholism or with diagnosis of nutritional deficiency, narcotherapy with LSD, sedative action electro stimulation therapy.

Hospice Care - Hospice care charges for Inpatient Hospice facility services and supplies; professional and other services and supplies.

Hypnotherapy - Treatment by hypnotism.

Illegal Acts – Charges for any Injury or Sickness which is incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. 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.

Impregnation - Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Individual and Family Counseling – Individual and Family Counseling relating to the following services are not covered: Marriage and Family, Marital, Financial, Legal, Sexual, Social, and Addictions other than alcohol or drug addiction.

Infertility – Any services/treatments for "Infertility Treatment." This exclusion includes procedures, services, tests and supplies for the purpose of inducing Pregnancy where a diagnosis of infertility has been clinically established. Procedures and tests include hormone level tests to determine the time of ovulation. Supplies include charges for fertility agents to induce ovulation and charges for the acquisition or storage of sperm (whether donor or spouse). This exclusion also includes services and testing to determine the cause of infertility.

Late-Filed Claims - Claims which are not filed with the Claim Administrator for handling within the required time periods as included in the Claims Procedures section.

Learning and Behavior Disorders - Childhood learning and behavior disorders including Hyperkinetic Syndrome or Mental Retardation other than as described in the Eligible Medical Expenses section.

Maintenance Care - Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him/her to live outside of an institution.

Mental Healthcare - Inpatient treatment of mental health conditions and substance abuse.

Midwife - Services of a registered nurse midwife.

Military Service - Charges for treatment of any injury sustained or illness contracted while in the military service of any country.

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

Negligence - Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

No Charge/No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under This Plan. Where Medicare coverage is involved and This Plan is a "secondary" coverage, this exclusion will apply to those amounts which a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

This exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).

Non-Emergency Services - Visits to an Emergency Room that are not Medically Necessary.

Non-Prescription Drugs - Drugs for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available.

Not Listed Services or Supplies - Any services, care or supplies not specifically listed in the Summary Plan Description as Eligible Expenses are not covered under the Plan.

Not Medically Necessary/Not Physician Prescribed - Any services or supplies which are: (1) not medically necessary; and (2) not incurred on the advice of a Physician - except as expressly included herein.

Obesity - see "Weight Control"

Occupational Therapy - Occupational therapy by a registered/certified occupational therapist to restore physical function.

Orthognathic (Jaw) Procedures - Jaw (mandibular) augmentation or reduction procedures.

Orthotics - Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and custom made.

Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payer or Medicaid Priority rules.

Services or supplies received from a healthcare department maintained by or on behalf of an employer, mutual benefit association, labor union, and trustees or similar person(s) or group.

Out-of-Network Preventive Care/Wellness – Services from a non-PPO provider.

Outside United States - Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services, drugs or supplies.

Personal Comfort or Convenience Items - Services or supplies provided for personal comfort and not necessary for treatment of covered Sickness, Accidental Injury, or Pregnancy including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets and/or mattress covers, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits) or supplies or attachments to such equipment.

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges which may occur in the transmittal of information to the Claim Administrator. Interest or financing charges.

Prosthetics - Artificial limbs, eyes and their fitting, other prosthetic appliances, and post-mastectomy breast prostheses and surgical bras.

Prior Coverage - Services or supplies for which the Covered Person is eligible for benefits under the plan which This Plan replaces.

Prior to Effective Date / After Termination Date - Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated.

Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Respiratory Therapy - Professional services of a licensed respiratory therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

Robotic Assisted Procedures – Reimbursement will be limited to the reimbursement provided had the service been provided without the Robotic component.

Self-Inflicted – Charges 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).

Self-Procured Services - Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any period of hospital confinement, which were/are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of Eligible Medical Expenses.

Sex-Related Disorders - Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies. Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.

Skilled Nursing Facility - Inpatient care in Skilled Nursing Facility.

Sleep Disorders - Diagnostic Services, Treatment and Testing for sleep disorders including sleep Apnea.

Speech Therapy - Speech therapy by a certified speech therapist to restore speech loss, correct an impairment due to a congenital defect for which corrective surgery has been performed, or to correct an impairment caused by an Accidental Injury or Sickness.

Sterilization Reversal Surgery - Reconstruction (reversal) of prior elective sterilization, including repeat sterilization, procedures (i.e., a vasectomy for a male or a Tubal ligation for a female).

Subrogation, Reimbursement, and/ or Third Party Responsibility – Charges of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Substance Abuse - shall mean 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.

Surrogate Mother - Charges resulting from the Pregnancy of a surrogate mother.

Telemedicine - Advice or consultation given by or through any form of telemedicine.

Third Party Liabilities - Any expenses caused by any third party when payment for such expenses has been paid (or will be paid) by the third party or the third party's insurance company. See section entitled Subrogation for further information.

Transplants – Organ Transplants (kidney, pancreas, heart, liver, lung and bone marrow. Includes prep and transport.)

Travel - Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges as included in the list of Eligible Medical Expenses.

Vision Care - Eye examinations for the purpose of prescribing corrective lenses, vision supplies (eyeglasses or contact lenses, etc.) or their fitting, replacement, repair or adjustment; Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or laser surgery.

NOTE: This exclusion will not apply to: (1) services necessitated by a covered Sickness, or (2) the initial purchase of glasses or contact lenses following cataract surgery.

Vitamins or Dietary Supplements - Prescription or non-prescription organic substances.

Vocational Testing or Training - Vocational testing, evaluation, counseling or training.

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications there from, or service (past or present) in the armed forces of any country.

Weight Control - Except as specifically stated otherwise, no benefits will be payable for any medical or surgical treatment for obesity, weight control, weight reduction, weight loss or dietary control, whether or not it is in any case, part of the treatment plan for any other disease process. These treatments include but are not limited to medical management with or without medication, or surgical interventions including but not limited to gastric bypass, gastric stapling or insertion of a gastric bubble. In addition, any complications resulting from the above mentioned exclusion would not be coverable under the policy provisions.

Work-Related Conditions - Any condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain. Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. However, if the Plan provides benefits for any such condition, the Plan Administrator will be entitled to establish a lien upon such other benefits up to the amount paid.

Article 10. Pre-Certification Program

The Pre-Certification Program is applicable to all inpatient confinements, certain outpatient procedures, and other treatment and services as outlined in the section entitled Important Notices.

No benefits will be paid when the Insured Person does NOT comply with Pre-Certification.

Pre-Certification is a screening process using established medical criteria to determine whether the proposed length and date of an Inpatient Hospital Confinement, the proposed treatment plan, or the proposed services and supplies are Medically Necessary and being provided in an appropriate setting. It may also include proposing alternative treatment plans and continued stay review.

The Policy requires Pre-Certification by an Insured Person of all:

- Proposed Inpatient Confinements in a Hospital, as defined by the Policy for more than 23 hours; and
- Certain surgical and diagnostic procedures (see section entitled Important Notices)

Retrospective Review

Retrospective Reviews will be allowed only within 48 hours of the event or 72 hours if the event occurs on a weekend or holiday.

Pre-Certification of Non-Emergency Services

To request Pre-Certification, the Insured Person or the Insured Person’s attending Physician must contact the designated pre-certification service at least seven days prior to obtaining the requested treatment, service or supply. The pre-certification service may be reached by writing; or by telephone during normal business hours each business day. The name of the pre-certification service and instructions are provided to each Insured Person. The Insured Person will be requested to provide:

- Name, address and the telephone number of the attending Physician;
- The proposed treatment plan; and
- The Insured Person's authorization (or, if a minor, authorization on his behalf) to release medical information.

The pre-certification service will then consult with the Insured Person's attending Physician. If the precertification service concurs with the Insured Person's attending Physician with the appropriateness of the setting and Medical Necessity of the proposed treatment plan, the pre-certification service will notify the Insured Person in writing and the Insured Person will be deemed to have complied with the Pre-Certification requirement described herein.

The pre-certification service may also conduct a continued stay review for any ongoing Inpatient Confinement. The continued stay review is a process of monitoring an Insured Person’s progress on a daily basis to determine if the Insured Person will be discharged within the pre-certified number of days and to determine the appropriate number of additional days of stay that may be required according to the Insured Person’s condition and plan of treatment. Hospital admissions will be monitored to assure that the Insured Person will be discharged timely. The attending Physician and the Hospital utilization review nurses will be contacted to determine the progress of the Insured Person and the need, if any, for an extension of certified Hospital days. If an extension of the Inpatient stay is not certified for all or part of the requested day(s), the Insured Person and the attending Physician will be notified.

In absence of Pre-Certification, no benefits will be paid.

No benefits will be paid for Covered Charges incurred for any Inpatient Hospital confinement or treatment plan which extends beyond the number of days deemed by the pre certification service to be Medically Necessary.

Pre-Certification is not a guarantee of payment. Payment of benefits will be determined by Us in accordance with and subject to all the terms, conditions, limitations and exclusions of the Policy.

If the pre-certification service does not concur with the Insured Person's Physician, the pre-certification service will so notify the Insured Person in writing and the Insured Person will not be deemed to be in compliance with the pre-certification requirement described herein and the additional deductible will apply.

Pre-Certification of Emergency Care

Inpatient Confinements for Emergency Care must be certified in the same manner as a non-emergency Inpatient Confinement; however, the Insured Person or the Insured Person's Physician may notify the pre certification service of the Emergency Inpatient confinement within 48 hours of the Inpatient Admission or as soon as reasonably possible and be in compliance with the pre-certification requirement. The attending Physician must verify that an Emergency condition existed.

In the absence of Pre-Certification for Emergency Care, no benefits will be paid.

APPLICABLE WHEN THE SCHEDULE OF BENEFITS PROVIDES IN-NETWORK PROVIDER BENEFITS: If an Insured Person is taken to an Out-Of-Network Provider Hospital for Emergency Care, Inpatient Hospital Confinement benefits will be paid by Us at the In Network level of benefit as specified in the Schedule of Benefits. However, the Insured Person must arrange transfer to an In-Network Hospital within 48 hours, or as soon as the transfer may take place without detriment to the Insured Person's health. Otherwise, benefits will be reduced to the Out-Of-Network Provider benefit level.

Pre-certification of Pregnancy

You are required to obtain pre-certification for Pregnancy or for a post-delivery Inpatient Confinement of 48 hours or less for a vaginal delivery or 96 hours or less for delivery by Cesarean Section. We recommend that You notify Us of a Pregnancy as early as possible following Your diagnosis in order to allow Us to include You in the health care coordination program, if appropriate.

If, following delivery, Your Physician determines that You need to remain Confined in a Hospital for more than 48 hours following vaginal delivery or 96 hours following delivery by Cesarean Section, You or Your Physician must notify the pre-certification service of the continuing Hospital Inpatient Confinement as soon as reasonably possible following the determination to continue Your Hospital Inpatient Confinement.

