PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

WESTMINSTER VILLAGE WEST LAFAYETTE, INC.

EFFECTIVE DATE OF THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION:

January 1, 2014

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INTRODUCTION

Westminster Village West Lafayette, Inc. (herein referred to as "the Company") has established the Plan for your benefit, on the terms and conditions described in this Plan Document and Summary Plan Description.

This document is both the Plan Document and the "Summary Plan Description" or "SPD" required by ERISA. It has been written for your use and understanding of the broad range of benefits available to you and your Dependents under this Plan. This document is effective as of 12:00 a.m. on January 1, 2014, and is intended to replace all previously distributed materials. Any word or phrase that is capitalized in this document has a special meaning and is defined for you in the "Definitions" section or within the document.

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

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

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

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

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

Verification of Benefits

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

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

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

Your Role In Controlling Health Care Costs

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

Practice Good Health Habits

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

See Your Doctor Early

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

Make Sure You Need Surgery

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

Use Outpatient Services for X-ray or Laboratory Tests

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

Compare Prescription Drug Prices

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

Consider Hospital Stay Alternatives

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

Review Medical Bills Carefully

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

Talk to Your Doctor

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

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

ELIGIBILITY FOR COVERAGE

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

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

If provided by Company policy, your coverage will be continued during an approved leave of absence, including disability. Your applicable contribution for coverage continuation must be paid when due if your approved leave of absence is unpaid. The duration of coverage continuation will be as specified by the Company's leave policy. However, in no event will this extension be for longer than 26 weeks; coverage will terminate at the end of the month in which this extension expires. COBRA continuation coverage will be offered at the end of this extension. The maximum COBRA continuation coverage period will be measured beginning on the date this extension ends.

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

General Eligibility Provisions

Eligible Employees

Employees eligible for Plan coverage (hereafter referred to as "Eligible Employees") are all regular full-time employees who are regularly scheduled to work a minimum of 35 hours per week. In no event will leased employees, temporary employees or independent contractors be deemed to be Eligible Employees.

Eligible Dependents

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

1. Your legal spouse, of the opposite sex, who is a resident of the same country as you. Such spouse must have met all requirements of a valid marriage contract of the state in which you were married. This does not include common law marriage or any other such arrangements which may be recognized by the state in which you reside.

2. Your child who meets **all** of the following conditions:

   a. Is a natural child, step-child, legally adopted child, or a child who has been placed under your Legal Guardianship; and,

   b. Is less than age 26.

   A Dependent child will continue to be eligible beyond age 26 if the child is mentally or physically handicapped and incapable of self-sustaining employment, unmarried, financially dependent upon you for support and maintenance, and a resident of the United States. The child need not be covered under the Plan on the date the incapacitating handicap occurred. However, such Condition must have begun prior to the child's attainment of age 26, and must be of such severity as to incapacitate the child for an extended period of time. Proof of incapacity acceptable to the Plan Administrator must be submitted upon enrollment or, if later, within 60 days after the date on which the Dependent no longer will be eligible because of age, and at reasonable intervals thereafter.

3. Your grandchild or other blood relative who is less than 24 years of age and who depends on you for more than 50% of his or her financial support. Such child must reside within the United States. The Plan Administrator reserves the right to request evidence demonstrating an individual's financial dependence upon you at any time.

4. Any child who is placed with you under an interim court order prior to finalization of adoption.
5. Any children as required by a Qualified Medical Child Support Order (QMCSO).

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

1. A spouse from whom you are legally separated by a court order;
2. A former spouse from whom you are legally divorced;
3. Any person on active military duty, unless otherwise required by law;
4. Any person covered under this Plan as an Eligible Employee;
5. Any person who is covered as a Dependent by another employee;
6. A Dependent child's spouse or child (unless your grandchild qualifies as an eligible Dependent as defined in this section).

Age Limitation for Eligible Dependent Children

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

Initial Eligibility Date

Your initial eligibility date for Plan coverage is the first day of the month following the completion of the following Waiting Period:

- Class 1, All Salaried Employees and Licensed Employees (A "Licensed Employee" is defined to mean a Registered Nurse and a Licensed Practical Nurse) – Your Waiting Period is 30 days of full-time Active Service as an Eligible Employee.
- Class 2, All Other Eligible Employees – Your Waiting Period is 60 days of full-time Active Service as an Eligible Employee.

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

If you are not eligible for coverage on your date of hire because you do not meet the eligibility requirements defined in the section "Eligible Employees", the Waiting Period will begin on the date you become eligible for coverage rather than your date of hire.

Written application for coverage, as required by the Plan, must be made within 30 days of your initial eligibility date. Coverage elections are irrevocable and may be changed only during the Open Enrollment Period or, if sooner, during a Special Enrollment Period.

Open Enrollment Period

The Company will designate an Open Enrollment Period during the month of October and/or November. An enrollment or change in coverage made during the Open Enrollment Period will become effective on January 1st of the following Calendar Year, provided such request is made by written application as required by the Plan.

Enrollment Rules

Coverage must be requested by written application (and in the manner required by the Plan) within 30 days of your initial eligibility date.

If you do not have eligible Dependents on the date your coverage begins, you must file your written application for Dependent Coverage within 30 days of the date you acquire your Dependent through marriage, birth, adoption, court order or decree. Once you are enrolled for Dependent Coverage, each newly acquired Dependent must also be enrolled within 30 days of the date your spouse or child becomes eligible.

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

Special Enrollment Periods

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

Loss of Other Coverage

The Plan will permit you or your Dependent(s) who lose other coverage to enroll under the terms of the Plan, with coverage to be effective on the event date, if the following conditions are met:

1. You and your Dependent(s) are eligible for coverage under the terms of this Plan;
2. You or your Dependent already had other coverage when the Plan was previously offered;
3. You stated in writing at such time that another source of coverage was the reason for declining enrollment; and
4. a. Coverage was not under a COBRA continuation provision and was terminated as a result of:

   (1) A loss of eligibility for the coverage, other than Medicaid or State Child Health Insurance Plan. A "loss of eligibility" includes, but is not limited to, a loss that is a result of legal separation, divorce, death, termination of employment, reduction in hours of employment, a child ceasing to qualify as an eligible dependent under the other plan, or the coverage is no longer being made available to a class of similarly situated individuals; or

   (2) Termination of all employer contributions towards such coverage.

   Coverage must be requested not later than 30 days after the loss of other coverage. When loss of eligibility is the result of meeting the overall lifetime maximum benefit, the 30 day Special Enrollment Period will begin the date the individual receives written notification of attaining or exceeding the lifetime limit.

   b. The person was covered under COBRA continuation coverage which was exhausted and the person requested enrollment not later than 30 days after the end of the COBRA coverage.

Acquiring a New Dependent

The Plan will permit a Special Enrollment Period for persons who become a Dependent through marriage, birth, adoption or placement for adoption. The Dependent Special Enrollment Period will be for 30 days following the actual event.

If you are eligible for enrollment, but not enrolled, you may also enroll at this time. In the case of the birth or adoption of a child, your spouse also may be enrolled as a Dependent, if your spouse is otherwise eligible for coverage but not already enrolled. If you enroll a Dependent during the 30-day Dependent Special Enrollment Period, coverage will become effective as of the date of birth, adoption or placement for adoption, or marriage.

Medicaid or State Child Health Insurance Plan

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

1. Your coverage or your Dependent's coverage under Medicaid or a State Child Health Insurance Plan (i.e. CHIP) has terminated as a result of loss of eligibility and you request coverage under the Plan within 60 days after the termination; or
2. You or your Dependent become eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and you request coverage under the Plan within 60 days after eligibility is determined.

If you enroll during the 60-day Special Enrollment Period defined above, coverage will become effective on the first day of the month following the date the Plan receives your request for special enrollment.

Late Enrollees

If you or an eligible Dependent qualifies for a Special Enrollment Period, the Late Enrollee provisions of this Plan will not apply if all of the provisions of HIPAA are complied with. Otherwise:

1. You will be considered a Late Enrollee if you waive coverage or do not properly enroll within 30 days of your initial eligibility date. You will also be considered a Late Enrollee if you voluntarily terminate Participant Coverage and later wish to re-enroll, unless otherwise specified by Company policy.

2. A Dependent will be considered a Late Enrollee if you do not properly enroll within 30 days of your initial eligibility date, if you waive Dependent Coverage or, if you do not enroll an eligible Dependent within 30 days of the date you acquire the Dependent. A Dependent will also be considered a Late Enrollee if you wish to re-enroll following your previous request to voluntarily terminate Dependent Coverage for any reason other than due to a Dependent failing to meet the Plan's eligibility requirements.