Important Notices

Pre-Authorization Requirements:

This Plan requires pre-authorization of the services listed below. Check your ID card for the number to call to pre-authorize these listed services. Failure to pre-authorize these services will result in no benefits will be paid:

- All Inpatient Hospital admissions
- All Transplant Services
- Outpatient Diagnostic Services, listed below
- Surgical Procedures, listed below

Outpatient Diagnostic Procedures That Must Be Pre-Authorized:

- All MRIs
- All MRAs
- All CT Scans
- All PET scans

Surgical Procedures That Must Be Pre-Authorized:

- Nasal surgeries
- Blepharoplasty
- Ventral hernia repair
- Varicose vein surgery
- Sclerotherapy
- Panniculectomy
- Breast Reduction
- UP3/UPPP - uvulopalatopharyngoplasty
- Excess skin removal arms and chest and legs
- Maxillo-facial surgery
- Shock wave lithotripsy for plantar fasciitis
- Hysterectomies
- Tonsillectomies/Adenoidectomies in adults
- Biopsies
- AICD and Biventricular device insertions
- Bariatric (weight loss) Surgery
- Following back or neck procedures: IDET (intradiscal Electrothermal Annuloplasty),
- Percutaneous Radiofrequency Neurotomy, Artificial Intervertebral Disk Implantation,
- Automated Percutaneous Lumbar Diskectomy (APLD)
- All treatment that includes the use of robotics, regardless where performed (see Limitations and Exclusions)

Benefits When Services Are Pre-Authorized

When the above referenced procedures, surgeries, or services are pre-authorized, benefits will be paid under this Plan as shown in the Schedule of Medical Benefits.

Penalties When Services Are Not Pre-Authorized

When the above tests, procedures, or surgeries are not pre-authorized, then no benefit will be paid.

Note: Any amounts resulting from a reduction in benefits for failure to pre-authorize any diagnostic tests or surgical procedures will not be applied toward meeting the per person or family maximum Co-Insurance or Out-of-Pocket liability limit under this Plan.

Article 11. Outpatient Prescription Drug Benefits

The Plan Sponsor offers coverage for Outpatient prescription drugs through a program administered by Integrated Prescription Management (IPM). Prescription drugs obtained from any pharmacy not participating in IPM are not covered under this Plan, and no benefits will be provided for any such prescription drugs.

11.1 Outpatient Prescription Drugs obtained at a Participating Pharmacy

The retail network of Participating Pharmacies is available for prescriptions needed immediately or for a short time only (such as antibiotics). Covered Persons may obtain up to a 30-day supply of medication for your co-pay.

To obtain prescription drugs at a Participating Pharmacy, the Covered Person must present their EDIS Identification Card. They will be responsible for the applicable co-pay as shown in the Schedule of Benefits which will be collected by the pharmacist at the time the Drugs are obtained.

If an ID card was not presented at time of fill, the Covered Person can submit a prescription drug claim for reimbursement. Prescription drug claim forms are available from BEN E LECT. The completed form must contain the Employee's name and home address, their ID number, the patient's name and a copy of the pharmacy label receipt. Completed prescription drug claim forms can be mailed to:

EDIS
P. O. Box 7809
Visalia, CA 93290

11.2 Outpatient Prescription Drugs obtained through Mail Service Pharmacy

Prescriptions for chronic long-term health conditions (such as high blood pressure) may be ordered up to a 90-day supply of medication through IPM mail service pharmacy. A mail order enrollment form is available from EDIS or IPM. The completed form should be sent to IPM at the address indicated on the form along with an original prescription and the Mail Service co-pay. Covered Persons should allow up to 14 days to receive the Drugs. The Covered Persons' Physician must indicate the prescription quantity to be dispersed.

11.3 Definitions

Brand Name Drugs – FDA approved Drugs under patent to the original manufacturer and only available under the original manufacturer's branded name.

Co-Pay – The amount to be paid by the Covered Person toward the cost of each separate prescription order or refill of a covered drug when dispensed by a Participating Pharmacy or obtained through Mail Service.

Drugs – FDA approved Drugs which require a prescription either by Federal or California law; Insulin and disposable hypodermic Insulin needles and syringes; diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets); oral contraceptives; and inhalers and inhaler spacers for the management and treatment of asthma.

Formulary – A comprehensive list of Drugs maintained by Integrated Prescription Management (IPM) for use under the Outpatient Prescription Drug benefit. This list includes an extensive list of available prescription drugs offered by the plan to serve the member pharmaceutical needs of patients. Formulary drugs are evaluated to ensure that they are safe, effective and economical. Choosing drugs within your formulary helps you reduce your out of pocket costs. Formulary drugs will only be covered by the plan when no generic is available.

Generic Drugs – FDA approved Drugs that are a therapeutic equivalent to the Brand Name Drug; contain the same active ingredients and are equal in strength and dosage as the Brand Name Drug; and cost less than the Brand Name equivalent.

Non-Formulary Drugs – Drugs determined by IPM as having preferred Formulary Drug alternatives available. Non-Formulary Drugs are high expense drugs, often the newer or highly advertised medications. Many of these drugs have a brand or generic equivalent. Non-Formulary Drugs will only be covered by the plan when no generic is available.

Non-Participating Pharmacy – a pharmacy which does not participate in IPM's pharmacy network. Prescription drugs obtained from Non-Participating Pharmacies are not covered.

Participating Pharmacy – a pharmacy which does participate in IPM's pharmacy network.

11.4 Prescription Drug Exclusions

Expenses which are excluded from coverage under the Prescription Drug Program include:

- Patent or over-the-counter medicines, or medicines not requiring a written prescription, except for insulin or diabetic test strips;
- Medications that are experimental, or non-experimental medications that are prescribed for experimental purposes or indications not approved by the United States Food and Drug Administration, except that off-label use of an FDA-approved drug for the treatment of a life threatening condition is covered, subject to the following requirements:
    a. The drug must be recognized for treatment of the health condition by one of the following: (1) The American Medical Association Drug Evaluations; (2) The American Hospital Formulary Service Drug Information; (3) The United States Pharmacopoeia Dispensing Information, Volume 1 "Drug Information for the Health Care Professional", or (4) two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.
    b. The prescribing Doctor must submit documentation supporting compliance with the requirement stated above if required by the Claim Administrator
    c. For the purpose of this benefit, "life threatening" means either or both of the following: (1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or (2) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
- Cosmetics, health or beauty aids, dietary or nutritional supplements, anorectics (i.e., appetite suppressants) or any other diet medications;
- Drugs used for cosmetic purposes (e.g., Retin-A for Covered Persons over age forty (40) and Rogaine for hair growth). Retin-A will be covered for Covered Persons under age forty (40) for the treatment of acne vulgaris only;
- Drugs when prescribed for smoking cessation purposes (over the counter or by prescription);
- Contraceptive devices, injections or implants;
- Infertility medications, whether used to treat infertility or other conditions such as endometriosis;
- Drugs and medications used to induce non-spontaneous abortions, or menstrual induction medications;
- Medical devices or supplies, except as specifically listed as covered under the Durable Medical Equipment / Prosthetics / Orthotics benefit;
- Hypodermic syringes and/or needles, except when dispensed for use with insulin or other self-injectable drugs or medications;

- Any medication to be taken by or administered to a Covered Person while the person is a patient in a nursing home, Hospital, sanitarium, Skilled Nursing Facility, rest home, or Facility of similar character;
- Blood or blood products;
- Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy or the mail service pharmacy;
- Drugs for which a Covered Person is not legally obligated to pay or for which no charge is made; and
- Any medication dispensed in connection with any health condition which is not covered under the terms of the medical benefits of the Plan;
- Formulary and non-formulary drugs or medications are not covered.
- Specialty drugs are not covered. This includes, but is not limited to: Growth Hormones; Immunosuppressants; AZT, or HIV artiroviral medication; “Off Label” use; Orphan Drugs; Investigative New Drugs (IND) and Group C Cancer Drugs.

Article 12. Payment of Medical Claims

12.1 Claim Payment Procedures

Submitting Claims: All claims for benefits made under this Plan must be submitted in writing to the Claim Administrator. Fully completed claim forms and supporting documentation may be mailed to the Claim Administrator at:

EDIS
P.O. Box 211003
Eagan, MN 55121

Electronic Payer ID: EDHP1

If a claim form is not used for submitting a claim, then the information provided must clearly identify: the name of the Covered Person, the name of the person receiving medical services, the date the medical services were rendered, the full name and business address of the provider of service, the diagnostic code or diagnosis identifying the Illness, Injury or condition for which services were rendered, an itemization of all services rendered using the appropriate code or nomenclature and showing the fee for each itemized service or supply, and whether or not benefits were assigned by the Covered Person or patient to the service provider.

Payment of Claims: Benefits for incurred medical expenses which are covered under this Plan will be paid by the Claim Administrator within thirty (30) days of the receipt by the Claim Administrator of proper written proof of loss. Payment of accrued period payments for continuing losses which are covered under this Plan will be made within thirty (30) days of the receipt by the Claim Administrator of proper written proof of loss for the applicable time period.

Payment of Benefits: To the Covered Person: All benefits available under this Plan are payable to the Covered Person whose Sickness, Injury or covered condition is the basis of a claim.

In the Event of the Death or Incapacity of the Covered Person: in the event of the death or incapacity of a Covered Person and in the absence of written evidence to the Claim Administrator of the qualification of a guardian for the Covered Person's estate, the Claim Administrator may, at its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Claim Administrator, is or was providing the care and support of such Covered Person.

If any benefit is payable to an estate, a minor or anyone not competent to give valid release, the Plan and/or any Plan Sponsor providing benefits to Covered Persons may pay such benefit, up to $1,000, to anyone related by blood or marriage that it considers equitably entitled. Any payment so made in good faith will discharge the Plan and any such Plan Sponsor to the extent of the payment.

Assignments: Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the person or institution rendering the medical services for which the expenses were incurred. No such assignment will bind the Claim Administrator prior to the payment of the benefits assigned. The Claim Administrator will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person and the assignee, has been received by the Claim Administrator before the proof of loss is submitted.

Assignments for Reference Based Pricing: Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered. An Assignment of

Benefits occurs when a Participant assigns their right to submit a request for benefits to the Plan to a services Provider. Assignment of Benefits should be provided to a Provider, and accepted by a Provider, as payment in and of itself, for services rendered. As such, Assignment of Benefits is itself consideration from the Participant to the Provider, and must be deemed payment in full in order to be achieved.

If benefits are paid directly to the Member, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

Note: By submitting a claim to the Third Party Administrator, the Provider is expressly agreeing to these provisions, and to be bound by these and all other provisions of the Plan.

If a Provider refuses to accept an Assignment of Benefits as compensation in full for services rendered, the Assignment of Benefits will be payable to the Member and not the Provider. If benefits are paid directly to the Member, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. In that event, the Member will be responsible for, and in addition to any copayments, coinsurance, and deductibles, any amount above the Plan's Reasonable amount, up to the Provider's charges.

The Plan pays the percentage listed on the following pages for Covered Benefits at the Reasonable reimbursement level. The Member is responsible for the difference between the percentage the Plan paid and 100% for the negotiated rate for Providers. For Providers, the Member is responsible for the difference between the percentage of the Reasonable Charge reimbursement level and 100% of the billed amount. The Member's portion of the coinsurance represents the out-of -pocket expenses.

The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant and the assignee, has been received before the proof of loss is submitted.

No Member shall, at any time, either during the time in which he or she is a Member in the Plan, or following his or her termination as a Member, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

If a Provider refuses to accept an Assignment of Benefits as compensation in full for services rendered, the Assignment of Benefits will be revoked and returned to the Participant such that benefits will be payable to the Participant and not the Provider. If benefits are paid directly to the Participant, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits.

The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

Discharge of Liability: Any payment made in accordance with the provisions of this Section shall fully discharge the liability of the Plan to the extent of such payment.