Late Enrollees are eligible to enroll for coverage only during the Plan's Open Enrollment Period.

Qualified Medical Child Support Orders

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

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

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

1. Provides for child support with respect to a Covered Person's child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

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

1. Name of an issuing state agency;

2. Name and mailing address (if any) of an employee who is a Participant under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and

4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the

right to, receive benefits for which a Covered Person or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Person and the name and mailing address of each such Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

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

1. Contains the information set forth above in the definition of "National Medical Support Notice";

2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;

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

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

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

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

1. Notify the Covered Person and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

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

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

   a. Whether the child is covered under the Plan; and

   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

Participant Eligibility

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

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

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

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

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

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

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

Participant Effective Date

Your Participant Coverage under the Plan will become effective at 12:00 a.m. on the date of your eligibility, provided written application for coverage is made **on or within 30 days of such date.**

All Dependent Coverage under the Plan will commence at 12:00 a.m. on the date such coverage is effective.

Participant Termination

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

1. End of the month in which termination of your employment occurs or you retire;
2. End of the month in which you cease to be in a class eligible for coverage;
3. Date of expiration of the last period for which you have made a contribution, in the event you fail to make any required contribution for coverage or end of the month in which you file a written election to discontinue coverage; *Note: If you elect to make your contribution for coverage on a pre-tax basis under the Company's Section 125 Plan, you will be allowed to discontinue coverage only if permitted in the Section 125 Plan.*
4. Date the Plan is terminated, or with respect to any Participant benefits of the Plan, the date of termination of such benefits;

5. Date of your death. If you are enrolled for Family coverage, coverage for your Dependents ends on the last day of the month;

6. End of the month in which you are on lay-off or an approved leave of absence, except as otherwise stated.

Upon the termination of coverage, there is no extension of any benefits under this Plan for any reason unless specifically noted in the Plan.

Participant Reinstatement

The Waiting Period defined under the General Eligibility Provisions will not apply if either of the below listed circumstances apply to you when you return to Active Service as an Eligible Employee following coverage termination:

1. If you return to Active Service as an Eligible Employee on your first scheduled work day immediately following layoff or an approved leave of absence; or,

2. If you return to Active Service as an Eligible Employee and you have continuously maintained COBRA continuation coverage during the entire course of your break in eligibility.

No benefits will be paid for expenses Incurred when coverage was not in force.

In all other instances, a terminated employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Dependent Eligibility

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

1. Newborn children will be eligible for coverage from the moment of birth for Injury or Illness, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, **provided you properly enroll the child as a Dependent within 30 days of the child's date of birth.** This provision does not apply to nor in any way affect the normal maternity provisions applicable to the mother.

2. An adopted child will be eligible for coverage on the date the child is legally adopted or placed with you in anticipation of adoption, provided the child is properly enrolled as a Dependent within 30 days.

3. A spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is otherwise eligible and properly enrolled prior to the date of marriage, or within 30 days of the date of marriage. If an otherwise eligible spouse is not a resident of the same country as you, your spouse will be considered an eligible Dependent on the date he or she satisfies this residence requirement provided your spouse is properly enrolled within 30 days of such date.

4. If a Dependent is acquired other than at the time of birth, due to a court order, decree or marriage, that Dependent will be considered an eligible Dependent from the date of such court order, decree or marriage, provided that this new Dependent is properly enrolled prior to or within 30 days of such an event and is otherwise eligible.

5. A Dependent who continues coverage under COBRA.

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

If a Dependent child or spouse is not enrolled within the 30-day period outlined above, the Dependent will be considered a Late Enrollee.

Dependent Effective Date

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

1. If you make such written request within 30 days of your earliest eligibility date, any person who is then your Dependent will become covered on the date your Participant Coverage begins.
2. If you acquire an eligible Dependent after your Participant Coverage begins, your Dependent will become covered on the date the Dependent becomes eligible (that is, the date of marriage, birth, adoption, court order or decree) provided the newly acquired spouse or child is enrolled for coverage within 30 days of such date.
3. If Dependent Coverage under the Plan is requested and you make such written request after the end of the 30-day period specified above; or after your previous termination of Dependent Coverage for any reason other than due to a Dependent failing to meet the Plan's eligibility requirements, your Dependent(s) will be considered Late Enrollees. Late Enrollees are eligible for coverage only as outlined in the section "Late Enrollees".

Dependent Termination

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

1. Date of termination of your coverage under the Plan;
2. End of the month in which the Dependent ceases to be an eligible Dependent under the Plan;
3. End of the month in which you cease to be in a class of Participants eligible for Dependent Coverage;
4. Date of expiration of the last period for which you have made a contribution, in the event you fail to make any required contribution for Dependent Coverage or end of the month in which you file a written election to discontinue Dependent Coverage; *Note: If you elect to make your contribution for coverage on a pre-tax basis under the Company's Section 125 Plan, you will be allowed to discontinue coverage only if permitted in the Section 125 Plan.*
5. Date the Plan is terminated, or with respect to any Dependent benefit of the Plan, the date of termination of such benefit; or
6. Date the Dependent dies.

Upon the date of termination of coverage, there is no extension of any benefits under this Plan for any reason unless specifically noted in the Plan.

UTILIZATION MANAGEMENT SERVICE (UMS)

This Plan includes a utilization management requirement. This means that, subject to all other provisions of the Plan, each proposed Hospital admission which is to be performed, as outlined below, will be reviewed on behalf of the Plan. The Plan Administrator has retained the service of Hines & Associates to perform this utilization management review.

The phone number to contact Hines & Associates is: (800) 944-9401

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

Hines & Associates must be contacted:

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

Hines & Associates, on behalf of the Plan, will certify:

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

The person calling Hines & Associates will need to provide:

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

In the case of emergency, get treatment.

You are not required to call Hines & Associates first. You will not be penalized if you do not call before getting emergency treatment.

However, Hines & Associates must be contacted:

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

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

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

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

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

Ineligible Expenses

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

If certain Inpatient days are determined by Hines & Associates Physicians to be not Medically Necessary, then the Hospital Room and Board charges for those days will be considered ineligible expenses.

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

Right to Appeal a Utilization Management Decision

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

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

Second Opinions

Hines & Associates may require a second opinion before granting pre-certification for certain medical or surgical treatment. Benefits for a second surgical opinion consultation will be payable at the same level shown for a Physician office visit; please refer to the "Schedule of Medical Benefits" for benefit information.

Case Management Program

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

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

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

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

Specialty Care Benefit

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

These services are freestanding and are separate from any PPO or non-PPO contracts or benefits.

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

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

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

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

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

MEDICAL EXPENSE BENEFITS

All Plan expenses are subject to the following requirements:

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

Comprehensive Major Medical Benefits

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

Preferred Provider Benefit (PPO)

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

Benefits will be payable at the PPO level of benefits shown in the Schedule of Medical Benefits when Covered Charges are billed by a PPO provider. In addition, when a PPO Hospital is used, benefits for Hospital ancillary providers (such as anesthesiologists, pathologists, radiologists, assistant surgeons or emergency room Physicians) will be paid at the PPO level of benefits where it is shown that the services were provided at the PPO Hospital.

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

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.

Schedule of Medical Benefits

Calendar Year Deductible

	PPO Providers	Non-PPO Providers
Per Covered Person	$1,000	$2,000
Per Family (aggregate)	$2,000	$4,000

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

Coinsurance by Plan

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

PPO Provider: 80% after satisfying the Deductible
Non-PPO Provider: 50% after satisfying the Deductible

Coinsurance Limit

The Coinsurance limit includes the Deductible.

	PPO Providers	Non-PPO Providers
Per Covered Person	$4,500	$10,000
Per Family (aggregate)	$8,500	$20,000

After your Coinsurance equals the above stated amounts per Calendar Year, the Plan will pay 100% of all charges eligible for the Coinsurance limit for the balance of the Calendar Year.

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

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

Covered Services	PPO Providers	Non-PPO Providers
Allergy Injections	100% after $20 Copay per visit (no Deductible)	50% after Deductible
Ambulance Services	80% after Deductible	80% after PPO Deductible, PPO Coinsurance limit applies
Chiropractic Services Manipulative treatments are limited to 20 visits per person per Calendar Year.	100% after $20 Copay (no Deductible)	50% after Deductible
Dental Services – Accident Only Benefits are limited to $900 per tooth and up to $3,000 per Calendar Year.	80% after Deductible	80% after PPO Deductible, PPO Coinsurance limit applies

Covered Services	PPO Providers	Non-PPO Providers
Diagnostic X-Ray & Lab - Outpatient:		
• **Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine***	80% after Deductible	50% after Deductible
• **All Other X-Rays and Lab**	100% (no Deductible)	50% after Deductible
Effective March 1, 2014, benefits will be paid at 100%, no Deductible, when charges are Incurred with a Quest/LabCard provider.		
Durable Medical Equipment Benefits are limited to $2,500 per Calendar Year. Covered Charges include the purchase (or replacement) of Durable Medical Equipment limited to once every 3 years; however, this limit does not apply to wound vacuums. Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device while covered under the Plan. Benefits for repair/replacement are limited to once every 3 years. Such benefits are included in the annual limits stated above.	80% after Deductible	50% after Deductible
Emergency Services Copay is waived if admitted directly from the Emergency Room.	100% after $200 Copay per visit (no Deductible)	100% after $200 Copay per visit (no Deductible)
For purposes of this benefit, “Emergency Services” means treatment given in an emergency department of a Hospital for an Emergency Medical Condition. Such treatment includes a medical screening examination within the capability of the Hospital emergency department, including ancillary services routinely available to evaluate such Emergency Medical Condition and further examination and treatment required to stabilize the patient. An “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or, (ii) serious impairment to bodily functions; or, (iii) serious dysfunction of any bodily organ or part.		
Hearing Aids Covered Charges are limited to $2,500 per Calendar Year and one purchase (including repair/replacement) per hearing impaired ear every 3 years.	80% after Deductible	50% after Deductible
Home Health Care Limited to a maximum of 60 visits per person per Calendar Year. One visit equals up to 4 hours of skilled care services.	80% after Deductible	50% after Deductible
Hospice Care	80% after Deductible	50% after Deductible

Covered Services	PPO Providers	Non-PPO Providers
Hospital - Inpatient/Outpatient Services	80% after Deductible	50% after Deductible
The Calendar Year Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Organ Transplants Benefits for transplant procedures performed at a Non-PPO facility (other than cornea transplants) are limited to a maximum of $30,000 per transplant.	Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Ostomy Supplies Benefits are limited to a maximum of $2,500 per person per Calendar Year.	80% after Deductible	50% after Deductible
Physician Office Visit, including Second Surgical Opinion Consultation Benefit includes injections and diagnostic x-ray and laboratory services rendered during the office visit other than major diagnostics (i.e. CT, PET, MRI, MRA and Nuclear Medicine). All other services performed at a Physician office are payable as shown for "Physician Office Services". For maternity services, the office visit Copay will apply only to the initial office visit.		
• **Primary Care Physician (PCP)** A Primary Care Physician is a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/ gynecology, family practice or general medicine.	100% after $20 Copay per visit (no Deductible)	50% after Deductible
• **Specialist**	100% after $50 Copay per visit (no Deductible)	50% after Deductible
Physician Office Services Benefit includes major diagnostics (i.e. CT, PET, MRI, MRA and Nuclear Medicine), pharmaceutical products*, therapeutic procedures, and office Surgery, including scopic procedures.	80% after Deductible	50% after Deductible
Physician Services – Other	80% after Deductible	50% after Deductible
Pre-Admission Testing Performed on an Outpatient basis prior to a scheduled admission.	80% after Deductible	50% after Deductible
Preventive Services Charges for Preventive Services as outlined in the section "Medical Expense Covered Charges". Preventive Services include, but are not limited to, routine physical exams and screenings, Well Baby and Well Child Care, routine x-ray and lab, mammograms, pap smears, PSA tests, immunizations, and colonoscopies at the age and frequency recommended under federal guidelines required by law or by current American Cancer Society guidelines.	100% (no Deductible)	Not Covered

Covered Services	PPO Providers	Non-PPO Providers
Prosthetics Benefits are limited to a maximum of $2,500 per body part for each eye, ear, nose, or face. Covered Charges are limited to a single purchase of each type of prosthetic device every 3 years. Benefit limits do not apply to artificial arms, legs, feet or hands, or to breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.	80% after Deductible	50% after Deductible
Skilled Nursing Facility Limited to a maximum of 60 days per person per Calendar Year.	80% after Deductible	50% after Deductible
Surgery	80% after Deductible	50% after Deductible
Therapy – Outpatient Calendar Year benefits are limited as follows except when such services are provided for treatment of a Pervasive Development Disorder (Home Health Care limits apply when services are rendered under a Home Health Care plan).		
• Cardiac Rehabilitation Therapy – 36 visits • Cognitive Rehabilitation Therapy – 20 visits • Manipulative Treatments – 20 visits • Occupational Therapy – 20 visits • Physical Therapy – 20 visits • Post Cochlear Implant Aural Therapy – 30 visits • Pulmonary Rehabilitation – 20 visits • Speech Therapy – 20 visits	100% after $20 Copay (no Deductible)	50% after Deductible
Treatment of Mental Health Illness/ Substance Abuse	Benefits are paid in the same manner as any other Illness. With regard to Physician Office Visits, a Primary Care Physician ("PCP") is considered to include those providers listed as eligible Physicians or Mental Health/Substance Abuse Providers under the "Definitions" section. Please refer to the specific service or supply outlined in this Schedule for the applicable benefit.	
Urgent Care Center Visit Benefit includes injections and diagnostic x-ray and laboratory services rendered during the visit other than major diagnostics (i.e. CT, PET, MRI, MRA and Nuclear Medicine). All other services performed at an Urgent Care Center are subject to the Deductible and Coinsurance.	100% after $35 Copay (no Deductible)	50% after Deductible
Overall Maximum Benefit for All Benefits: **Unlimited** This Plan does not include an overall lifetime or annual limit on the dollar value of Essential Health Benefits. However, limits on specific treatments, services or supplies may apply if stated in this Schedule of Medical Benefits.		

Coinsurance and Deductible

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

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

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

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

Allocation and Apportionment of Benefits

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

Medical Expense Covered Charges

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

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

Covered Expenses are subject to any limits specified under the Schedule of Medical Benefits and are limited to:

1. **Ambulance.** Charges for local professional ground ambulance service to the nearest facility where emergency medical care or treatment is rendered, or the Medically Necessary transfer from one facility to another. The "nearest facility" is defined as one that is specialized and equipped to care for the person's Condition.

   Charges for Medically Necessary air ambulance service to the appropriate facility for emergency medical care or treatment if the patient's Condition is life threatening.

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

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

4. **Autism Spectrum Disorder.** Charges for the following services prescribed by a Physician and rendered by a licensed provider when such treatment is Medically Necessary and result in improved clinical status:

   a. Psychiatric care;

   b. Psychological care;

   c. Habilitative or rehabilitative care (i.e. counseling and treatment programs intended to develop, maintain, and restore the function of an individual);

   d. Therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas: self care and feeding; pragmatic, receptive, and expressive language; cognitive functioning; applied behavioral analysis, intervention, and modification; motor planning; and, sensory processing.

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

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

7. **Chiropractic.** Charges for chiropractor services.

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

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

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

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

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

   a. The investigational item, device or service itself;

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

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

9. **Cochlear Implants.** Charges for placement of one cochlear implant. Benefits will also include the repair and replacement of an implant when required because of a change in a patient's Condition.

10. **Dental Services – Accident.** Charges for treatment required because of Accidental Injury to sound natural teeth, but not from chewing. Covered Charges include replacement of lost teeth due to the Injury by implant, denture or bridge but do not include repair or replacement of a denture. Such expenses must be Incurred within 12 months of the Accident unless extenuating circumstances exist (such as prolonged hospitalization).

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

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

    b. Diabetes Outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working

in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.

c. Medical eye examinations (dilated retinal examinations) and preventive foot care.

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

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

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

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

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

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

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

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

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

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

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

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

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

Covered Charges will also include adjustments or repairs of Durable Medical Equipment to restore useful function or replacement when required because of normal wear or change in a patient's Condition.

16. **Feet.** Charges for treatment of medical Conditions of the feet. Covered Charges do not include custom molded orthotics.

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

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

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

18. **Hearing Aids.** Charges for hearing aids which are required for the correction of a hearing impairment. Covered Charges include the hearing aid and the associated fitting, and testing (audiological services). Benefits under this section do not include bone anchored hearing aids which are considered a covered medical/surgical expense only when Medically Necessary for Covered Persons who have either of the following:

    a. Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

    b. Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

19. **Home Health Care.** Charges made by a Home Health Care Agency for Medically Necessary care. Such expenses may include, but are not limited to:

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

    b. Home health aides.

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

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

20. **Hospice Care.** Charges made by a Hospice care program for services, supplies and treatment which are ordered by a Physician for the care of a terminally ill person. Charges include bereavement counseling for the patient's immediate family members while the Covered Person is receiving Hospice care.

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

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

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

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

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

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

22. **Inherited Metabolic Disease.** Charges for medical foods that are prescribed by a Physician for the treatment of inherited metabolic disease.