12.2 Claim Determination and Appeal Procedures.

Definitions of Terms (as they are used in this section)

Adverse Benefit Determination - Any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; or
- 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.

Claim – Any request for a Plan benefit, made by a Covered Person or by a representative of a Covered Person that complies with a Plan's reasonable procedure for making a Claim for benefits. A request for benefits includes a request for coverage determination, for pre-authorization or approval of a Plan benefit, or for a medical review determination in accordance with the terms of the Plan.

Clean Claim – A "Clean Claim" is one 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, or fees under review for Reasonable and Appropriateness 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 Plan Participant has failed to submit required forms or additional information to the Plan as well.

Claimant – Any Covered Person who submits a request for Plan benefits substantially in accordance with the Plan procedures for doing so. A Covered Person may appoint an authorized representative to act on his or her behalf pursuant to filing a Claim or appealing an Adverse Benefit Determination by furnishing the Claim Administrator with written notice of the appointment sufficient to identify the Claimant and the representative. All further communications from the Claim Administrator regarding the Claim shall be directed to the authorized representative instead of the Claimant, and all duties of the Claimant concerning such communications shall be assumed by the representative, until the appointment is rescinded in writing by either party. In the case of an Urgent Care Claim, a health care professional with knowledge of the Claimant's medical condition may act as an authorized representative without prior written notice of the

appointment, typically in situations where a Claimant is incapacitated and unable to act on his or her own behalf.

Concurrent Care Decisions – Any decision by the Plan to terminate or reduce benefits for a course of care approved for a certain period of time or number of treatments (for example, an inpatient hospital stay originally approved for 4 days which is later reduced to 2 days due to lack of medical necessity for continued confinement after some unforeseen change in the Claimant's situation). The Claim Administrator will notify the Covered Person of the Adverse Benefit Determination sufficiently in advance of the reduction or termination, when possible, to allow the Covered Person to appeal and obtain a determination on review of the initial decision before the benefit is reduced or terminated. Concurrent Care Decisions may be subject to the urgent care rules, if appealed by the Claimant under circumstances meeting the definition of an Urgent Care Claim.

Disability Claim – Certain Plan benefits are conditioned upon the Claimant demonstrating that he or she is affected by a disabling condition. While the actual benefit provided may be medical (for instance, extended coverage of hospitalization after loss of eligibility for totally disabled persons), the Plan's determination regarding the Claim shall be made under the time limit guidelines for Disability Claims, since deciding the validity of the disability must precede granting the Claimant any further benefits.

Post-Service Claim – Any Claim that involves only the payment or reimbursement of the cost for medical care that has already been provided. Post-Service Claims are never considered to be Urgent Care Claims, even when the benefit for which reimbursement is now sought had been provided on an emergency basis.

Pre-Service Claim – Any Claim submitted prior to provision of a covered benefit to the Claimant, when the terms of the Plan condition receipt of the benefit, in whole or in part, upon approval of the benefit in advance of obtaining medical care. A Pre-Service Claim will become reclassified as a Post-Service Claim at the time services are actually provided, regardless of when this might occur during the stages of Claim determination and appeal.

Urgent Care Claim – Any Pre-Service Claim with respect to which the application of the Plan's normal time limits for Claim determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, in the judgment of a physician with knowledge of the Covered Person's 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.

12.3 Time Limits for Claims Decisions and Appeals.

CLAIM ACTION	**TYPE OF CLAIM**			
	Urgent Care	***Pre-Service***	***Post-Service***	***Disability***
Initial Claim determination	As soon as possible, but never later than 72 hours following submission of claim	15 days	30 days	45 days
Maximum extension for initial Claim determination	None	Up to15 additional days	Up to15 additional days	Up to 60 additional days (30 days per extension)

Plan request for missing Claim information prior to initial determination	24 hours	5 days	30 days	45 days
Claimant response to Plan request for missing information (may be extended at Plan's reasonable discretion)	48 hours	45 days	45 days	45 days
Claimant appeal of Adverse Benefit Determination	180 days*	180 days	180 days	180 days
Plan determination regarding appeal	72 hours**	30 days	60 days	90 days (45 day period plus one 45 day extension when necessary)

**Not applicable to Concurrent Care Decisions being treated as Urgent Care Claims – appeal must be filed by Claimant within a shorter time period set at the Plan's reasonable discretion.*

***24 hours for Concurrent Care Decisions appealed at least 24 hours before the benefits of a previously approved course of care were to be reduced or eliminated.*

The period of time allowed for making a decision on a Claim begins when a Claim is filed in accordance with the reasonable filing procedures of the Plan (for Urgent Care and Pre-Service Claims, without regard to whether all of the information necessary to decide the Claim accompanies the filing). If the Claim Administrator needs an extension because of the failure of a Claimant to provide necessary information, counting towards the time period for the Plan's determination is suspended from the date on which notice of the missing information is sent to the Claimant until the date on which the Claimant responds to the notice.

If the Plan requires an extension on a Pre- or Post-Service Claim, due to matters beyond the control of the Plan, the Claimant will be notified, prior to the expiration of the appropriate initial Claim determination period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

12.4 Filing Appeals/Appeals Process. Claimants will have 180 days to file an appeal of an adverse benefit determination. The Plan's review of an Adverse Benefit Determination will be conducted according to the following guidelines:

- It shall be conducted by an appropriate named fiduciary who is neither the party who made the initial Adverse Benefit Determination, nor the subordinate of such party;
- The review shall not afford deference to the initial Adverse Benefit Determination; and

- The review shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.

In addition, consultation with an appropriately qualified health care professional is required on review of denied Claims involving medical judgments. The names of medical professionals consulted as part of the appeal process will be disclosed to the Claimant in the event of any Adverse Benefit Determination.

The Plan's notice to the Claimant of an Adverse Benefit Determination, at both the initial Claim and appealed Claim level, shall either state the protocol (internal rule or guideline) on which the denial was based or include a statement that a protocol was relied upon and that a copy of such protocol will be made available to the Claimant free of charge upon request.

A notice that a Claim is denied because it is not medically necessary, is experimental in nature, or due to some similar Plan exclusion or limitation shall either be accompanied by an explanation of the scientific or clinical judgment of the Claim Administrator in applying the terms of the Plan to the Claimant's medical circumstances, or include a statement that such an explanation will be provided free of charge to the Claimant on request. Additionally, the notice will include a statement notifying Claimants that they can seek additional information about potential alternative dispute resolution methods.

The Claim Administrator will provide to a Claimant, upon request after issuing an adverse benefit determination, any information that the Claim Administrator has generated or obtained in the process of ensuring and verifying that, in making the particular determination, the Plan complied with its own administrative processes and safeguards that ensure consistent decision-making.

The Claim Administrator shall provide Claimants, upon request, with all relevant documents and other information that were consulted during the determination process, or were submitted to the Claim Administrator, considered by the Claim Administrator, or generated by the Claim Administrator, without regard to whether such documents or other information were actually relied upon in making the determination.

12.5 External Review Process.

Scope.

- 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.
- 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).

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

- **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.

- **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.

- **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 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.
- **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.

Expedited external review.

- **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.

- **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.
- **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.
- **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.

12.6 Incomplete Claims/Notice Requirement

Urgent Care Claims – If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claim Administrator shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The Claimant will be afforded a reasonable amount of time, but not less than 48 hours, to provide the specified information. The Claimant will be notified of the Claim Administrator's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

- The Plan's receipt of the specified information, or
- The end of the period of time afforded the Claimant to provide the specified missing information.

Pre-Service Claims – A notice will also be provided to the Claimant if they have improperly filed a Claim that involves a Pre-Service Claim. This notification shall be provided as soon as possible, but no later than 5 days following receipt of the Claim. Notification by the Claim Administrator may be oral, unless written notification is requested by the Claimant or the Claimant's authorized representative. This notice is issued only when the Claim names a specific Claimant, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested, and the communication is directed to the Claim Administrator.

Post-Service Claims – If the Claimant files an incomplete Claim, causing the Plan to require an extension of time, the notice of extension to the Claimant shall specify the required information, and the Claimant will be given at least 45 days from receipt of the notice to provide the specified information. This notice will be provided by the Claim Administrator within the time limit allowed for initial Claim determinations. At the Claim Administrator's reasonable discretion, an incomplete Post-Service Claim may simply be denied instead, and a notice of the Adverse Benefit Determination will be issued without a prior request to the Claimant for the missing information. In this event, the Claimant would have the opportunity to submit such omitted information in an appeal of the Adverse Benefit Determination.

Notice Requirements. Unless specifically noted, all notifications to Claimants regarding benefit decisions will be in written form (including transmission via electronic media such as e-mail, when feasible and appropriate).

Legal Action. Legal Action regarding any Claim determination may not be brought until the Plan's appeals procedure has been exhausted. If a Claimant fails to follow these procedures for appealing denied claims, or fails to do so within any of the time limits set forth in this section, the Claimant will have given up his or her rights to bring suit against the Plan or its agents. The Claimant may not transfer his Right to appeal or Right to Legal Action to a third party, such as a provider or an attorney.

Assignments. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

12.7 Recovery of Payments. Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- In error;
- Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- With respect to an ineligible person;
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

12.8 In the Event of Early Termination of the Plan. If the Plan terminates prior to the end of its contract period, any Plan Benefits Incurred or Paid after the termination date will not be eligible for reimbursement.

Article 13. Coordination of Benefits

This coordination of benefits (COB) provision applies when a Covered Person has health care coverage under more than one plan. For the purposes of this provision, "plan" is defined below.

The order of benefit determination rules below determines which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits is pays so that payments from all group plans do not exceed 100% of the total allowable expense.

13.1 Definitions

- A "plan" is any of the following that provides benefits or services for medical care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered as parts of the same plan and there is not COB among those separate contracts.
    - "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
    - "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); Hospital indemnity insurance; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies and coverage under other governmental plans, unless permitted by law.
- The order of benefit determination rules determine whether this plan is a "primary plan" or a "secondary plan" when compared to another plan covering the Covered Person.

When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

- "Allowable expense" means the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section herein, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for Hospital private rooms) is not an allowable expense.
b. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

c. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.
e. The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, pre-certification of admissions, and preferred provider arrangements.

- "Claim determination period" means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.
- "Closed panel plan" is a plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

13.2 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.

13.3 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. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. 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.

13.4 Order of Benefit Determination Rules. When two or more plans pay benefits, the rules for determining the order of payments are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of

membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
    a. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, members, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
    b. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:
        - The primary plan is the plan of the parent whose birthday is earlier in the year if:
        - The parents are married;
        - The parents are not separated (whether or not they have ever been married); or
        - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

        If both parents have the same birthday, the plan that covered either of the parents longer is primary.

    c. Active or inactive employee. The plan that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled B 1.
    d. Continuous coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
    e. Longer or shorter length of coverage. The plan that covered the person as an employee, member, subscriber or retiree longer is primary.
    f. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this Plan will not pay more than it would have paid had it been primary.

13.5 Effect on the Benefits of this Plan. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be

recorded as a benefit reserve for the Covered Person and used by this Plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Plan will:

a. Determine its obligation to pay or provide benefits under its contract;
b. Determine whether a benefit reserve has been recorded for the Covered Person; and
c. Determine whether there are any unpaid allowable expenses during that claim determination period.