23. **Mastectomy.** Charges for reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce symmetrical appearance; and coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the

patient. Such coverage may be subject to the annual Deductibles and Coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan.

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

25. **Mental Health Illness/Substance Abuse.** Charges for services rendered for Psychiatric Care and/or for Substance Abuse Treatment. Covered Charges include treatment rendered as an Inpatient, Outpatient, or through an Intensive Outpatient Plan, and include services at a Residential Treatment Facility. Professional services are limited to only those providers listed as covered Physicians or Mental Health/Substance Abuse Providers under the "Definitions" section.

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

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

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

27. **Nursing.** Charges for the services of a Nurse, acting within the scope of his or her license. However, Covered Charges do not include private duty nursing services.

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

    It is IMPORTANT that you contact Hines & Associates as soon as you are told that you or a covered Dependent is a candidate for a covered organ transplant. Hines & Associates will work with you and your Physicians to make sure that the most appropriate treatment program is developed.

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

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

    c. **Other Charges.**

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

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

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

30. **Pervasive Developmental Disorder.** Charges for services that are provided in connection with the treatment plan for Pervasive Developmental Disorders when prescribed by a Physician and when such treatment results in improved clinical status.

    A "Pervasive Developmental Disorder" means a neurological condition, including Asperger's syndrome and Autism Spectrum Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Plan in conflict with the coverage described in this provision will not apply.

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

32. **Pregnancy.** Charges for treatment of pregnancy for you or your covered Dependent.

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

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

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

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

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

34. **Preventive Services.** Charges Incurred with a PPO provider for Preventive Services including, but not limited to, routine physical exams and screenings, Well Baby and Well Child Care, routine x-ray and lab, mammograms, pap smears, PSA tests, immunizations, and colonoscopies, at the age and frequency recommended under federal guidelines or by current American Cancer Society guidelines.

    Federal guidelines fall under four broad categories as shown below:

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

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

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

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

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

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

(2) Breastfeeding support, supplies, and counseling.

(3) Gestational diabetes screening.

Additional information about Preventive Services required under the Affordable Care Act (ACA) is available at the government's web site http://www.healthcare.gov

35. **Prosthetics.** Charges for placement of the original prosthetic devices, special appliances and surgical implants (not to include dental or penile implants) required as a result of an Illness or Injury. Benefits will also include adjustments, repairs and replacements of covered prosthetic devices, special appliances and surgical implants when required because of normal wear or change in a patient's Condition.

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

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

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

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

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

39. **Sterilization.** Charges for elective sterilization for you or your covered spouse.

40. **Surgical Assistants.**

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

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

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

41. **Therapy.** Charges for the following short-term Outpatient rehabilitation services when performed by a Physician or by a qualified licensed therapy provider:

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

b. **Cognitive Rehabilitation**. Charges for cognitive rehabilitation therapy when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

c. **Manipulative Treatment.** Charges for the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

d. **Physical Therapy.** Charges for treatment or services designed and adapted to promote the restoration of a useful physical function. Physical therapy does not include educational training.

e. **Post-cochlear implant aural therapy.**

f. **Pulmonary rehabilitation therapy.**

g. **Occupational Therapy.** Charges for therapeutic goal-oriented activity to achieve optimum function. Occupational therapy includes, but is not limited to, various forms of exercise with or without equipment, designed and adapted to improve function as it relates to bed mobility, wheelchair transfers and balance activities. Therapy employing similar modalities with emphasis on activities of daily living, such as grooming, bathing and hygiene are not included. Occupational therapy does not include educational training, or services designed to develop work, play or leisure time task performance skills.

h. **Speech Therapy**. Treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, congenital anomaly, or Autism Spectrum Disorders.

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

42. **Urgent Care Center.** Charges received at an urgent care center for treatment of an Illness or Injury.

OUTPATIENT PRESCRIPTION DRUG CARD BENEFIT

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

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

Covered Services

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

1. Drugs that require, by Federal law, a written prescription;
2. Injectable insulin, including syringes and needles purchased by prescription, and diabetic supplies (other than insulin pumps and pump supplies which are eligible for medical benefits);
3. The following smoking cessation medications prescribed by a Physician, up to a maximum of 90 days per Calendar Year: Chantix and transdermal patches. Patches that are sold “over-the-counter” are eligible when purchased with a valid prescription; and,
4. Preventive Services, as required by the Affordable Care Act, including FDA approved women’s contraceptives.

Benefits for these drugs will then be provided when you have been given a written prescription for them by your Physician. Quantity limits may apply to select medications. In addition, certain drugs (such as growth hormones) require that you or your Physician obtain prior authorization from the prescription drug card vendor.

Not all drugs are covered by this Plan. Those not covered include, but are not limited to, drugs prescribed to treat infertility, appetite suppression or weight loss medications, and medications used for cosmetic purposes such as hair growth products. In addition, benefits will not be provided for any refills if the prescription is more than one year old.

Please contact the prescription drug card vendor listed on your Plan I.D. card if you have any questions concerning which drugs or devices qualify for benefits.

Preventive Services

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

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

Benefit Payment for Prescription Drugs

Specialty Prescription Drugs and Prescriptions from a Retail Pharmacy

When you obtain drugs from a retail pharmacy or a specialty pharmacy, your Copay for each prescription or refill is:

	Retail or Specialty Pharmacy (31-day supply)	*Retail Pharmacy Only (90-day supply)**
Preventive Services	No Copay	No Copay
Generic Drugs	$10	$30
Brand-Name Drugs: Formulary	$35	$105
Non-Formulary	$60	$180

* *Specialty drugs are excluded from the "90-Day at Retail" benefit.*

Benefits will be provided for the remaining eligible charge.

If you fill a prescription at a retail pharmacy that is not a Participating Pharmacy, you must file a claim for reimbursement with the prescription drug card vendor. You will be reimbursed based on the prescription drug card vendor's discounted price (which will be less than your cost), less the applicable Copay.

Maintenance Prescription Drugs Purchased from the Mail Order Pharmacy

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

Preventive Services		No Copay
Generic Drugs		$25.00
Brand-Name Drugs:	Formulary	$87.50
	Non-Formulary	$150.00

Maintenance drug prescription means up to a 90-consecutive-day supply of a drug. Specialty drugs are not available through the maintenance drug Mail Order Pharmacy.

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

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

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

1. **Alternative Therapies.** No benefits will be paid for alternative therapies including but not limited to aromatherapy, light therapy, rolfing, homeopathy, hydrogen peroxide, magnetic, naturopathic, acupuncture or chelation therapy (except for the extraction of heavy metal poisoning), massage therapy or any other treatments that are not conventional or the treatment of choice by mainstream medicine.

2. **Behavior Modification.** No benefits will be paid for milieu therapy; any confinement in an institution primarily to change or control one's environment; services or treatment of behavioral problems, learning disabilities, or dysfunctional relationships.

3. **Biofeedback**. No benefits will be paid for biofeedback.

4. **Close Relative.** No benefits will be paid for services rendered by a Physician, Nurse, licensed therapist or other covered provider, if such Physician, Nurse, licensed therapist or other covered provider is a Close Relative of the Covered Person, or resides in the same household as the Covered Person.

5. **Cosmetic.** No benefits will be paid for charges Incurred in connection with, including any complications resulting from, the care, treatment or Surgery performed for a Cosmetic Procedure. This exclusion will not apply, as allowed by applicable law, when:
   a. Such treatment is rendered to correct a Condition resulting from an Accidental Injury;
   b. When reconstructive Surgery is performed for the treatment of a disease, but only if the disease is considered a covered Condition under the Plan; or
   c. When rendered to correct a Medically Necessary congenital abnormality other than for psychological reasons.

6. **Counseling.** No benefits will be paid for counseling for marital difficulties, social maladjustment, pastoral issues, financial issues, behavioral issues, or lack of discipline or other antisocial action, except when specifically required to treat a Mental Health Illness Condition.

7. **Custodial.** No benefits will be paid for charges Incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use; in connection with Custodial Care, education or training; or actually Incurred by other persons.

8. **Effective Date.** No benefits will be paid for charges Incurred prior to the effective date of coverage under the Plan, or after coverage is terminated, unless otherwise stated in the Plan.

9. **Elective Abortions.** No benefits will be paid for elective abortions. However, this exclusion does not apply to charges Incurred for treatment of complications arising during the course of an elective abortion or if the life of the mother is endangered.

10. **Equipment.** No benefits will be paid for charges related to:
    a. Personal comfort or convenience items including, but not limited to, air conditioners, humidifiers and purifiers, exercise therapy equipment, ramps, elevators, TDD/TTY communication devices and personal safety alert systems. This exclusion also applies to expenses Incurred for the modification of homes, vehicles or personal property to accommodate patient convenience.
    b. Purchase or rental of luxury medical equipment when standard equipment is appropriate for the patient's Condition (for example, motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).

11. **Exercise Programs**. No benefits will be paid for charges Incurred for participation in exercise programs, including Phase III cardiac rehabilitation programs.

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

13. **Feet.** No benefits will be paid for charges resulting from the treatment of weak, unstable or flat feet, bunions (unless an open cutting procedure is performed), corns, calluses, toenails (unless part of the nailbed or nail root is removed), orthopedic shoes, modative inlays or inserts, foot orthotics or custom molded orthotics.

14. **Felonious Act.** No benefits will be paid for charges resulting from or occurring during the commission of a Felonious Act or aggravated assault by the Covered Person; or while the Covered Person is engaged in an illegal occupation.

15. **Fertility.** No benefits will be paid for charges related to, or in connection with, fertility studies, sterility studies, procedures to restore or enhance fertility (including fertility drugs), artificial insemination, in-vitro fertilization, gamete intra-fallopian transfer (G.I.F.T. Program) or similar programs or infertility medication or testing.

16. **Food Supplements.** No benefits will be paid for charges related to food supplement or augmentation, in any form (unless Medically Necessary to sustain life in a critically ill person).

17. **Government.** No benefits will be paid for charges Incurred while confined in a Hospital owned or operated by the United States Government or any agency thereof; or charges for service, treatment or supplies furnished by the United States Government or any agency thereof; unless applicable law requires the Plan to pay.

18. **HMO.** No benefits will be paid for services rendered to an employee who is covered under a Company-sponsored HMO or similar organization.

19. **Legally Obligated.** No benefits will be paid for charges Incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay, that would be covered by a grant; or for which a charge would not ordinarily be made in the absence of this coverage. Not to be affected by this exclusion is the Plan's liability as outlined in the section entitled "Coordination of Benefits" in connection with another plan that is an HMO.

20. **Medically Necessary.** No benefits will be paid for charges Incurred in connection with services and supplies which are:

    a. Not Medically Necessary for the treatment of an Injury or Illness; or

    b. Not recommended and approved by a Physician unless specifically shown as a Covered Expense elsewhere in the Plan.

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

    Charges for services, supplies or treatment not recognized by the Food and Drug Administration, National Institute of Health or the Centers for Medicare and Medicaid Services (CMS) as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the Food and Drug Administration, National Institute of Health or CMS as having no medical value.

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

21. **Mental Health/Substance Abuse.** No benefits will be paid for professional services in connection with Mental Health Illness, Substance Abuse, functional nervous disorders or for

psychiatric or psychoanalytic care for any reason unless such services are rendered by a covered Mental Health Illness/Substance Abuse provider as outlined in the “Definitions” section.

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

23. **Not Covered.** No benefits will be paid for services or supplies that are not specifically covered under this Plan.

24. **Nursing.** No benefits will be paid for private duty nursing services.

25. **Obesity.** No benefits will be paid for treatment of obesity including but not limited to suction lipectomy, weight reduction, dietary consultations, or surgical treatment of obesity or complications thereof. X-ray and laboratory tests performed to determine the cause of obesity are covered.

26. **Occupation/Occupational.** No benefits will be paid for:

    a. Charges arising out of or in the course of any occupation for wage or profit that a Covered Person has with another employer. Another employer includes being self-employed; however, self-employed is not intended to include minors with jobs such as a paper route.

    b. Charges for which benefits are available under any workers’ compensation or occupational disease law, or any such similar law which applies to any company the Covered Person works for, whether or not such coverage is actually in effect.

    c. Charges for which benefits are available under any workers’ compensation coverage provided by the Company for their employees. However, if benefits are denied under such coverage, expenses may be eligible under the Plan.

27. **Period of Coverage.** No benefits will be paid for charges Incurred prior to or after any period of coverage under this Plan, except as specifically provided herein.

28. **Physician.** No benefits will be paid for:

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

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

29. **Reasonable, Usual and Customary.** No benefits will be paid for charges which exceed the Reasonable, Usual and Customary charge as defined in this Plan.

30. **School.** No benefits will be paid for services rendered or billed for by a school or half-way house or a member of its staff.

31. **Sex.** No benefits will be paid for services related to sex transformations, non-organic sexual dysfunctions or inadequacies. Any implants or sexual counseling is excluded regardless of the cause.

32. **Smoking.** No benefits will be paid for services rendered for the purpose of nicotine addiction, e.g., hypnosis, stop smoking clinics and programs. However, this exclusion does not apply to smoking cessation medications which are covered under the Outpatient Prescription Drug Card Benefit or to the Physician office visit in which the medication is prescribed.

33. **Sterilization.** No benefits will be paid for charges resulting from or in connection with the reversal of sterilization procedures.

34. **Teeth.** No benefits will be paid for charges Incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes. However, this exclusion does not apply to charges Incurred for the following:

a. The removal of completely bony impacted wisdom teeth (no allowance for other extractions) on an Outpatient basis unless Hospital confinement is Medically Necessary. Charges will be eligible for medical benefits only after such charges have been considered by the Covered Person's dental plan;

b. The removal of tumors in the oral cavity;

c. Treatment required because of Accidental Injury as outlined in the section "Medical Expense Covered Charges"; and,

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

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

No benefits will be paid for charges for appliances, medical or surgical treatment for correction of malocclusion or protrusion or recession of the mandible; maxillary hyperplasia, or maxillary hypoplasia. (Malocclusion occurs when teeth do not fit together properly, which is also referred to as a "bite problem;" mandible protrusion or recession; "underbite," or which the chin is excessively large; "overbite," or when the chin is abnormally small; maxillary hyperplasia, or "overbite" due to excess growth of upper jaw; maxillary hypoplasia, or undergrowth of upper jaw).

35. **Temporomandibular Joint.** No benefits will be paid for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether services are considered to be medical or dental in nature.

36. **Testing.** No benefits will be paid for any examination or procedure performed for screening, surveys, research or an examination rendered in connection with a physical examination ordered or required for the use of a third party, educational testing or training, including Intelligence Quotient testing, or court-ordered evaluations or programs (unless deemed Medically Necessary).

37. **Travel.** No benefits will be paid for charges Incurred outside the United States if the Covered Person traveled to such a location for the purpose of obtaining medical services, drugs or supplies. The exclusion does not apply to charges Incurred while outside the United States for the purpose of business, travel or education, so long as the charges meet all other criteria for a Covered Expense.

38. **Ultrasounds.** No benefits will be paid for ultrasounds or other tests performed solely to determine a fetal age or fetal sex.

39. **Vision.** No benefits will be paid for:

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

    b. Any expense for orthoptics and any other form of vision training and therapy, including any devices used in such training. Radial keratotomy, keratoplasty, keratomileusis, photorefractive keratectomy (PRK) or any other eye Surgery to improve nearsightedness, farsightedness and/or astigmatism, or to correct, treat or improve any related Conditions or causes of these Conditions.

40. **Vocational Services.** No benefits will be paid for vocational or training services. However, this exclusion will not apply to education services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be Medically Necessary by the Plan.

41. **War.** No benefits will be paid for charges Incurred as a result of war or any act of war, whether declared or undeclared, when the Covered Person is an active member of the armed forces of any country or caused during service by a Covered Person in the armed forces of any country. Excluded charges also include treatment of an Illness or Injury sustained due to a Covered Person's participation in any act of aggression or any terrorist activity.

42. **Weekend Admissions.** No benefits will be paid for charges Incurred for weekend admissions, including Friday, unless for Accidents, life-threatening Conditions, maternity or when Surgery is scheduled on that day or before 10:00 a.m. the following day.

43. **While Imprisoned.** No benefits will be paid for charges Incurred for treatment of an Illness or Injury sustained while a Covered Person was incarcerated, or in the custody of any Federal, State or Local authority.

44. **Wig**. No benefits will be paid for wigs regardless of the reason for hair loss.

DEFINITIONS

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

ACA

"ACA" means the Affordable Care Act as amended by the Health Care and Education Reconciliation Act (March 2010).

Accident

"Accident" means an unintentional or unexpected happening which:

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

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

Active Service

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

Ambulatory Surgical Center

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

Birthing Center

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

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

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

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

Brand-Name Drug

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

Calendar Year

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

Claims Administrator

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

Close Relative

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

COBRA

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

Coinsurance

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

Company

"Company" is as defined in the "Introduction" section.

Condition

See definitions of "Illness" and "Injury."

Copay

"Copay" means that amount shown in any benefit schedule which is the Participant's responsibility for charges Incurred for doctor's office visits, prescription drugs, or other services. Copays do not apply toward satisfaction of the Deductible or the Coinsurance limit, unless otherwise specified.