If there is a benefit reserve, the secondary plan will use the Covered Person's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

If a Covered Person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

13.6 Right to Receive and Release Needed Information. Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Claim Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Claim Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claim Administrator any facts it needs to apply these rules and determine benefits payable.

13.7 Facility of Payment. A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Claim Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Claim Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

13.8 Right of Recovery. If the amount of payments made by the Claim Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Article 14. Medicare

14.1 Applicable to Active Employees and Their Spouses Ages 65 and Over. An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

14.2 Applicable to All Other Participants Eligible for Medicare Benefits. To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payer (as described under the Article entitled "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare approved expenses.

14.3 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan. If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges incurred on or after February 1, 1991 and before August 5, 1997), and for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

Article 15. Third Party Liability and Recovery

15.1 Payment Condition. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(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").

Plan Participant(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 Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(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 Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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 Plan Participant(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.

15.2 Subrogation. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(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 Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(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.

If the Plan Participant(s) fails to file a claim or pursue damages against:

- The responsible party, its insurer, or any other source on behalf of that party;

- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Workers' compensation or other liability insurance company; or
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(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.

15.3 Right of Reimbursement. 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 Plan Participant(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 Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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.

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 Plan Participant(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.

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 Plan Participant(s).

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 sickness, injury, disease or disability.

15.4 Excess Insurance. If at the time of injury, sickness, 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:

- The responsible party, its insurer, or any other source on behalf of that party;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Worker's compensation or other liability insurance company; or

- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

15.5 Separation of Funds. Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(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.

15.6 Wrongful Death. In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is 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 Plan Participant(s) and all others that benefit from such payment.

15.7 Obligations.

It is the Plan Participant(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 sickness, 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 Plan Participant may have against any responsible party or Coverage.

If the Plan Participant(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 Plan Participant(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 Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

15.8 Offset. Failure by the Plan Participant(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 Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

15.9 Minor Status. In the event the Plan Participant(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.

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.

15.10 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.

15.11 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.

Article 16. General Provisions of the Medical Plan

16.1 Participant's Responsibilities. Each Participant is responsible for providing the Claim Administrator and the Plan Administrator with his or her current address. Any notices required or permitted to be given shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Claim Administrator nor the Plan Administrator shall have any obligation or duty to locate a Participant. If a Participant becomes entitled to payment under the Plan and it cannot be made because:

- The current address is incorrect;
- The Participant does not respond to the notice sent to the current address;
- There are conflicting claims to such payment; or
- Any other reason;

The amount of such payment, if and when made, shall be that determined under the applicable Plan provisions, without interest.

16.2 Notice of Claim. Written notice of claim must be given to the Claim Administrator within twenty (20) days after a claim starts or as soon as reasonably possible. Notice should be sent to the Claim Administrator at its address with information sufficient to identify the Covered Person. The Claim Administrator will consider this as the required notice to the Plan.

16.3 Proof of Loss. Written Proof of Loss must be given to the Claim Administrator within ninety (90) days of claim. If it is not possible to give Proof of Loss within ninety (90) days, the Claim Administrator will not deny the claim provided Proof of Loss is given as soon as is reasonably possible. In any case, Proof of Loss must be sent no later than six (6) months from the time specified, unless the Claimant is legally incapacitated.

16.4 Timely Payment of Claim. Payments for covered claims will be made as they accrue, in accordance with the provision of the previous section of this document entitled “Claim Payment Procedures.” Any balance unpaid at the end of liability will be paid on receipt of written Proof of Loss.

16.5 Grace Period. After payment of the first contribution, any Provider providing benefits to the Plan will allow the Employer a grace period of thirty-one (31) days following a contribution due date to pay subsequent contributions. During this grace period, the Plan will remain in force. The Employer will be liable for payment of contributions for the period the Plan continues in force.

16.6 Fraud. The following actions by any Participant, or a Participant’s 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 the Participant is a member:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan;
- Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which 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.

16.7 Legal Action. No legal action will be brought to recover benefits under the Plan prior to the expiration of sixty (60) days after written Proof of Loss has been furnished, and the Appeals Process (see page 37) has been completed. No such action will be brought after the expiration of three (3) years following the time written Proof of Loss is required to be furnished.

16.8 Workers' Compensation. The Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

16.9 Plan Booklets. The Employer will issue, or make available for delivery to each Covered Person, individual copies of this Summary Plan Description describing the benefits to which Covered Persons are entitled and to whom such benefits will be payable. The Summary Plan Description will also be made available at www.benelect.com.

16.10 Limitation of Liability. The Plan shall not be obligated to pay any benefits under the Plan for any claims if the Proof of Loss for such claim was not submitted within the specified time period, unless it is shown that (1) it was not reasonably possible to have submitted the Proof of Loss within such time period, and (2) the Proof of Loss was submitted as soon as it was reasonably possible.

In no event will the Plan be obligated to pay benefits for any claim if the Proof of Loss for such claim is not submitted to the Plan within six (6) months after the date of loss, except in the case of legal incapacity of the Covered Person.

16.11 Physical Examinations. The Claim Administrator reserves the right to have a Doctor of its own choosing examine any Covered Person whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Claim Administrator. This right may be exercised when and as often the Claim Administrator may reasonably require during the pendency of a claim. The opportunity to exercise this right shall be a condition precedent to obtaining payment of benefits for the claim.

16.12 Autopsy. The Employer reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Sickness or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

16.13 Statements. All statements made by the Company or by a Plan Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Plan Participant.

Any Plan Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Plan Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

16.14 Secondary Coverage. Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which are payable by such secondary coverage when said coverage is primary, except to the extent that such costs are payable in any event by the Plan.

Article 17. Important Info. Regarding Your ERISA Rights

17.1 Your ERISA Rights. As a Participant in your Employer's Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

17.2 Receive Information about Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated 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 Participant with a copy of this summary annual report.

17.3 Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary Plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

17.4 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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 Plan Participants and beneficiaries. No one, including your 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 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims and appeal procedures available to you under the Plan (discussed under the heading "Claim Determination and Appeal Procedures"), you may file suit in a state or Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should 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.

17.5 Assistance with Your Questions.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 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.

17.6 Additional Employee Benefits Security Administration Contact Information:

Employee Benefits Security Administration Toll-free Hotline: 1-866-444-EBSA (3272)

Division of Technical Assistance and Inquiries: (202) 219-8776

Office of Participant Assistance and Communications
Public Disclosure Room
200 Constitution Avenue, N.W., Suite N-1513
Washington, DC 20210
Phone: (202) 219-8673

Article 18. Your Continuation Coverage Rights Under COBRA

18.1 Introduction. The following information describes your right to continue your group health care coverage. This information is very important. Please read it carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan in certain circumstances when that coverage would otherwise end. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, also known as COBRA. COBRA continuation coverage can become available to you in certain circumstances when you would otherwise lose your group health coverage under the Plan. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA continuation coverage, when it may become available to you and other family members covered under the Plan, and what you need to do to protect your right to receive this coverage. Please note that the Plan provides no greater COBRA continuation coverage rights than what COBRA requires, and nothing in this description of COBRA should be understood to expand your rights beyond what COBRA requires.

The Plan provides medical and prescription drug coverage, and you are enrolled in the PPO Plan. COBRA (and the description of COBRA coverage contained in this Summary Plan Description) applies only to the medical and prescription drug coverage under the PPO Plan. COBRA does not apply to any other benefits offered by your Employer such as life insurance, disability insurance or accidental death and dismemberment benefits.

For additional information about your rights and obligations under the Plan and under federal law with respect to COBRA, contact the Plan Administrator.

18.2 What Is COBRA Continuation?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA Continuation Coverage?"

COBRA continuation coverage is the same group health coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the component(s) of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage. Your Employer will not pay any part of the cost of a qualified beneficiary's COBRA continuation coverage.

After a qualifying event occurs and any required notice of that event is properly provided to your Employer, COBRA continuation coverage must be offered to each person who loses or will lose coverage under the Plan who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA continuation coverage if coverage under the Plan is lost because of the qualifying event. Also, if a child is born to you or adopted by you or placed for adoption with you during a period of COBRA continuation coverage, or if you are required to provide coverage to a child under the terms of a Qualified Medical Child Support Order (QMCSO), that child may become a qualified beneficiary. This is discussed in greater detail in separate paragraphs below.

For purposes of this description of COBRA continuation coverage, the pronoun "you" in the following paragraphs refers to each person who is covered under the Plan who is or may become a qualified beneficiary.

18.3 Who Is Entitled to Elect COBRA Continuation Coverage?

If you are an employee, you will become a qualified beneficiary and entitled to elect COBRA continuation coverage if you lose your group health 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 an employee, you will become a qualified beneficiary and entitled to elect COBRA continuation coverage if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse. If an employee reduces or eliminates group health coverage for a spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered the qualifying event for the spouse, even though the spouse's coverage under the Plan was reduced or eliminated before the occurrence of the divorce or legal separation. If the spouse notifies the Plan Administrator within 60 days after the divorce or legal separation and can establish that the employee earlier reduced or eliminated the spouse's coverage under the Plan in anticipation of the divorce or legal separation, then COBRA continuation coverage may be available for the period after the divorce or legal separation.

If you are the dependent child of an employee and you are enrolled in the Plan, you will become a qualified beneficiary and entitled to elect COBRA continuation coverage if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your parent-employee dies;
- Your parent-employee's hours of employment are reduced;
- Your parent-employee's employment ends for any reason other than his or her gross misconduct;
- Your parents become divorced or legally separated; or
- You stop being eligible for coverage under the Plan as a "dependent child."

18.4 COBRA Continuation Coverage and the Family and Medical Leave Act

If an employee takes an approved leave under the Family and Medical Leave Act (FMLA) and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA continuation coverage if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered under the Plan during the FMLA leave); and (2) they will lose coverage under the Plan within 18 months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA continuation coverage at the end of the FMLA leave even if they were not covered under the Plan during the FMLA leave.) COBRA continuation coverage elected in these circumstances will begin on the last day of the FMLA leave, with the

same 18-month maximum COBRA coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction in hours of employment. (See the section below entitled "Length of COBRA Continuation Coverage."

18.5 Special Second COBRA Election Period for Certain Eligible Employees

Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) because of a loss of employment or reduction in hours of employment resulting from worker displacement due to international trade competition. If these individuals did not already elect COBRA continuation coverage following the termination of employment or reduction in hours of employment, these individuals are entitled to a second opportunity to elect COBRA continuation coverage for themselves and certain family members during a special second election period. This special second COBRA election period lasts for 60 days and begins on the first day of the month in which the employee or former employee becomes eligible for TAA or ATAA , but only if the COBRA election is made within the six month period beginning with the individual's loss of group health coverage under the Plan. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the Plan Administrator using the Plan contact information provided below. CONTACT THE PLAN ADMINISTRATOR PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE THE RIGHT TO ELECT COBRA CONTINUATION COVERAGE DURING A SPECIAL SECOND COBRA ELECTION PERIOD.

18.6 When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified in a timely manner that a qualifying event has occurred.

When the initial qualifying event is the end of employment or reduction of hours of employment death of the employee, your Employer must notify the Plan Administrator of the qualifying event. You do not need to notify your Employer of the occurrence of any of these three qualifying events.