Cosmetic Procedure or Cosmetic

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

Covered Charges or Covered Expenses

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

Covered Person

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

Craniomandibular Disorder

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

Custodial Care

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

Deductible

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

Dependent

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

Dependent Coverage

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

Durable Medical Equipment

The term “Durable Medical Equipment” means equipment which is:

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

Eligible Expenses

See definition of “Covered Charges” or “Covered Expenses.”

Emergency Medical Condition

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

Emergency Services

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

Employer

“Employer” is the Company, as defined in the “Introduction” section.

Enrollment Date

“Enrollment Date” means the earlier of the effective date of coverage or the first day of the Waiting Period, if any, for coverage. The Enrollment Date for Late Enrollees or individuals enrolling during a Special Enrollment Period is the actual date of coverage.

ERISA

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

Essential Health Benefits

“Essential Health Benefits” means essential health benefits under section 1302(b) of the Affordable Care Act (ACA) and applicable regulations. Section 1302(b) of ACA defines such benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including pediatric oral and vision care.

Experimental, Investigational/Investigative or Unproved

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

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

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

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

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

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

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

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

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

Extended Care Facility

See definition of "Skilled Nursing Facility."

Family

"Family" means a Participant and eligible Dependents.

Felonious Act

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

Generic Drug

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

Health Breach Notification Rule

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

HIPAA

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

Home Health Care Agency

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

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

Home Health Care Plan

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

Hospice

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

Hospice Benefit Period

"Hospice Benefit Period" means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the Covered Person's attending Physician

certifies a diagnosis of terminally ill, and the Covered Person is accepted into a Hospice program. The period will end the earliest of six months from this date or at the death of the Covered Person. A new benefit period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof may be required by the Plan Administrator before such a new benefit period can begin.

Hospital

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

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

Hospital Miscellaneous Expenses

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

Illness

"Illness" means a disorder or disease of the body or mind, or pregnancy as classified in the ICD.9.CM Manuals (or updated version). All Illnesses due to the same cause, or to a related cause, will be deemed to be one "Illness."

Incurred

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

Injury

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

Inpatient

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

Intensive Outpatient Plan or Partial Hospitalization

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

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

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

Late Enrollee

"Late Enrollee" means an individual who declines enrollment or is not enrolled in the Plan at the earliest regular opportunity for any reason other than because the individual has other verified health insurance at the time he failed to enroll. "Late Enrollee" does not include any individual who qualifies under a Special Enrollment Period.

Legal Guardianship

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

Maintenance Care

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

Maximum Amount or Maximum Allowable Charge

"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 and Reasonable 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.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Necessity or Medically Necessary

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

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

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

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

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

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

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

Medical Record Review

"Medical Record Review" is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the medical record review and audit results.

Medicare

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

Mental Health Illness

"Mental Health Illness" includes, but is not limited to, schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive Illness), anxiety disorders, somatoform disorders, personality disorders, psychosexual disorders, and bipolar affective disorders or any psychiatric disorder caused by chemical imbalance, as classified in the ICD9.CM Manual or updated version.

Named Fiduciary

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

Nurse

"Nurse" means any of the following:

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

Open Enrollment Period

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

Orthotic Appliance

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

Outpatient

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

bedpatient at that Hospital, an Outpatient Psychiatric Facility or an Outpatient Alcoholism Treatment Facility.

Outpatient Alcoholism Treatment Facility

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

Outpatient Psychiatric Facility

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

Participant

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

Participant Coverage

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

Physician

"Physician" will include the following health care providers:

1. **Physician.** "Physician" means a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, optometrist, Physician assistant, physical therapist, speech therapist, occupational therapist, audiologist, speech language pathologist, certified consulting psychiatrist, psychologist or licensed or certified mental health/Substance Abuse provider to the extent they, within the scope of their license, are permitted to perform the services provided in this Plan.
2. **Mental Health/Substance Abuse Provider.** "Mental Health/Substance Abuse Provider" means a legally licensed psychiatrist, psychologist, licensed or certified social worker, clinical psychiatric counselor or psychiatric Nurse clinician. In states where licensing and certification are not available, this Plan will recognize a provider that holds a Masters level degree in the field of mental health or Substance Abuse.
3. **Nurses.** Nurses, as defined herein.

Plan

"Plan" means the Company's employee welfare benefit plan, which is described in this Summary Plan Description.

Plan Administrator

"Plan Administrator" means the Company.

Pre-admission Testing

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

Pre-existing Condition

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

Preventive Service

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

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

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

Psychiatric Care

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

QMCSO

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

Reasonable

"Reasonable" and/or "Reasonableness" shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. 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.

Residential Treatment Facility

"Residential Treatment Facility" means a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

a. It is established and operated in accordance with applicable state law for residential treatment programs.

b. It provides a program of treatment under the active participation and direction of a Physician.

c. It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.

d. It provides at least the following basic services in a 24-hour per day, structured milieu:

    (1) Room and board.

    (2) Evaluation and diagnosis.

    (3) Counseling.

    (4) Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Room and Board

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

Skilled Nursing Facility

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

1. It is licensed to provide, and is engaged in providing on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Nurse under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;

2. Its services are provided for compensation from its patients and under full-time supervision of a Physician or Registered Nurse;
3. It provides 24-hour-per-day nursing service by licensed Nurses, under the direction of a full-time Registered Nurse;
4. It maintains a complete medical record on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally retarded persons, Custodial Care, educational care or care of mental disorders; and
7. It is approved by Medicare and licensed by the state in which it is located.

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

Substance Abuse

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

Substance Abuse Treatment

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

Substance Abuse Treatment Facility

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

Summary Plan Description

"Summary Plan Description" means this Plan Document and Summary Plan Description, which constitutes both the Plan Document and the "Summary Plan Description" or "SPD" required by ERISA.

Surgery

"Surgery" means only the following:

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

9. *Diagnostic and therapeutic endoscopic procedures.

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

TMJ Dysfunction

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

Totally Disabled

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

Traumatic Event

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

Urgent Care

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

Usual and Customary

"Usual and Customary" (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 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 for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

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

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

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

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

Well Baby Care

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

Well Child Care

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

COORDINATION OF BENEFITS PROVISION

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

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

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

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

Definitions

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

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

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

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

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

Coordination Procedure

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits payable under all plans will not exceed the total of Allowable Expenses Incurred during any Claim Determination Period.

Payments

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

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

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

child as a dependent child will pay third. A plan that pays third will only pay benefits if there are unpaid allowable expenses after the first and second plans have paid.

6. If a person is a covered active employee under one plan and a covered retired or laid off employee under another plan, the plan that covers the person as an active employee or a dependent of an active employee is the primary plan.

7. If a person covered under a right of continuation pursuant to federal or state law is also covered under another plan, the plan that covers the person as an employee, member or subscriber is the primary plan and the plan providing continuation coverage is secondary.

8. If the order described above fails to establish the order of payment, then the plan which the person has been covered for the longest period of time is the primary plan.

9. In the event that you or your Dependent is covered by another group medical plan which, by its terms:

    a. The plans cannot agree on the primary versus secondary order; or

    b. Provides that it is secondary to other health plans, and the provisions of this Plan would make coverage under this Plan secondary to other applicable health plan coverage;

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

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

The Plan Administrator has the right:

1. To obtain or share information with an insurance company, Plan Administrator or other organization regarding coordination of benefits without the claimants consent;

2. To require that the claimant provide the Plan Administrator with information on such Other Plans so that this provision may be implemented; and

3. To refund the amount due under this Plan to an insurer, plan or other organization if this is necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

Accumulation of Benefit Savings

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

Facility of Payment

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

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

Right of Recovery

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

COORDINATION WITH MEDICARE

If You or Your Dependent are Eligible for Medicare:

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

1. An active employee or spouse of an active employee age 65 or over.
2. An employee or his covered Dependent who is less than age 65 and covered under the Plan by virtue of his current employment status (as defined by Medicare) and eligible for Medicare by reason of a disability condition other than End Stage Renal Disease. However, this provision does not apply when the Employer has less than 100 employees.
3. A Covered Person eligible for Medicare due to End Stage Renal Disease during the period defined by Federal regulations in effect at the time the claim is incurred.

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

Active Employees Age Sixty-Five And Over

If you will soon be age 65, check your eligibility for Medicare prior to your 65th birthday. As long as you are an employee in Active Service past the age of 65, you will be eligible for the same health benefits as employees under age 65 in Active Service.

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

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

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

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

FIRST AND/OR THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Benefits Subject to This Provision

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

When This Provision Applies

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

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

If requested, the Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;

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

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

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

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

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

Amount Subject to Subrogation or Reimbursement

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

"Another Party"

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

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

"Recovery"

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

"Subrogation"

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

Right of Reimbursement

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

"Reimbursement"

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

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to

the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

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

When the Covered Person is a Minor or is Deceased

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

When a Covered Person Does Not Comply

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

PRIVACY STANDARDS

1. Disclosure of Summary Health Information to the Plan Sponsor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

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

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

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

5. Other Disclosures and Uses of PHI

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

SECURITY PRACTICES

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

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

1. Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

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

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

4. Report to the Plan any Security Incident of which it becomes aware;

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

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

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

CLAIM PROCEDURES

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

Claims

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

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

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

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

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

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

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

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

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

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

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

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

When Claims Must Be Filed

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 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 Participant has failed to submit required forms or additional information to the Plan as well.

Clean Claims must be filed with Professional Benefit Administrators, Inc. (PBA) within one year of the date charges for the service were Incurred or, if sooner, within 180 days following the date the Company changes carriers under this Plan. Should the Plan be terminated, Clean Claims must be filed within 90 days following the date of termination. Benefits are based upon the Plan's provisions at the time the charges were Incurred (or, in the case of disability claims, at the time of the onset of the disability). Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.**

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

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

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

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

Timing of Claim Decisions

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

1. Pre-service Urgent Care Claims.

   a. If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

   b. If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:

      (1) The Plan's receipt of the specified information; or

      (2) The end of the period afforded the claimant to provide the information.

2. Pre-service Non-urgent Care Claims.

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

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

3. Concurrent Claims.

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

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

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

4. Post-service Claims.

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

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

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

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

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

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

Notification of an Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

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

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate Named Fiduciary of the Plan, who will be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
7. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the Plan Administrator or Professional Benefit Administrators, Inc. (PBA); information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and
8. In an Urgent Care Claim, for an expedited review process pursuant to which:
    a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
    b. All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

First Appeal Level

Requirements for First Appeal

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

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

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

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

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

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

1. The name of the Employee/claimant;
2. The Employee/claimant's individual identification number printed on the Plan I.D. Card;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

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

Timing of Notification of Benefit Determination on First Appeal

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

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

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

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

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document and Summary Plan Description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion

was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures;
9. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims;
10. A statement of the claimant's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

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

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

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

Timing of Notification of Benefit Determination on Second Appeal

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

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

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

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

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

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

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Second Appeal

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

External Review

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

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

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

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

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

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from Professional Benefit Administrators, Inc.

(PBA). However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the claimant's medical Condition to act as the claimant's authorized representative without completion of this form. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

COBRA CONTINUATION COVERAGE

Introduction

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

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

Westminster Village West Lafayette, Inc.
2741 N, Salisbury Street
West Lafayette, IN 47906
(765) 463-7546

What is COBRA Continuation Coverage?

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

What is a Qualifying Event?

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

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

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

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

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

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

1. The parent-Covered Employee dies;
2. The parent-Covered Employee's hours of employment are reduced;
3. The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);

5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

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

The employer must give notice of some Qualifying Events

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

You must give notice of some Qualifying Events

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

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

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

Deadline for providing the notice

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

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

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

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

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

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

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

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

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

Who can provide the notice

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

Required contents of the notice

The notice must contain the following information:

1. Name and address of the Covered Employee or former employee;
2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age or other);
7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. **If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.**

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

If the Qualified Beneficiary is totally incapacitated and is not legally competent to make an election for COBRA continuation coverage, the 60 day election period is tolled until such time as the Qualified Beneficiary is able to make an election or a guardian or legal representative is appointed who is able to make the election on behalf of the Qualified Beneficiary.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event; however, if the first Qualifying Event is the Covered Employee's entitlement to Medicare benefits, followed by termination or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of (i) 36 months after the date the Covered Employee became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a

Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any dependent children receiving COBRA Continuation Coverage if the Covered Employee or former employee dies, or gets divorced or legally separated, if the dependent child stops being eligible under the Plan as a dependent child, or becomes entitled to Medicare benefits (under Part A, Part B, or both), **but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.**

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date your employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules) However, a Qualified Beneficiary who becomes covered under a group health plan which has a Pre-existing Condition limit must be allowed to continue COBRA Continuation Coverage for the length of a Pre-existing Condition or to the COBRA maximum time period, if less; or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator.

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator will make a charge of $.25 for each page.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

GENERAL PLAN INFORMATION

Name of Plan

The name of the Plan is the Westminster Village West Lafayette Group Health Plan.

Plan Sponsor

The Plan Sponsor is the Company. The Plan Sponsor will have the authority to amend and terminate the Plan, determine its policies, appoint and remove other supervisors, fix their compensation and exercise general administrative authority over them.

Plan Sponsor's Employer Identification Number

The Plan Sponsor's Employer Identification Number (EIN) is 31-1002846.

Named Fiduciary, Plan Administrator

The Named Fiduciary and Plan Administrator is the Company. The Plan Administrator may delegate certain ministerial functions which do not require the use of discretionary authority to the Claims Administrator.

Plan Year

January 1 through December 31

Plan Number

501

Plan Type

Medical

Contributions to the Plan

Contributions are to be made on the following basis:

The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed (if any) by each Participant, in its sole discretion. Any employee contributions are used by the Plan for the payment of claims.

In the event that the Plan Sponsor terminates the Plan, then as of the effective date of termination, the Plan Sponsor and Participants will have no further obligation to make additional contributions to the Plan for claims Incurred after the date of termination.

Plan contributions for PARTICIPANT and DEPENDENT Coverage are shared by the Company and employee.

If you elect to have your contribution for coverage deducted from your pay on a pre-tax basis under the Company's Section 125 plan, you will only be allowed to change your coverage election during the annual Section 125 election period or, if sooner following a change in family status as defined in the Company's Section 125 plan.

Contributions and Benefits

The tax treatment of contributions and/or benefits under this Plan is governed by Section 105(b) and Section 152 of the Internal Revenue Code and is the sole responsibility of the Participant.

Effective Date

The effective date of the Plan is January 1, 2010. The effective date of this Plan Document and Summary Plan Description is January 1, 2014.

Claims Administrator

The Claims Administrator of the Plan is Professional Benefit Administrators, Inc. ("PBA"), 900 Jorie Boulevard, Suite 250, Oak Brook, Illinois 60523-3827.

The Company, Plan Sponsor, Plan Administrator and Agent for Service of Process

The agent for service of process is:

Plan Administrator
Westminster Village West Lafayette, Inc.
2741 N. Salisbury Street
West Lafayette, IN 47906
(765) 463-7546

The Plan is a distinct legal entity separate from the Company. As such, legal notice may be filed with, and legal process served upon, the Plan Administrator.

Plan Construction, Type of Administration and Funding

This Summary Plan Description will be construed in accordance with ERISA and, where not preempted, the laws of the state in which the Plan Sponsor is located.

This is a self-funded Plan with a Claims Administrator. The Plan Administrator is responsible for all claims decisions, and the Plan Sponsor is responsible for providing funds for the payment of the claims out of its general assets.

Masculine pronouns used in this Summary Plan Description will include masculine or feminine gender unless the context indicates otherwise.

Wherever any words are used herein in the singular or plural, they will be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Purpose

The purpose of this Summary Plan Description is to set forth the provisions of the Plan which provide for the payment or reimbursement of a portion of the eligible medical expenses. The Plan Sponsor's purpose in establishing the Plan is to help to offset, for Eligible Employees, the economic effects arising from a non-occupational Injury or Illness. To accomplish this purpose, the Plan Sponsor and the Plan Administrator must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Summary Plan Description, to allow for allocation of the resources available to help those individuals participating in the Plan to the maximum feasible extent.

GENERAL PROVISIONS

Amendments or Changes

The terms of this Plan will not be amended or changed except as provided below under the section entitled “Amending and Terminating the Plan.”

Plan Is Not A Contract

This Plan will not be deemed to constitute a contract of employment, give any Participant the right to be retained in the service of the Company or interfere with the right of the Company to discharge or otherwise terminate the employment of any Participant.

Protection Against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or to become due to any Participant (or former Participant), the Plan Administrator, in its sole discretion, may terminate the interest of such person. In such case, the Plan Administrator will determine how to apply the payment to the benefit of the Participant (or former Participant) or his/her estate. Any such application shall be complete discharge of all liability with respect to such benefit payment.

Free Choice of Physician and Treatment

The Covered Person has free choice of any Physician or surgeon, and the Physician-patient relationship will be maintained. The Covered Person, together with his Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of such care. Providers who are members of any network used by the Plan are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any provider. The Plan will not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any officer or employee or on the part of any Physician in the course of performing services for Covered Persons.