For the other initial qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify your Employer in writing within 60 days after the later of the date of the qualifying event or the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

You must provide this notice in writing by appropriately completing the Plan's form entitled "Notice of A COBRA-Related Event" or comparable Notice prepared by your Employer. You must follow the procedures specified below in the section entitled "Notice Procedures." Oral notice, including notice by telephone, is not acceptable. If you do not follow these procedures or if you fail to provide written notice to the Plan Administrator within the 60-day notice period, YOU AND ANY OTHER FAMILY MEMBERS WHO WOULD OTHERWISE BE QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHTS UNDER COBRA, INCLUDING THE RIGHT TO ELECT COBRA CONTINUATION COVERAGE.

18.7 How To Elect COBRA Continuation Coverage

If notice is properly given in a timely manner when a qualifying event happens, CONEXIS will send a COBRA Election Notice to the qualified beneficiaries affected by the qualifying event. To elect COBRA continuation coverage, you must complete the COBRA Election Form that is part of the Plan's COBRA Election Notice and submit it to CONEXIS. Under federal law, you must have at least 60 days after the date of the COBRA Election Notice provided to you as a result of your qualifying event in which to decide whether to elect COBRA continuation coverage under the Plan.

You must mail the completed COBRA Election Form to:

CONEXIS
P.O. Box 226466
Dallas, TX 75222-6466
Or email customerdelivery@CONEXIS.com

The COBRA Election Form must be completed in writing and mailed to the department and address specified above. The following are not acceptable as COBRA elections and will not preserve your COBRA rights: oral communications regarding COBRA continuation coverage, including in-person or telephone statements regarding an individual's COBRA continuation coverage or his or her decision to elect COBRA continuation coverage; and electronic communications, including e-mail and faxed communications.

If mailed, the envelope containing your COBRA Election Form must be postmarked no later than 60 days after the date of the COBRA Election Notice provided to you following your qualifying event. IF YOU DO NOT SUBMIT A FULLY COMPLETED COBRA ELECTION FORM WITHIN THE 60-DAY PERIOD DESCRIBED IN THIS PARAGRAPH, YOU WILL FORFEIT YOUR STATUS AS A QUALIFIED BENEFICIARY AND LOSE YOUR RIGHT TO ELECT COBRA CONTINUATION COVERAGE.

If you reject COBRA continuation coverage before the end of the 60-day COBRA election period described in the preceding paragraph, you may change your mind and elect COBRA continuation coverage as long as you furnish a fully completed COBRA Election Form to CONEXIS before the end of the 60-day period described in the preceding paragraph. However, if you reject COBRA continuation coverage in writing and then change your mind, your COBRA continuation coverage will be retroactive to the date of your election; it will not be retroactive to the date of your loss of coverage under the Plan. This may result in a gap in your group health coverage under the Plan and claims for services incurred during the gap in your coverage will not be covered under the Plan.

You do not have to send any premium payment with your COBRA Election Form when you elect COBRA continuation coverage. Important additional information regarding the cost of COBRA continuation coverage and when and how you must pay for it is included below.

Once the Plan Administrator receives a timely notice that a qualifying event has occurred, the Plan Administrator will offer COBRA continuation coverage to each of the qualified beneficiaries who lost (or will lose) coverage under the Plan because of the occurrence of the qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. For example, the covered employee's spouse may elect COBRA continuation coverage even if the covered employee does not. A parent may elect COBRA continuation coverage for only one, several or all dependent children who are qualified beneficiaries. However, individual elections are not necessarily required. For example, a covered employee and spouse (if the spouse is a qualified beneficiary) may elect COBRA continuation coverage on behalf of all qualified beneficiaries in the family. Any qualified beneficiary for whom COBRA continuation coverage is not elected within the 60-day election period specified in the Plan's COBRA Election Notice WILL FORFEIT THEIR STATUS AS A QUALIFIED BENEFICIARY AND LOSE HIS OR HER RIGHT TO ELECT COBRA CONTINUATION COVERAGE.

When you complete the COBRA Election Form, you must notify CONEXIS if any qualified beneficiary has become entitled to benefits under Medicare (Part A, Part B or both) and, if so, the date of the individual's Medicare entitlement. If you become entitled to benefits under Medicare (or first learn that you are entitled to benefits under Medicare) after submitting the Election Form, you must immediately notify CONEXIS of the date of your Medicare entitlement at the address specified above for delivery of the COBRA Election Form.

Qualified beneficiaries may be enrolled in one or more group health care components of the Plan at the time a qualifying event occurs. A qualified beneficiary who is entitled to elect COBRA continuation coverage as a result of a qualifying event may elect COBRA continuation coverage under any or all of the group health care components of the Plan under which he or she was covered on the day before the occurrence of the qualifying event.

Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they have other group health plan coverage in effect or are entitled to benefits under Medicare (under Part A, Part B or both) on or before the date they elect COBRA continuation coverage. However, as discussed in more detail below, a qualified beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA continuation coverage, he or she becomes covered under another group health plan or becomes entitled to benefits under Medicare (under Part A, part B or both). See the section below entitled "Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period."

18.8 Special Considerations in Deciding Whether to Elect COBRA Continuation Coverage

In deciding whether to elect COBRA continuation coverage, you should take into account that a failure to elect COBRA continuation coverage will affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under this Plan ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you elect and pay for COBRA continuation coverage for the maximum time available to you.

18.9 How Long COBRA Continuation Coverage Will Last

COBRA continuation coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA continuation coverage can end before the end of the maximum COBRA coverage period for several reasons, which are described in the section entitled "Termination of COBRA Continuation Coverage before the End of the Maximum COBRA Coverage Period."

When the qualifying event is the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.

When the qualifying event is a termination of employment or reduction of hours of employment, and the employee became entitled to benefits under Medicare (under Part A, Part B, or both) less than 18 months before the qualifying event, then COBRA continuation coverage for qualified beneficiaries (other than the employee) may last up to 36 months after the date of the employee's entitlement to Medicare benefits. For example, if a covered employee becomes entitled to benefits under Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children who lost coverage under the Plan due to the employee's termination of employment can last up to 36 months after the date of the employee's Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA continuation coverage for the covered spouse and any covered dependent children is available only if the covered employee becomes entitled to benefits under Medicare within 18 months before the employee's termination of employment or reduction in hours of employment. In this situation, the covered employee's maximum COBRA coverage period will be 18 months from the later of the date of his or her loss of coverage under the Plan.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally may last for only up to a total of 18 months.

18.10 Extension of the Maximum COBRA Coverage Period

There are three ways in which the 18-month maximum COBRA coverage period resulting from a qualifying event that is a termination of employment or a reduction in hours of employment can be extended.

If the initial qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction in hours of employment, an extension of the maximum COBRA coverage period may be available if a qualified beneficiary is disabled or if a second qualifying event occurs within the COBRA coverage period. You must notify your Employer in a timely manner of a disability or of the occurrence of a second qualifying event in order to extend the period of COBRA continuation coverage. If you fail to provide timely notice of a disability or of a second qualifying event, you will lose your right to extend the COBRA coverage period beyond the 18 months required for an initial qualifying event that is a termination of employment or reduction in hours of employment.

Also, please note that an extension in the COBRA coverage period is not available under any circumstances if the qualifying event is the employee's death, divorce or legal separation from the covered employee or a dependent child's loss of eligibility under the Plan.

18.11 Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum COBRA coverage period of 29 months. This extension of the COBRA coverage period is available only for qualified beneficiaries who are receiving COBRA continuation coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours of employment. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours of employment and must last at least until the end of the 18-month period of continuation coverage resulting from the initial qualifying event. Each qualified beneficiary in your family will be entitled to the disability extension if one of them qualifies.

The additional 11 months of COBRA continuation coverage will be available as long as the disabled individual continues to be disabled. For example, if the Social Security Administration subsequently makes a final determination that the disabled individual is no longer disabled, and the cessation of disability occurs before the end of the 11th month of additional coverage (but after the 18th month of COBRA continuation coverage resulting from the initial qualifying event), then the Plan Administrator will terminate the COBRA continuation coverage for all qualified beneficiaries in your family as of the first day of the month that is more than 30 days after the date of the Social Security Administration's final determination that the disabled qualified beneficiary is no longer disabled. However, if the Social Security Administration's final determination that the disabled individual is no longer disabled is made before the end of the first 18 months of COBRA continuation coverage, then the disabled qualified beneficiary and all other qualified beneficiaries in the same family will be entitled only to a maximum COBRA coverage period of 18 months.

The disability extension of the COBRA coverage period is available only if you notify the Plan Administrator in writing of the Social Security Administration's disability determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction in hours of employment; or

- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the covered employee's termination of employment or reduction in hours of employment.

In addition, you must provide the Plan Administrator with this written notice of the Social Security Administration's disability determination within 18 months after the covered employee's termination of employment or reduction in hours of employment in order to be entitled to the disability extension of the COBRA coverage period. If you provide notice to the Plan Administrator of the Social Security Administration's disability determination at a date more than 18 months after the covered employee's termination of employment or reduction in hours of employment, you will not be entitled to the disability extension of the COBRA coverage period, even if you provided the notice within 60 days after receiving the Social Security Administration's disability determination.

You must provide your Employer with written notice of the disability by appropriately completing the Plan's "Notice of A COBRA-Related Event," or comparable notice provided by your employer, and you must follow the procedures specified in the section below entitled "Notice Procedures." If you do not follow these procedures or if you fail to provide written notice to the Plan Administrator within the 60-day notice period (and within 18 months after the covered employee's termination of employment or reduction in hours of employment), THEN YOU WILL NOT BE ENTITLED TO THE DISABILITY EXTENSION OF YOUR COBRA CONTINUATION COVERAGE. (You may obtain a copy of the Notice to your Employer from the Plan Administrator.)

18.12 Second qualifying event extension of 18-month (or 29-month) period of continuation coverage

If a second qualifying event occurs during the 18 months (or, in the case of a disability extension, 29 months) of COBRA continuation coverage resulting from an initial qualifying event that is the covered employee's termination of employment or reduction in hours of employment, an extension of the COBRA coverage period will be available to the spouse and dependent children who are receiving COBRA continuation coverage. The maximum period of COBRA continuation coverage available when a second qualifying event occurs during the initial 18 months of COBRA continuation coverage (or during the first 29 months if the COBRA coverage period was extended due to a disability) is 36 months. Such second qualifying events may include the death of the employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage under the Plan as a dependent. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to benefits under Medicare, because under the terms of the Plan Medicare entitlement does not result in the employee losing coverage under the Plan.)

For second qualifying events (death of the employee, divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would lose coverage under the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

You must provide this notice by appropriately completing the Notice to your Employer and you must follow the procedures specified in the section below entitled "Notice Procedures." If you do not follow these procedures or if you fail to provide written notice to the Plan Administrator within the 60-day notice period, THEN YOUR SPOUSE OR DEPENDENT CHILDREN WILL NOT BE ENTITLED TO AN EXTENSION OF THEIR COBRA CONTINUATION COVERAGE DUE TO THE OCCURRENCE OF A SECOND QUALIFYING EVENT. (You may obtain copies of the Notice to your Employer and of the "Notice Procedures" from the Plan Administrator.)

Termination of COBRA Continuation Coverage Before the End of the Maximum COBRA Coverage Period

CONEXIS will automatically terminate your COBRA continuation coverage before the end of the maximum COBRA coverage period if:

- You do not pay the required premium in full in a timely manner;
- After electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan;
- After electing COBRA continuation coverage, a qualified beneficiary becomes entitled to benefits under Medicare (Part A, part B or both);
- YOUR EMPLOYER ceases to provide any group health plan for its employees; or
- During a disability extension period, the Social Security Administration makes a final determination that a qualified beneficiary previous determined to be disabled is no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of the Maximum COBRA Coverage Period.

YOUR EMPLOYER may also terminate your COBRA continuation coverage for any reason that the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (for example, filing fraudulent claims).

You must notify YOUR EMPLOYER in writing within 30 days if, after electing COBRA continuation coverage, a qualified beneficiary becomes entitled to benefits under Medicare (Part A, Part B or both) or becomes covered under another group health plan. You must provide this notice by using the Plan's "Notice of A COBRA-Related Event," or similar form provided by your Employer, and you must follow the procedures specified below in the section entitled "Notice procedures." You may also obtain a copy of the Notice from the Plan Administrator at no charge upon request.

Your COBRA continuation coverage will terminate (retroactively if applicable) as of the date of the qualified beneficiary's entitlement to benefits under Medicare (Part A, Part B or both) or as of the effective date of the other group health plan coverage. YOUR EMPLOYER will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provided notice to YOUR EMPLOYER of the Medicare entitlement or the other group health plan coverage.

If the Social Security Administration determines that a disabled qualified beneficiary is no longer disabled, you must notify EDIS of that fact within 30 days after the date of the Social Security Administration's determination that the disabled qualified beneficiary is no longer disabled.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA continuation coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. YOUR EMPLOYER will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provided notice to YOUR EMPLOYER that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of the Maximum COBRA Coverage Period").

18.13 Cost of COBRA Continuation Coverage

Each Qualified Beneficiary is required to pay the entire cost of COBRA continuation coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. The amount of your COBRA premiums may

change from time to time during your period of COBRA continuation coverage and will most likely increase over time. You will be notified of COBRA premium changes.

18.14 Payment for COBRA Premiums

All COBRA continuation coverage premiums must be paid by check.

Your initial COBRA premium payment and all subsequent monthly COBRA premium payments must be mailed to:

CONEXIS
P.O. Box 226466
Dallas, TX 75222-6466

If mailed, your payment is considered to have been made on the date that the envelope containing your check is postmarked. You will not be considered to have made any payment by mail of a check if your check is returned due to insufficient funds or otherwise.

If you elect COBRA continuation coverage, you do not have to send any payment with the COBRA Election Form. However, you must make your initial payment for COBRA continuation coverage not later than 45 days after the date of your election. This is the date the COBRA Election Form is post-marked if you mail it back to us, the date embedded in the fax transmittal if you fax the COBRA Election Form back to us, or the date your COBRA Election Form is received by the individual specified above if you hand-deliver the notice to us. See the section above entitled "How to Elect COBRA Continuation Coverage."

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the Plan would otherwise have terminated up through the end of the month before the month in which you must make your initial COBRA premium payment. For example, assume your group health coverage terminates on September 30, and you lose your group coverage under the Plan on September 30. You must elect COBRA continuation coverage by November 29 (60 days after your loss of coverage). If you elect COBRA continuation coverage on November 29, your must make your initial COBRA premium payment on or before January 13 (45 days after your COBRA election). Your initial COBRA premium payment must be in an amount equal to the monthly premiums for October, November and December. You are responsible for making sure that the amount of your first payment is correct. You may contact CONEXIS using the contact information provided below to confirm the correct amount of your first COBRA premium payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA continuation coverage and made the initial payment for the COBRA continuation coverage.

If you do not make your initial payment for COBRA continuation coverage in full within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. (You may choose to pay the initial COBRA premium in two or more "installments" provided only that you pay the full amount of your initial COBRA premium on or before the 45th day after you elect COBRA continuation coverage.)

After you make your initial payment for COBRA continuation coverage, you will be required to make monthly payments for each subsequent month of COBRA continuation coverage. In the above example, you would be responsible for making monthly COBRA premium payments beginning with the monthly COBRA premium payment for January (since this premium for January was not included in the amount of the initial COBRA premium payment). The amount due for each month for each qualified beneficiary will be specified in the COBRA election notice you receive following your initial qualifying event. Under the Plan, each of these monthly payments for COBRA continuation coverage is due on the first day of the month for that month's coverage period. If you make a monthly COBRA premium payment on or before the first day of the month to which it applies, your COBRA continuation coverage under the Plan will continue for that month without any

break. CONEXIS will not send periodic notices of payments due for these coverage periods, nor will CONEXIS otherwise bill you for your COBRA continuation coverage. It is your responsibility to pay your COBRA premiums on time.

Although monthly COBRA premium payments are due on the on the first day of each month of COBRA continuation coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

If you fail to make a monthly COBRA premium payment before the end of the grace period for that month, you will lose all rights to COBRA continuation coverage under the Plan.

18.15 More Information About Individuals Who May Be Qualified Beneficiaries

Children Born To or Placed for Adoption with the Covered Employee During a Period of COBRA Continuation Coverage

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA continuation coverage for himself or herself. (If the covered employee is a qualified beneficiary but the covered employee has not elected COBRA continuation coverage, then a child born to, adopted by, or placed for adoption with the covered employee during another family member's period of COBRA continuation coverage will not be considered a qualified beneficiary.) The newborn or adopted child's COBRA continuation coverage begins when the child is enrolled in the Plan, whether under the special enrollment rights mandated by the Health Insurance Portability and Accountability Act (HIPAA) or during an open enrollment period, and the new born or adopted child's COBRA continuation coverage lasts as long as COBRA coverage lasts for other family members who have previously elected COBRA continuation coverage. To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements of the Plan (for example, regarding attained age or student status).

Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by YOUR EMPLOYER during the covered employee's period of employment with YOUR EMPLOYER is entitled to the same rights to elect COBRA continuation coverage as an eligible dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent under the eligibility requirements of the Plan.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

18.16 Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep YOUR EMPLOYER informed of any changes in the addresses of family members. You must do this by submitting a fully completed Change of Address form to YOUR EMPLOYER. The Change of Address form is available upon request from YOUR EMPLOYER at no charge. You should also keep a copy, for your records, of any notices you send to YOUR EMPLOYER.

18.17 Plan Contact Information

You may obtain information about the Plan and COBRA continuation coverage on request from:

Contract Administrator

EDIS
P.O. Box 7809
Visalia, CA 93290
Phone: (888) 886-7973

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description. If you are not sure whether this is the Plan's most recent Summary Plan Description, you may request the most recent one from YOUR EMPLOYER.

18.18 Notice Procedures: Notice to Your Employer

You must provide notice to YOUR EMPLOYER of certain qualifying events and of other events that affect the continuation or duration of your COBRA continuation coverage. These qualifying events and other events are described below.

Specifically, you must use this Notice to inform YOUR EMPLOYER of the following:

- Certain **initial** qualifying events:
    - A divorce or legal separation of the covered employee and the covered spouse; or
    - A covered dependent child ceasing to be a dependent under the terms of the Plan;
- The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA continuation coverage with a maximum COBRA coverage period of 18 or 29 months; and
- The occurrence of the following events which may affect the continuation or duration of a qualified beneficiary's COBRA continuation coverage after COBRA has been elected:
    - After electing COBRA, a qualified beneficiary becomes covered under another group health plan;
    - After electing COBRA, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);
    - The determination by the Social Security Administration that a qualified beneficiary who is entitled to COBRA continuation coverage with a maximum COBRA coverage period of 18 months is disabled at any time during the first 60 days of COBRA continuation coverage; and
    - The final determination by the Social Security Administration that a qualified beneficiary previously determined to be disabled is no longer disabled.

Oral notice of any event listed above, including notice by telephone, is not acceptable. Electronic notice via e-mail of any event listed above is not acceptable. Your Employer may require completion of a form, such as "Notice to your Employer" or similar written documentation.

Please note that you do not need to notify YOUR EMPLOYER of an initial qualifying event that is the end of employment or reduction of hours of employment or the death of the employee. Instead, YOUR EMPLOYER must notify the Plan Administrator of these three initial qualifying events.

The procedures and deadlines for providing the Notice of the different COBRA-related events are described below.

Procedure for Giving Notice of an Initial Qualifying Event that is a Divorce, Legal Separation or Loss of Dependent Status

When the initial qualifying event is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child under the terms of the Plan, you must notify YOUR EMPLOYER in writing within 60 days after the later of (1) the date of the qualifying event or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

If the initial qualifying event is a divorce or legal separation, you must include a copy of the decree of divorce or legal separation with your notice to the Employer.

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you wish to notify YOUR EMPLOYER that your coverage under the Plan was reduced or eliminated in anticipation of the divorce or legal separation, you must provide the Notice within 60 days of the divorce or legal separation in accordance with these Notice Procedures, and in addition you must provide evidence satisfactory to YOUR EMPLOYER that your coverage under the Plan was reduced or eliminated in anticipation of the divorce or legal separation.

If the initial qualifying event is a dependent child's loss of eligibility under the terms of the Plan, you must provide documentation of the date of the qualifying event that is satisfactory to YOUR EMPLOYER. Examples of satisfactory documentation include:

- A birth certificate to establish the date that a child reached the limiting age under the terms of the Plan;
- A marriage certificate to establish the date that a dependent child married; or
- A transcript showing the last date of enrollment in an educational institution.

Such documentation will allow YOUR EMPLOYER to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA continuation coverage.

If you provide YOUR EMPLOYER with a written notice of an initial qualifying event that does not contain all of the information required by these Notice Procedures, the Plan will nevertheless consider your notice to be timely if all of the following conditions are met:

- The notice is mailed, faxed or hand-delivered to the individual and address specified above;
- The notice is provided by the deadline specified above;
- From the written notice provided, YOUR EMPLOYER is able to determine that the notice relates to the Plan;
- From the written notice provided, YOUR EMPLOYER is able to identify the covered employee and the qualified beneficiary(ies), the nature of the initial qualifying event and the date on which the initial qualifying event occurred; and
- The notice is supplemented in writing with the additional information and/or documentation necessary to meet the Plan's requirements (as described in these Notice Procedures). If the Plan requests additional information or documentation, you must provide the additional information or documentation within 15 business days after YOUR EMPLOYER's written or oral request to provide the information (or, if later, by the 60-day deadline for giving notice of an initial qualifying event described above).

If all of these conditions are met, the Plan will treat the notice as having been provided in a timely manner.

If any of these conditions is not met, YOUR EMPLOYER will reject the incomplete notice and will not offer COBRA continuation coverage to you. If you fail to give YOUR EMPLOYER timely and proper notice of an initial qualifying event, YOU WILL FORFEIT YOUR STATUS AS A QUALIFIED BENEFICIARY AND LOSE YOUR RIGHT TO ELECT COBRA CONTINUATION COVERAGE.

If you submit a Notice to your Employer that is sufficiently incomplete such that the Plan cannot determine the nature and/or date of the initial qualifying event and the names of the covered employee and any related qualified beneficiaries, then YOUR EMPLOYER will reject the Notice and return the Notice to you for completion. In the event YOUR EMPLOYER returns an incomplete Notice to you, you must complete the Notice and return it to YOUR EMPLOYER with any required documentation by the 60-day deadline specified above. If you do not submit a complete and appropriately documented Notice by the 60-day deadline specified above, YOU WILL FORFEIT YOUR STATUS AS A QUALIFIED BENEFICIARY AND LOSE YOUR RIGHT TO ELECT COBRA CONTINUATION COVERAGE.