Alternate Care and Treatment

Alternate forms of care and treatment, which can be provided without impairing the quality of care, if recommended by utilization management, and if approved by the Plan Administrator can be considered a Covered Charge. Alternate treatment or care which is not included in the Plan, is included in the Plan but is limited, or is included in the Plan but on a basis that differs from the care and treatment now recommended, will be payable under the Plan on the same basis as the care and treatment for which they are substituted if it can be shown to be cost effective. This is subject to the approval of the Plan Administrator, Covered Person, the Covered Person’s Family, and the Attending Physician.

This provision is not intended to override the Experimental or Investigational treatment exclusion or any lifetime maximum contained in the Plan.

Workers’ Compensation Not Affected

This Plan is not in lieu of, and does not affect, any requirement for coverage by workers’ compensation insurance.

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any workers’ compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that the Participant received or is eligible to receive workers’ compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless

of the amount or terms of any settlement the Participant receives from workers' compensation. The Plan will exercise its right to recover against the Participant.

A Participant is required to notify the Plan Administrator immediately when a claim for coverage under workers' compensation is filed if a claim for the same Injury or Illness is or has been filed with this Plan.

Rights in Recovery

Whenever payments have been made by the Plan Administrator with respect to allowable expenses in excess of the amount of payment necessary to satisfy the intent of this Plan, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to recover such excess payments. Further, the Plan Administrator reserves the right to deduct the amount of any excess payment from future benefits to which a Participant or any of his covered Dependents may become entitled. This right of recovery also applies when a Covered Person, or any plan that pays benefits for which benefits are also paid by the Plan, receives duplicate payments under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

Physical Examination/Consultation/Peer Review

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

The Plan Administrator also has the right to seek and utilize the professional opinion of consultants, peer review and other such entities for the purpose of determining the eligibility of both individuals and claims under this Plan. The expenses related to these services will be considered an eligible expense under this Plan, but only for a Covered Person.

Legal Proceedings

No action at law or in equity shall be brought to recover from the Plan prior to the expiration of 90 days after all administrative remedies under the Plan have been exhausted, nor will such action be brought at all unless brought within three years from the time all administrative remedies under the Plan have been exhausted.

Conformity With Law

This Plan will be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Summary Plan Description. It is intended that the Plan will conform to the requirements of ERISA and ACA, as it applies to group health plans, as well as any other applicable law.

GINA

"GINA" means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

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

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

The term Genetic Information includes participating in clinical research involving genetic services.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes.

This Plan will not discriminate in any manner with its participants on the basis of such Genetic Information.

Rescission

The Plan may rescind coverage for a Covered Person if the individual (or a person seeking coverage on behalf of the individual):

1. Performs an act, practice or omission that constitutes fraud; or
2. Makes an intentional misrepresentation of a material fact.

Both such items are prohibited by the terms of this Plan. The Plan Administrator will determine whether an action or inaction constitutes fraud or an intentional misrepresentation of a material fact.

The Plan will provide 30 days advance written notice of any rescission. The rescission can affect the Covered Person's entire family, even if only one individual committed the fraud or misrepresentation.

Examples of fraud include, but are not limited to, the following:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

In the event of any rescission, the Plan's notice of rescission of coverage is considered to be an adverse benefit determination under the law. Claimants have the right to appeal an adverse benefit determination. A description of how to file an appeal is outlined under the "First Appeal Level" and "Second Appeal Level" of the "Claim Procedures" section. The first appeal must be filed within 180 days following receipt of the Plan's notice of rescission of coverage. After the claimant has exhausted the internal appeals process, the claimant has a right to submit a request for external review.

Plan Administration

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of Professional Benefit Administrators, Inc. to provide certain claims processing and other technical services.

The Plan is administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

When the Company acquires a new unit, whether through acquisition, merger or any other transaction, the employees of the new unit may become eligible under this Plan, waiving any and all Waiting Periods. The Plan Sponsor maintains the right to make the election to do this on an acquisition, merger or transaction basis, as business needs dictate.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. If this Plan is subject to, in whole or in part, one or more collective bargaining agreements, the Plan is intended to automatically comply with any such agreement that has valid bearing on this Plan, whether or not the Plan has been specifically amended or modified. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to

eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. In the event of administrative error or oversight, the Plan Administrator has the right to determine the effective date or termination date of coverage. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, will receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

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

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which will be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. Notice will be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination will be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action will be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan will become effective as of a date established by the Plan Sponsor. Contributions by the Plan Sponsor will continue to be issued for the purpose of paying benefits under this Plan with respect to claims arising before such termination.

Indemnification of Employees

Except as otherwise provided by ERISA, no director, officer or employee of the Company or the Claims Administrator will incur any personal liability for the breach of any responsibility, obligation or duty in connection with any act done or omitted to be done in good faith in the administration or management of

the Plan; and each such director, officer and employee will be indemnified and held harmless by the Company from and against any such liability, including all expenses reasonably Incurred in their defense if the Company fails to provide such defense.

Assignment of Benefits

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

Clerical Error

Clerical error on the part of the Plan Administrator or Claims Administrator in keeping the records in connection with a Participant's coverage will not invalidate coverage otherwise in force, nor continue coverage otherwise terminated.

Manuals

Manuals and reference material used by the Plan in order to determine the appropriate administrative procedures, appropriate diagnosis, Usual and Customary allowances and Medical Necessity of claims submitted in compliance with this Summary Plan Description include, but are not limited to, the following:

1. ICD.9.CM (or updated version)
2. Usual and Customary Data Bases, Fee Schedules and Claims Edit Programs
3. 1964 California Relative Value Study (C.R.V.S.)
4. CPT 4 (or updated version)
5. Physician's Desk Reference
6. Merck Manual
7. Taber's Cyclopedic Medical Dictionary
8. The Kennedy Series Medical/Disability and Dentistry Handbooks
9. The Medical Disability Advisor
10. The Hayes Manuals
11. The Trilogy Consulting Group Manuals (as modified by PBA administrative memos)
12. Others as developed or needed
13. Red Book or other NDC References.

Provision Enforcement

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect the right to enforce any other provision of this Plan.

Severability

If any provision within the Plan Document is found to be invalid or illegal, that finding only applies to those such provisions and such a finding will not have any affect or change the obligations of the parties as to the remaining sections and be severable.

Section Titles

Section titles are for convenience of reference only, and are not to be considered in interpreting this Plan.

Active Military Duty

Reservists who are covered under the Plan and who are called to active military duty will be eligible for coverage as outlined in the USERRA Act of 1994 according to the following:

1. Employees - who return under the parameters of the USERRA Act of 1994.
2. Employees - on the day they return to full-time Active Service with the Employer.
3. Dependents - on the day the Dependent meets the definition of an eligible Dependent under the Plan.

Credit will be given toward satisfaction of any required Waiting Period and reinstatement of coverage will comply with HIPAA.

Quality of Care Provision

This provision allows the Plan Administrator, based upon a case management recommendation, to approve as an Eligible Expense, a treatment technique not addressed by this Plan. If the Plan utilizes a Preferred Provider Organization ("PPO"), the Plan Administrator may recommend and approve a non-PPO Physician or Hospital that is recognized, in its opinion, to be significantly superior in the treatment of the applicable diagnosis to warrant this special consideration, and to pay this Physician and facility as if they were PPO providers.

Foreign Claims

In the event a Covered Person incurs a Covered Expense in a foreign country due to an unexpected Illness or Injury, the Covered Person will be responsible for providing the following information to the Claims Administrator before reimbursement of any benefits due are payable.

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. Proof that the bills have been paid. Benefits cannot be assigned to a non-U.S. provider.

A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must also be submitted with the claim.

Unclaimed Payments

Any benefit payment issued under the Plan that is not cashed by the payee within the 12-month period immediately following its date of issue will be considered void and will only become a Plan liability upon receipt of the employee's written request for re-issuance. Such request must be made within the 24-month period immediately following the date the benefit payment was issued. Any request that is filed later will be denied.

RECEIPT OF SUMMARY PLAN DESCRIPTION

I, _____, acknowledge the receipt of my Summary Plan Description on _____. I
(NAME) (DATE)

understand that it is important to read the entire Summary Plan Description to fully understand the extent of my coverage under the Plan, and that I must read my Continuation Rights under COBRA.

_____ _____
SIGNATURE DATE

RECEIPT OF SUMMARY PLAN DESCRIPTION

I, _____, acknowledge the receipt of my Summary Plan Description on _____.
(NAME) (DATE)

I understand that it is important to read the entire Summary Plan Description to fully understand the extent of my coverage under the Plan, and that I must read my Continuation Rights under COBRA.

SIGNATURE

DATE