The following individuals may provide the Notice of the initial qualifying event:

- The covered employee (that is, the employee or former employee who is or was covered under the Plan);
- A qualified beneficiary with respect to the initial qualifying event being reported in the Notice; or
- A representative acting on behalf of the covered employee or a qualified beneficiary.

A Notice of an initial qualifying event provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage under the Plan due to the qualifying event identified in the Notice.

18.19 Procedure for Giving Notice of a Second Qualifying Event Following Termination of Employment or Reduction of Hours

When you wish to give notice of a second qualifying event (such as the covered employee's death, a divorce or legal separation of the employee and spouse, or a dependent child's loss of eligibility under the terms of the Plan) following an initial qualifying event that is the end of employment or reduction of hours of employment, you must notify YOUR EMPLOYER in writing within 60 days after the later of (1) the date of the second qualifying event; or (2) the date on which the qualified beneficiary (that is, the covered spouse or dependent child) would lose coverage under the terms of the Plan as a result of the second qualifying event (if this qualifying event had occurred while the qualified beneficiary was still covered under the Plan). You must provide notice of a second qualifying event by using the Plan's "Notice of A COBRA-Related Event" or comparable Notice prepared by your Employer.

If you fully complete the Notice to your Employer according to the instructions accompanying the Notice and you attach the required documentation as described in the following paragraphs, you will provide the information required by these Notice Procedures.

If the second qualifying event is a divorce or legal separation from the covered employee, the covered employee's death or the dependent child's loss of eligibility under the terms of the Plan, you must provide documentation of the date of the second qualifying event that is satisfactory to YOUR EMPLOYER. Examples of satisfactory documentation include:

- A copy of the decree of divorce or legal separation to establish the date of the divorce or legal separation;
- A death certificate or published obituary to establish the date of the employee's death;
- A birth certificate to establish the date that a child reached the limiting age under the terms of the Plan;
- A marriage certificate to establish the date that a dependent child married; or
- A transcript showing the last date of enrollment in an educational institution.

Such documentation will allow YOUR EMPLOYER to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of the COBRA coverage period.

If you provide YOUR EMPLOYER with a written notice of a second qualifying event that does not contain all of the information required by these Notice Procedures, the Plan will nevertheless consider your notice to be timely if all of the following conditions are met:

- The notice is mailed, faxed or hand-delivered to the individual and address specified above;
- The notice is provided by the deadline specified above;
- From the written notice provided, YOUR EMPLOYER is able to determine that the notice relates to the Plan;
- From the written notice provided, YOUR EMPLOYER is able to identify the covered employee and the qualified beneficiary(ies), the nature of the second qualifying event and the date on which the second qualifying event occurred; and
- The notice is supplemented in writing with the additional information and/or documentation necessary to meet the Plan's requirements (as described in these Notice Procedures). If the Plan requests additional information or documentation, you must provide the additional information or documentation within 15 business days after YOUR EMPLOYER's written or oral request to provide the information (or, if later, by the 60-day deadline for giving notice of a second qualifying event described above).

If all of these conditions are met, the Plan will treat the notice of a second qualifying event as having been provided in a timely manner.

If any of these conditions is not met, YOUR EMPLOYER will reject the incomplete notice and will not provide an extension of the COBRA continuation coverage period that would otherwise be available to you as a result of a second qualifying event. If you fail to give YOUR EMPLOYER timely and proper notice of a second qualifying event, your COBRA coverage period will end at the expiration of the of the maximum COBRA coverage period to which you are entitled because of the occurrence of the initial qualifying event.

If you submit a Notice to your Employer that is sufficiently incomplete such that the Plan cannot determine the nature and/or date of the second qualifying event and the names of the covered employee and any related qualified beneficiaries, then YOUR EMPLOYER will reject the Notice and return the Notice to you for completion. In the event YOUR EMPLOYER returns an incomplete Notice to you, you must complete the Notice and return it to YOUR EMPLOYER with any required documentation by the 60-day deadline specified above. If you do not submit a complete and appropriately documented Notice by the 60-day deadline specified above, the Plan will not provide an extension of the COBRA continuation coverage period that would otherwise be available to you as a result of a second qualifying event. If you fail to give YOUR EMPLOYER timely and proper notice of a second qualifying event, your COBRA coverage period will end at the expiration of the of the maximum COBRA coverage period to which you are entitled because of the occurrence of the initial qualifying event.

The following individuals may provide the Notice of a second qualifying event:

- The covered employee (that is, the employee or former employee who is or was covered under the Plan);
- A qualified beneficiary who lost coverage under the Plan due to the covered employee's termination of employment or reduction in hours of employment and is still receiving COBRA continuation coverage; or
- A representative acting on behalf of the covered employee or a qualified beneficiary.

A Notice of a second qualifying event provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the occurrence of the second qualifying event reported in the Notice.

18.20 Procedure for Giving Notice of the Social Security Administration's Determination of Disability

When the Social Security Administration determines that a qualified beneficiary is disabled and you wish to qualify for the disability extension of the maximum COBRA coverage period, you must provide YOUR EMPLOYER with the Notice to your Employer within 60 days after the latest of (1) the date of the Social Security Administration's disability determination, (2) the date of the covered employee's termination of employment or reduction in hours of employment, or (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction in hours of employment. In addition, you must provide this notice of the Social Security Administration's determination of disability within 18 months after the covered employee's termination of employment or reduction in hours of employment. You must provide notice of the Social Security Administration's determination of disability by using the Plan's "Notice of A COBRA-Related Event", or comparable notice prepared by your Employer.

If you fully complete the Notice to your Employer according to the instructions accompanying the Notice and you attach the required documentation as described in the following paragraph, you will provide the information required by these Notice Procedures.

You must include a copy of the Social Security Administration's determination of disability with your "Notice of A COBRA-Related Event" or comparable Notice prepared by your Employer.

Such documentation will allow YOUR EMPLOYER to determine if you gave timely notice of the Social Security Administration's determination of disability and were consequently entitled to an extension of the COBRA coverage period.

If you provide YOUR EMPLOYER with a written notice of Social Security Administration's determination of disability that does not contain all of the information required by these Notice Procedures, the Plan will nevertheless consider your notice to be timely if all of the following conditions are met:

- The notice is mailed, faxed or hand-delivered to the individual and address specified above;
- The notice is provided by the deadline specified above;
- From the written notice provided, YOUR EMPLOYER is able to determine that the notice relates to the Plan;
- From the written notice provided, YOUR EMPLOYER is able to identify the covered employee and the qualified beneficiary(ies), the fact that you are reporting the Social Security Administration's determination of disability and the date of the determination; and
- The notice is supplemented in writing with the additional information and/or documentation necessary to meet the Plan's requirements (as described in these Notice Procedures). If the Plan requests additional information or documentation, you must provide the additional information or documentation within 15 business days after YOUR EMPLOYER's written or oral request to provide the information (or, if later, by the 60-day deadline for giving notice of the Social Security Administration's determination of disability which is described above).

If all of these conditions are met, the Plan will treat the notice of the Social Security Administration's determination of disability as having been provided in a timely manner.

If any of these conditions is not met, YOUR EMPLOYER will reject the incomplete notice and will not provide an extension of the COBRA continuation coverage period that would otherwise be available to you as a result of the Social Security Administration's determination of disability. If you fail to give YOUR EMPLOYER timely and proper notice of the Social Security Administration's determination of disability, your COBRA coverage period will end at the expiration of the maximum COBRA coverage period to which you are entitled because

of the occurrence of the initial qualifying event (that is, the employee's termination of employment or reduction in hours of employment).

If you submit a Notice to your Employer that is sufficiently incomplete such that the Plan cannot determine the nature and/or date of the Social Security Administration's determination of disability and the names of the covered employee and any related qualified beneficiaries, then YOUR EMPLOYER will reject the Notice and return the Notice to you for completion. In the event YOUR EMPLOYER returns an incomplete Notice to you, you must complete the Notice and return it to YOUR EMPLOYER with any required documentation by the 60-day deadline specified above. If you do not submit a complete and appropriately documented Notice by the 60-day deadline specified above, the Plan will not provide an extension of the COBRA continuation coverage period that would otherwise be available to you as a result of the Social Security Administration's determination of disability. If you fail to give YOUR EMPLOYER timely and proper notice of the Social Security Administration's determination of disability, your COBRA coverage period will end at the expiration of the of the maximum COBRA coverage period to which you are entitled because of the occurrence of the initial qualifying event (that is, the employee's termination of employment or reduction in hours of employment).

The following individuals may provide the Notice of the Social Security Administration's determination that a qualified beneficiary is disabled:

- The covered employee (that is, the employee or former employee who is or was covered under the Plan);
- A qualified beneficiary who lost coverage under the Plan due to the covered employee's termination of employment or reduction in hours of employment and is still receiving COBRA continuation coverage; or
- A representative acting on behalf of the covered employee or a qualified beneficiary.

A Notice of the Social Security Administration's disability determination provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the Notice.

18.21 Procedure for Giving Notice of Obtaining Other Coverage After Electing COBRA

When, after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, the qualified beneficiary must give YOUR EMPLOYER notice of the other group health plan coverage within 30 days after the other group health plan coverage becomes effective. You must give this notice of other group health plan coverage by using the Plan's "Notice of A COBRA-Related Event" or comparable Notice prepared by your Employer.

The Notice to your Employer must include appropriate documentation of the other group health plan coverage. Such documentation must include the following:

- The names and addresses of all qualified beneficiaries who obtained coverage under the other group health plan;
- The date the other group health plan coverage became effective; and
- Evidence of the effective date of the other group health plan coverage (such as a copy of the other group health plan's identification card or enrollment form).

Such documentation will allow YOUR EMPLOYER to determine if you gave timely notice of the qualified beneficiary(ies) obtaining coverage under another group health plan.

If a qualified beneficiary first becomes covered under another group health plan after electing COBRA continuation coverage, YOUR EMPLOYER will terminate (retroactively, if applicable) that qualified

beneficiary's COBRA continuation coverage as described above in the section entitled "Termination of COBRA Continuation Coverage Before the End of the Maximum COBRA Coverage Period," regardless of whether or when the qualified beneficiary provides YOUR EMPLOYER with the Notice to your Employer pertaining to the qualified beneficiary's obtaining coverage under another group health plan after electing COBRA continuation coverage. YOUR EMPLOYER will require repayment to the Plan of all benefits paid after the termination date.

The following individuals may provide the Notice that a qualified beneficiary has, after electing COBRA continuation coverage, become covered under another group health plan:

- The covered employee (that is, the employee or former employee who is or was covered under the Plan);
- A qualified beneficiary with respect to the initial or second qualifying event; or
- A representative acting on behalf of the covered employee or a qualified beneficiary.

A Notice of a qualified beneficiary becoming covered under another group health plan after electing COBRA coverage which is provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other group health plan coverage reported in the Notice.

18.22 Procedure for Giving Notice of Becoming Entitled to Benefits Under Medicare After Electing COBRA

When, after electing COBRA continuation coverage, a qualified beneficiary becomes entitled to benefits under Medicare (Part A, Part B or both), the qualified beneficiary must give YOUR EMPLOYER notice of the Medicare entitlement within 30 days after the beginning of the Medicare entitlement (that is, the effective date shown on the qualified beneficiary's Medicare identification card). You must give this notice of Medicare entitlement by using the Plan's "Notice of A COBRA-Related Event" or comparable Notice prepared by your Employer.

The Notice to your Employer must include appropriate documentation of the Medicare entitlement. Such documentation must include the following:

- The names and addresses of qualified beneficiary who became entitled to benefits under Medicare (Part A, Part B or both);
- The date the entitlement to Medicare benefits was effective; and
- A copy of the qualified beneficiary's Medicare identification card showing the date of the individual's Medicare entitlement.

Such documentation will allow YOUR EMPLOYER to determine if you gave timely notice of the qualified beneficiary's entitlement to Medicare benefits.

If a qualified beneficiary first becomes entitled to benefits under Medicare (Part A, Part B or both) after electing COBRA continuation coverage, YOUR EMPLOYER will terminate (retroactively, if applicable) that qualified beneficiary's COBRA continuation coverage as described above in the section entitled "Termination of COBRA Continuation Coverage Before the End of the Maximum COBRA Coverage Period," regardless of whether or when the qualified beneficiary provides YOUR EMPLOYER with the Notice to your Employer pertaining to the qualified beneficiary's becoming entitled to benefits under Medicare (Part A, Part B or both) after electing COBRA continuation coverage. Your Employer will require repayment to the Plan of all benefits paid after the termination date.

The following individuals may provide the Notice that a qualified beneficiary has, after electing COBRA continuation coverage, become entitled to benefits under Medicare (Part A, Part B or both):

- The covered employee (that is, the employee or former employee who is or was covered under the Plan);
- A qualified beneficiary with respect to the initial or second qualifying event; or
- A representative acting on behalf of the covered employee or a qualified beneficiary.

A Notice of a qualified beneficiary becoming entitled to benefits under Medicare (Part A, Part B or both) after electing COBRA coverage which is provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the Medicare entitlement reported in the Notice.

18.23 Procedure for Giving Notice of the Social Security Administration's Determination of the Cessation of Disability

When the Social Security Administration determines that a qualified beneficiary previously determined to be disabled is no longer disabled, and that qualified beneficiary (or any related qualified beneficiary) is receiving COBRA continuation coverage during the disability extension period resulting from the qualified beneficiary's disability, you must give YOUR EMPLOYER notice of the cessation of the qualified beneficiary's disability within 30 days after the date of the Social Security Administration's determination of the cessation of disability. You must give this notice of the cessation of disability by using the Plan's "Notice of A COBRA-Related Event" or comparable Notice prepared by your Employer.

The Notice to your Employer must include appropriate documentation of the Social Security Administration's determination that the previously disabled qualified beneficiary is no longer disabled. Such documentation must include the following:

- The name and address of the qualified beneficiary previously determined by the Social Security Administration to be disabled;
- The date of the Social Security Administration's determination that the previously disabled qualified beneficiary is no longer disabled; and
- A copy of the Social Security Administration's determination of the cessation of disability.

Such documentation will allow YOUR EMPLOYER to determine if you gave timely notice of the qualified beneficiary's cessation of disability.

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, YOUR EMPLOYER will terminate (retroactively, if applicable) COBRA continuation coverage for all qualified beneficiaries whose COBRA continuation coverage was extended due to the disability as described above in the section entitled "Termination of COBRA Continuation Coverage Before the End of the Maximum COBRA Coverage Period," regardless of whether or when the qualified beneficiary provides YOUR EMPLOYER with the Notice to your Employer pertaining to the Social Security Administration's determination of a cessation of disability. YOUR EMPLOYER will require repayment to the Plan of all benefits paid after the termination date.

The following individuals may provide the Notice that the Social Security Administration has determined that a qualified beneficiary previously determined to be disabled is no longer disabled:

- The covered employee (that is, the employee or former employee who is or was covered under the Plan);
- A qualified beneficiary with respect to the initial qualifying event; or
- A representative acting on behalf of the covered employee or a qualified beneficiary.

A Notice of a cessation of disability which is provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the cessation of disability reported in the Notice.

Article 19. Additional Notices

19.1 Women's Health and Cancer Rights Act of 1998:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy- related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: ○ All stages of reconstruction of the breast on which the mastectomy was performed; ○ Surgery and reconstruction of the other breast to produce a symmetrical appearance; ○ Prostheses; and ○ Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator 1-888-886-7973

19.2 Newborns' Act of 1996:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

19.3 Children's Health Insurance Program Reauthorization Act of 2009:

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-888 KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll free 1-866-444-EBSA (3272)

For more information on premium assistance or special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/ebsa 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

19.4 Genetic Information Nondiscrimination Act of 2008:

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

- Such individual's genetic tests;
- The genetic tests of family members of such individual; and
- The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

19.5 Qualified Medical Child Support Order (QMCSO):

A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employment-based group health plans to extend health care coverage to the children of a parent-employee who is divorced, separated, or never married when ordered to do so by state authorities.

Generally, a state court or agency may require an ERISA-covered health plan to provide health benefits coverage to children by issuing a medical child support order (MCSO), sometimes even where the child may not be a "dependent" under the terms of the group health plan.

Participants and beneficiaries of The Plan may obtain a copy of the QMCSO procedure from the Plan Administrator, free of charge, upon request.

19.6 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.

19.7 Special Enrollment Rights:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you with certain special enrollment rights pertaining to your health care coverage. If you decline enrollment for yourself or your Eligible Dependents (including your Spouse) because of other health insurance coverage (such as coverage through another employer), you may in the future be able to enroll yourself or your Eligible Dependents in this Plan, provided that you request enrollment within 31 days after the other coverage ends.

In addition, if you have a new dependent as a result of marriage, you may be able to enroll yourself and your dependents, provided that you request enrollment in writing within 30 days of the marriage. You must provide documentation of the event.

If you also have a new dependent as a result of birth, adoption, or placement for adoption, you may be able to enroll yourself, your eligible spouse and your newborn child, adopted child or child placed for adoption provided that you request enrollment in writing within 30 days of the birth, adoption, or placement for adoption. You must provide documentation of the event.

Note children previously declined are not eligible to enroll during this special enrollment period.

19.8 HIPAA Privacy:

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

19.9 Choice of Providers

Covered persons have a choice of obtaining medical care, services and supplies (but not including prescription drugs) from providers participating in the preferred provider networks ("In-Network Providers", also referred to as "PPO Providers") or any other Covered Providers of their choice ("Out-of-Network Providers", also referred to as "Non-PPO Providers"). Prescription drugs must be obtained through the preferred provider network.

The Preferred Provider Network was selected by your Employer.

Refer to your ID card to determine which Network you were assigned.

To locate a network provider, use the Provider Locator at www.benelect.com.

You are not required to use an In-Network provider. However, if you use an Out-Of-Network Provider, your Plan will pay a lesser benefit.

- **In-Network Providers** – In-Network Providers have agreed to provide services to Covered Persons at reduced rates. When using In-Network Providers, Covered Persons are protected from balance

billing for differences between the providers' actual charges and the amount the Plan allows as Eligible Expenses

- **Out-of-Network Providers** – Out-of-Network Providers are those Covered Providers who are not participating in the preferred provider networks. Benefit levels for such providers are generally less than In-Network benefit levels to encourage Covered Persons to use In-Network Providers whenever possible.

19.10 Funding - Sources and Uses

Employee & Employer Obligations

Plan benefits are paid from the general assets of the Plan Sponsor. The Plan Sponsor may terminate, amend or eliminate benefits. The Plan Administrator shall, from time to time, evaluate and determine the amount to be contributed, if any, by each Employee or Plan participant.

See the COBRA Continuation Coverage section for more information.

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employee or Plan participant will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer.

Plan Funded Benefits

The contributions will be applied to provide the benefits under the Plan.

GROUP INFORMATION

Group Name: Dan Drake Enterprises, LLC

Effective date: January 1, 2017

Plan Number: 78869A

Address: P.O Box 612

City, State, Zip: Bakersfield, CA 93302

Group Contact: Alicia Feliscian

Group Phone: 661-324-6514

Tax ID #: 77-0506180

Waiting Period Days: first of the month following 60 days Minimum hours per week worked: 30

Measurement Method for Determining Full-time Status for Variable Hour/Seasonal Employees: Choose an item.

Minimum Value Plan (MVP) - Next Generation Schedule of Benefits

with PPO Network for benefits other than hospital/surgical
with Reference Based Pricing (RBP) for hospital and surgical benefits only

Dan Drake Enterprises, LLC

Plan 2
Effective 01/01/2017

The Minimum Value Plan (MVP) - Next Generation is a basic Preventive Health Coverage plan that includes all of the benefits that the MEC plan covers and some additional benefits with a shared cost between the Employee and the Employer.

While the Preventive Benefits are still covered at 100% by the Employer, the additional benefits are a cost share with the Employee having an out-of-pocket expense depending on the services being provided.

Minimum Value Plan (MVP) - Next Generation Covered Benefits	In-Network	Out-of-Network
Deductible	$0	$0
Coinsurance	0%	40%
Out-of-Pocket Maximum	$6,500 / 13,000	N/A
Covered Services	**Employee Pays**	
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-Rays) *Co-pays apply to the physician visit charge only.*	$25 Co-pay	Not Covered
Specialist Visit *Co-pays apply to the physician visit charge only.*	$75 Co-pay	Not Covered
Imaging (CT, PET Scans, MRI's) *Covers charges for CT, PET Scans and MRI's and the charges for related services. Failure to pre certify results in no benefits being paid.*	$300 Co-pay for each test	Not Covered
Laboratory Outpatient and Professional Services *Covers the professional components of labs including the office and outpatient charges.*	$100 Co-pay	Not Covered
X-Rays and Diagnostic Imaging *Covers the professional components of the X-Rays including the office and outpatient charges.*	$100 Co-pay	Not Covered
Urgent Care *Co-pays apply to the physician visit charge only.*	$100 co-pay + 20%	$500 Co-pay + 20%
Emergency Room Services *Covers all services performed in an emergency room including the hospital facility and all ancillary services.*	$500 Co-pay	$500 Co-pay
Emergency Room Professional Services *Covers all services performed in an emergency room including physician charges.*	$500 Co-pay	$500 Co-pay
Inpatient Hospital Facility Fees***	N/A - RBP	$5,000 Co-pay
Inpatient/Outpatient Surgery Performed in Office, Surgical Facility or Hospital Facility Fees Only***	N/A - RBP	50%
Preventive Care / Screening / Immunization (MEC) ** *Covers all of the services listed under the MEC covered benefits.*	100% No Deductible	40% No Deductible
Prescription Drugs*		
Generics / Tier 1[1]	$30 Co-pay	Not Covered
Preferred Brand Drugs / Tier 2	N/A	N/A
Non-Preferred Brand Drugs / Tier 3	N/A	N/A

* Specialty Drugs are not covered; mail order co-pays are 2.5 times the retail co-pay

** The above listed preventive care services do not include healthcare related services that are provided as a result of illness, injury or congenital defect.

*** These benefits are subject to Reference Based Pricing which is not part of any network. Coverage for facility fees only. Failure to pre certify results in no benefits being paid.

[1]If no generic is available, then a $60 co-pay applies.

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EMPLOYER DRIVEN HEALTH PLANS

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CA. Insurance License #0E50593

Appendix A. Schedule of Benefits

Appendix B. Method for Determining Full-Time Status of Variable Hour/Seasonal Employees